STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115545	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jonesboro Center for Nursing and Healing LLC	2650 Highway 138 SE Jonesboro, GA 30236

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy titled, Advance Beneficiary Notices, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) as required for three of three sampled residents (Resident (R) 160, R76, and R103) reviewed for beneficiary notices out of a sample of 50 residents. This failure had the potential to lead to financial burdens for residents, as they may have to pay out-of-pocket for care that is typically covered by Medicare.Findings include:Review of the facility provided policy titled, Advance Beneficiary Notices with a revision date of 11/23 indicated Policy:. It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. Policy Explanation and Compliance Guidelines:. 1. The Business Office Manager is the contact person for information regarding Medicare eligibility, coverage, and applying for benefits. A notice alerting residents/ representatives of this contact person shall be posted conspicuously in the facility. 2. The Business Office Manager will provide Medicare information to residents/ representatives upon request. 5. The current Centers for Medicare and Medicaid (CMS) approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulation regarding the use of the form: a. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), Form CMS-10055. 7. To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two-days before the end of a Medicare covered Part A stay when all of Part B therapies are ending. The notices must not be provided while the resident/ representative is under duress or in an emergency situation. 8. The Business Office Manager, or designee, is responsible for issuing notices. 10. Delivery requirements: a. The notice shall be written legibly in a language and/ or format that the resident/ representative understands. Verbal explanations detailing the reasons for the determination of possible non-coverage shall be provided. B. The notice shall be hand-delivered as possible to obtain beneficiary or representative signature. C. The notice shall be prepared with an original and at least two copies. The facility shall retain the original and give a copy to the resident/ representative. D. If the notice cannot be hand-delivered a telephone notice shall be made, followed up immediately with a mailed, emailed, faxed or hand-delivered notice. Documentation shall comply with form instructions regarding telephone notices. e. Mail, secure fax machine or internet e-mail may also be utilized for delivery of the notice if in-person issuance is not able to be performed and all methods of delivery must adhere to all statutory privacy requirements under HIPAA.1.Review R160's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed R160 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following a stroke, chronic kidney disease, stage 3, protein calorie malnutrition, and other personal risk factors.Review of R160's Notice of Medicare Non-Coverage (NOMNC), provided by the facility revealed it was provided to R160 by the facility and revealed R160's skilled nursing therapy services would end on 12/23/25. No SNF ABN was included.2. Review of R76's admission Record, located under the Profile tab of the EMR, revealed R76 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	following stroke, chronic kidney disease stage 5, vascular Dementia, type two diabetes with diabetic chronic kidney disease, dysphagia, depression, pain, and other personal risk factors.Review of R76's NOMNC, provided by the facility revealed it was provided to R76's representative and revealed R78's skilled nursing services will end on 01/25/26. No SNF ABN was included.3. Review of R103's admission Record, located under the Profile tab of the EMR, revealed R103 was admitted to the facility on [DATE] with a diagnosis of chronic kidney disease, stage 3, type 2 diabetes mellitus with diabetic arthropathy, Dementia with behavioral disturbance and Alzheimer's disease.Review of R103's NOMNC, provided by the facility revealed it was provided to R103's representative and revealed R103's skilled nursing services would end on 12/07/25. No SNF ABN was included. During an interview on 02/12/26 at 10:28 AM, the Minimum Data Set Coordinator (MDSC) revealed the new facility owners no longer have her sending NOMNC and SFN ABN to residents and their representatives but gave the responsibility to the Social Work Director (SWD) and the Business Office Manager (BOM).During an interview on 02/12/26 at 10:29 AM, the BOM revealed she does not do NOMNC and SNF ABN that the responsibility is with the SWD. She confirmed that when the new company purchased the facility, they changed it to where MDS no longer sends NOMNC and SNF ABN's out to the residents and their representatives. She confirmed MDSC previously issued Medicare Part A recipients the notices. During an interview on 02/12/26 at 10:31 AM, the SWD confirmed she did not send SNF ABN notices out with the NOMNC's. During an interview on 02/12/26 at 10:31 AM, the Director of Regulatory Compliance confirmed SNF ABN notices must be given with the NOMNC to the resident or resident representative. He confirmed the SNF ABN notices had not been sent out.During an interview on 02/12/26 at 2:19 PM, the Regional Director of Operations confirmed the facility has not sent out any SNF ABN notices.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, document review, and policy review, the facility failed to ensure tuna salad sandwiches were served at the proper temperature. This deficient practice had the potential to cause food born illnesses affect 115 out of 119 residents. Findings included: During the second kitchen observation and interview on 02/11/26 from 11:58 AM to 12:42 PM, the following observations were made with the Dietary Manager (DM):A small steam table pan was observed on the counter at the left end of the steam table. The steam table pan contained eight tuna salad sandwiches, stacked one on top of one another, in stacks of two. At 12:09 PM the [NAME] stated the tuna salad sandwiches were the alternate menu item and were ready to be served to residents in the dining room. The DM took the temperature of the tuna salad sandwiches; the temperature was 55 degrees Fahrenheit (F). The DM and the Registered Dietician (RD) stated the tuna salad sandwiches should be 41 degrees F to be served. The [NAME] stated she put the tuna sandwiches in the freezer to cool. At 12:20 PM the DM was observed making deli meat turkey sandwiches. The DM took the temperature which was 50 degrees F. There was more turkey sitting on ice next to where the DM was making sandwiches. The DM took the temperature, which was within the proper range. She proceeded to make turkey sandwiches for residents in the dining room. During an interview on 02/12/26 at 1:30 PM, the Director of Regulatory Compliance stated food that is served to residents should be served at the correct temperature.During an interview on 02/12/26 at 2:57 PM, the DM stated any cold food should be at least 41 degrees F and should be put on ice to maintain the correct temperature. Review of the facility's policy titled, Food Preparation and Service, dated 04/2024 revealed, Policy: Nutrition Services employees shall prepare and serve food in a manner that complies with safe food handling practices.All cold food on tray line should be held at 41 degrees F or colder.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy titled, Promoting/ Maintaining Resident Dignity, the facility failed to ensure staff dressed residents in daily clothing for one of one (Resident (R) 30) reviewed for dignity. This failure had the potential to cause embarrassment for the resident and failed to respect the resident's autonomy to maintain their personal identity.Findings include:Review of the facility provided a policy titled, Promoting/ Maintaining Resident Dignity, with a revision date of 03/25 indicated Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines:1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.Review of R30's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed R30 was admitted on [DATE] with a diagnosis of contracture of left knee.Revie of R30's Medicare five day Minimum Data Set (MDS), located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/07/26 revealed a Brief Interview for Mental Status (BIMS) score of six out of fifteen which indicated severe cognitive impairment and that R30 required partial to moderate assist for upper body dressing and was dependent for lower body dressing.Review of R30's Care Plan, located under the Care Plan tab of the EMR revealed R30 had an activity of daily living (ADL) self-care performance deficit requiring extensive to total assistance by one staff to dress initiated on 12/22/25.During an observation on 02/09/26 at 10:04 AM, R30 was lying in bed wearing a brief with a sheet across himself. R30 was not wearing any clothing. During an observation on 02/10/26 at 10:06 AM, R30 was lying in bed wearing a hospital gown. During an observation on 02/11/26 at 12:26 PM, R30 was lying in bed wearing a hospital gown. During an interview on 02/11/26 at 12:58 PM, Certified Nurse Assistant (CNA)7 was at R30's bedside and confirmed the resident was dressed in a hospital gown and that the resident should be in his own clothing as it is a dignity issue. CNA7 opened R30's armoire and confirmed that the resident had clothing he could be dressed in daily. During an interview on 02/11/26 1:09 PM, the Director of Nursing-Interim Regional Director of Clinical Operations (DON) confirmed residents should be dressed in their own clothing as it is more homelike and comfortable. She confirmed R30 should be dressed in his own clothing.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the facility policy titled, MDS3.0 Completion, the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) within the required timeframe when a resident experienced multiple areas of functional decline for one of five residents (Resident (R) 57) reviewed for resident assessments. This failure placed R57 at risk for further decline if care plan revisions and interventions addressing the resident's change in condition were delayed.Findings include:Review of the facility's policy titled, MDS3.0 Completion, dated October 2025, revealed, an SCSA within 14 days of identifying a qualifying status change that affects more than one area and requires Interdisciplinary Team review and revision of the care plan. Review of R57's admission Record, dated 02/12/26 located in the resident's electronic medical record (EMR) under the Profile tab, revealed R144 admitted to the facility on [DATE] with multiple diagnoses including Parkinson's disease (a progressive movement disorder of the nervous system).Review of R57's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/14/25, documentation revealed R57's Activities of Daily Living (ADL) assessment under the Section GG - Functional Abilities as follows: - Toileting: 05. Setup or clean-up assistance.- Upper body dressing: 05. Setup or clean-up assistance.- Lower body dressing: 05. Setup or clean-up assistance.- Personal hygiene:05. Setup or clean-up assistance. Review of R57's quarterly MDS, with an ARD of 06/13/25, revealed R57 had four areas of decline under Section GG-Functional Abilities as follows: - Toileting: 03. Partial/moderate assistance.- Upper body dressing: 03. Partial/moderate assistance.- Lower body dressing: 03. Partial/moderate assistance.- Personal hygiene:03. Partial/moderate assistance. During an interview and record review on 02/12/26 at 4:48 PM, the MDS Coordinator (MDSC) reviewed and compared R57's MDS record and confirmed that R57 had four areas of decline on the 06/13/25 quarterly MDS compared to the 03/14/25 annual MDS under Section GG. The MDSC stated that an SCSA MDS should have been completed with an ARD of 06/13/25 instead of a quarterly with an ARD of 06/13/25.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews, and review of the facility policy titled, MDS3.0 Completion, the facility failed to transmit Minimum Data Set (MDS) assessments within the federally required timeframe for two of five residents (Resident (R) 4 and R144) reviewed for Resident Assessments. This failure had the potential to affect the accuracy and timeliness of federally required resident assessments. Findings include:Review of the facility's policy titled, MDS3.0 Completion, dated October 2025, documented the MDS transmission requirements of All assessments shall be transmitted to the designated [Centers for Medicare and Medicaid Services] CMS System (iQIES) within 14 days of completion. 1. Review of R144's admission Record, dated 02/10/26 located in the electronic medical record (EMR) under the Profile tab revealed R144 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes, end stage renal disease, and dementia. Review of R144's admission MDS, with an Assessment Reference Date (ARD) of 06/12/25 and located in the EMR under the MDS tab indicated the admission MDS was completed on 06/18/25 and transmitted late on 07/03/25. During an interview and record review on 02/12/26 at 9:01 AM, the Minimum Data Set Coordinator (MDSC) reviewed R144's admission MDS and confirmed that the MDS was completed and dated 06/18/25 in the EMR system. She stated that the requirement was to submit the MDS to the Internet Quality Improvement & Evaluation System (iQIES) within 14 days of completion, which would have been by 07/02/25. During an interview on 02/12/26 at 10:01 AM, the MDSC confirmed that R144's admission MDS transmission to iQIES occurred on 07/03/25 and stated that it was late. 2. Review of R4's admission Record, dated 02/10/26 located in the EMR under the Profile tab, revealed R4 admitted to the facility on [DATE] with multiple diagnoses including hypertensive heart disease. R4 was discharged from the facility on 08/28/25. Review of R4's discharge returned anticipated MDS, with an ARD of 08/28/25 and found in the EMR under the MDS tab indicated that the Discharge Returned Anticipated MDS was completed and was never transmitted to iQIES. During an interview and record review on 02/12/26 at 4:43 PM, the MDSC reviewed R4's MDS records and stated that R4 was discharged on 08/28/25 and had a discharge MDS with an ARD of 08/28/25, completed on 09/02/25 that was not transmitted. She stated it should have been transmitted within 14 days of completion.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy titled, the facility failed to ensure accurate assessments were completed for four of 50 sample residents (Resident (R) 33, R117, R67 and R96) by failing to capture services the residents were receiving. This failure has the potential to prevent residents from receiving a needed service.Findings include: Review of the facility's policy titled, MDS 3.0 Completion, dated October 2025, indicated the discharge MDS assessment requirements as follows: Discharge Assessment – completed using the discharge date as the ARD and must be completed within 14 days of the discharge date /ARD. 1.Review of R33's Face Sheet, located in the electronic medical records (EMR) under the Profile tab indicated an admission date of 01/06/22 with diagnoses of chronic systolic (congestive) heart failure and dementia. Review of R33's annual Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/07/25 indicated R33 was unable to complete the Brief Interview for Mental Status (BIMS) which indicated the resident was severely cognitively impaired. The inaccurate MDS revealed R33 did not have impairments on either side of the upper and lower extremities. R33 was dependent on staff for bed mobility. Review of R33's modified annual MDS, located in the EMR under the MDS tab with an ARD of 12/07/25 revealed R33 had impairments of both sides of the upper extremities and impairments on one side of the lower extremities. This remained an inaccurate MDS. Review of R33's quarterly MDS, located in the EMR under the MDS tab with an ARD of 03/10/25, revealed R33 had impairments of both sides of the upper extremities and lower extremities. Review of R33's quarterly MDS, located in the EMR under the MDS tab with an ARD of 06/09/25, revealed R33 had impairments of both sides of the upper extremities and lower extremities. Review of R33's quarterly MDS, located in the EMR under the MDS tab with an ARD of 09/08/25, revealed R33 had impairments of both sides of the upper extremities and lower extremities. During an observation on 02/09/26 at 9:55 AM, R33 was observed lying in bed, under the covers. R33 had foam wedges on both her left and right side, near her body. Both of her arms were resting on top of her chest with her arms bent at a 45-degree angle with both the right and left hand bent at the wrist with her fingers curled completely into her right and left hands. During an observation on 02/12/26 at 7:31 AM, R33 was observed lying in bed, under the covers. R33 had foam wedges on both her left and right side, near her body. Both of her arms were resting on top of her chest with her arms bent at a 45-degree angle. Both of R33's hands were bent at the wrist with her fingers curled completely into her hands. During an interview on 02/12/26 at 10:52 AM, the MDS coordinator (MDSC) stated when completing quarterly and annual MDS' she would check and compare previous assessments. She reviewed previous MDS assessments for R33 and stated the 12/07/25 MDS was inaccurate. She stated it was important for the MDS to be accurate to ensure residents received the care they needed. She stated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she would correct the inaccurate MDS and resubmit. Review of the facility policy titled, MDS 3.0 Completion," revised on 10/2025 revealed, Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan.A Modification Request is used when an MDS record (assessment.) is already transmitted and accepted by CMS (Center for Medicare & Medicaid Services) . information in the record contains clinical or demographic errors." 2. Review of R117's admission Record, located under the Profile tab of the EMR revealed an admission date of 01/14/26 with diagnoses of acute and chronic respiratory failure with hypoxia, asthma, and obstructive sleep apnea. Review of R117's Orders, located under the Orders tab of the EMR revealed oxygen at three liters through nasal cannula (NC) for shortness of breath (SOB), monitor SOB when resident is lying flat, if SOB when lying flat lift head of bed, document and notify medical director (MD) of any changes, every shift starting 01/14/26. Review of R117's Medicare 5-day MDS, located under the MDS tab of the EMR with an ARD of 01/18/26 did not indicate the resident was on oxygen. During an observation on 02/09/26 at 10:57 AM, R117 had an oxygen concentrator present in her room running at one and a half (1.5) liters per minute (LPM) through NC. During an interview on 02/09/26 at 10:57 AM, R117 said she has been on oxygen for a long time and that she had oxygen at home too. R117 confirmed she has a tough time breathing without it. During an observation on 02/12/26 at 7:50 AM, R117 had an oxygen concentrator present in her room running at two (2) LPM through NC. During an interview on 02/12/26 at 8:01 AM, Licensed Practical Nurse (LPN)7 confirmed R117 was on oxygen. LPN7 also stated she never saw R117 go without her oxygen. During an interview on 02/12/26 at 1:43 PM, the MDSC confirmed R117 was admitted with oxygen and uses oxygen continuously. MDSC confirmed it was a coding error on the MDS. During an interview on 02/12/26 at 1:54 PM, the Director of Nursing- Interim Director of Clinical Operations (DON) confirmed R117 uses oxygen, a physician order was documented on admission and that the MDS should reflect R117's use of oxygen. Review of the facility provided policy titled, MDS 3.0 Completion, with a revision date on 10/25 indicated Policy:.Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Policy Explanation and Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. 3.Review of R67's admission Record, dated 02/12/26 located under the Profile tab in the EMR revealed an admission date of 09/13/25 with multiple diagnoses including stroke. R67 was discharged from the facility on 10/04/25. Review of R67's Discharge summary, dated [DATE] at 2:01 PM, and located under the Prog Note tab in the EMR indicated R67 was discharged from the facility. Review of R67's MDS, assessments completion list located in the EMR under the MDS tab included an entry MDS with ARD of 09/13/25, and an admission MDS with an ARD of 09/20/25. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R67's MDS, completion list revealed a discharge MDS was not completed. During an interview and record review on 02/12/26 at 4:46 PM, the MDSC reviewed R67's MDS record and stated that R67 was discharged on 10/4/25. The MDSC stated there was no discharge MDS for R67, and one should have been completed with an ARD of 10/4/25. 4. Review of R96's admission Record, dated 02/12/26 located in the EMR under the Profile tab revealed an admission date of 08/18/25 with multiple diagnoses including Type 2 diabetes mellitus. R96 was discharged from the facility on 09/19/25. Review of R96's Discharge summary, dated [DATE] at 1:32 PM, and located under the Prog Note tab in the EMR indicated R96 was discharged from the facility. Review of R96's MDS, completion list located under the MDS tab in the EMR included an entry MDS with ARD of 08/18/25, and an admission MDS with ARD of 08/25/25. Review of R67's MDS, completion list revealed a discharge MDS was not completed. During an interview and Record review on 02/12/26 at 4:44 PM, the MDSC reviewed R96's MDS record and stated that R96 was discharged on 09/19/25. The MDSC stated there was no discharge MDS for R96, and one should have been completed with an ARD of 09/19/25.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy titled, Resident Assessment-Coordination with PASARR Program, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level II assessment was completed for one resident (Resident (R) 94) reviewed for PASARR, who has a diagnosis of bipolar disorder and requires specialized services. This failure had the potential of placing R94 at risk for inappropriate care and lack of specialized services. Findings include:Review of the facility policy titled, Resident Assessment-Coordination with PASARR Program, with a revision date of 12/24 indicated Policy:.This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. A11 applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission. b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has (mental disorder) MD, (intellectual disorder) ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. 3. A record of the pre-screening shall be maintained in the resident's medical record. 4. Exceptions to the pre-admission screening program include those individuals who: b. Are admitted directly from a hospital, requires nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services. 5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID, or a related condition to the appropriate state designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 7. Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.Review of R94's admission Record, located under the Profile tab of the electronic medical record (EMR) indicated R94 was admitted on [DATE] with a diagnosis of bipolar disorder.Review of R94's PASSAR, evaluation provided by the facility dated 02/08/25 revealed the facility applied for R94's level II PASARR and it shows status pending.Review of R94's Care Plan, located under the Care Plan tab of the EMR revealed R94 uses antipsychotic medications related to her bipolar diagnosis initiated on 10/14/25.Review of the Initial Performance Improvement Plan, provided by the facility dated 01/23/26 revealed Description:.To ensure that residents have a qualifying diagnosis for a level II application are identified and submitted. Assessment Summary:.Performance Assessment: During an audit social service (SS) identified six potential residents that the facility failed to submit an application for level II services. Root Cause Analysis:.Previous SWD failed to submit levels on the identified resident. Plan Summary and (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implementation Tracking:. Goals: To ensure all residents receive the needed care and services that all requirements are met. Implementation:.1. Perform a 100% audit of all residents for qualifying diagnoses; 2. Submit new Level and DMA6 [specific form used by Georgia regarding physician recommendation concerning nursing facility placement] on all residents identified in the audit; 3. Review all new admissions to ensure that Level I was submitted and completed accurately. Those inaccurate, submit a new Level 1 and DMA6 with accurate diagnoses; 4/ Review all resident diagnoses according to the Minimum Data Set (MDS) schedule to ensure no new diagnoses have been added. Review of R94's Preadmission Screening and Resident Review (PASARR,) evaluation provided by the facility dated 01/25/25 revealed it did not indicate the resident has bipolar disorder.Review of Performance Improvement Plan (PIP), provided by the facility dated 01/27/26 revealed State Problem or Opportunity for Improvement: PASARR/ advanced directives on all residents admitted to [facility] and do not match each other. Supportive Data (why do you believe this is a problem): Current residents are lacking PASARR's and advanced directives in their medical files upon admission, start date 01/27/26. During an interview on 02/11/26 at 4:37 PM, the Social Work Director (SWD) confirmed the facility should have followed up on the pending PASSAR before now. She revealed on 01/23/26, the facility identified PASSAR's that needed to be followed up on and put a PIP in place. During an interview on 02/12/26 at 10:43 AM, the SWD revealed that even though the facility started with a PIP on 01/27/26 and a list of residents were provided to the Business Office Manager (BOM), no one has contacted the agency that provides PASSAR to make corrections. During an interview on 02/12/26 at 10:44 AM, the Director of Nursing (DON) revealed a PIP was started but she was unaware the agency for PASSAR had not been contacted since the PIP was in place as of 01/27/26.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the policy titled, Activities of Daily Living, the facility failed to ensure good hygiene was maintained for three residents (Residents (R) 1, R7, and R156) out of nine reviewed for activities of daily living (ADL) in the sample of 50 residents. This failure has the potential for the residents to develop skin infections, have poor hygiene and a general decline in health.Findings include:Review of the facility's policy titled, Activities of Daily Living, implemented October 2025, revealed, .based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs (activities of daily living) do not deteriorate unless deterioration is unavoidable.Care and services will be provided for the following activities of daily living: Bathing.1.Review of R1's Face Sheet, located in the electronic medical records (EMR) under the Profile tab indicated an admission date of 04/22/25 with diagnoses of chronic pleural effusion and chronic respiratory failure.Review of R1's quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 10/30/25 indicated R1 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident was cognitively intact. R1 required moderate assistance with bathing.Review of R1's admission MDS, located in the EMR under the MDS tab with an ARD of 04/29/25 revealed it was very important for the resident to choose between a bed bath or shower. Review of R1's Care Plan, created on 02/10/26, during the survey, located in the EMR under the Care Plan tab revealed, The resident has an ADL self-care performance deficit r/t (related to) decreased mobility, muscle weakness. The goal was for the resident to maintain current level of function in ADLs through the review date. Interventions included Bathing/Showering: Resident requires extensive assistance of one staff for bathing.Review of R1's POC (Point of Care) Response History, revealed R1 had a Scheduled bath/shower three times a week on Tuesday/Thursday/Saturday 7-3 (shift).Review of the Skin and Bath Report, revealed R1 had 42 opportunities to receive a bed bath or shower, and she received a bed bath or shower 12 times and refused once. R1 was offered a bed bath or shower 13 times since 11/01/25, which included: 11/04/25, 11/06/25, 11/11/25, 11/18/25, 11/20/25, 12/02/26, 12/11/25, 12/16/25, 01/06/26, 01/10/26, 01/13/26, and 01/24/26. She was offered and refused on 12/04/25. During an interview on 02/11/26 at 8:00 AM, R1 stated I have only gotten two showers since I've been here.2.Review of R7's Face Sheet, located in the EMR under the Profile tab indicated an admission date of 04/09/22 with diagnoses of vascular parkinsonism and dementia.Review of R7's quarterly MDS, located in the EMR under the MDS tab with an ARD of 12/11/25 indicated R7 had a BIMS score of eight out of 15 which indicated the resident was moderately cognitively impaired. R7 required moderate assistance with bathing.Review of R7's annual MDS, located in the EMR under the MDS tab with an ARD of 03/14/25 revealed it was very important for the resident to choose between a bed bath or shower. Review of R7's Care Plan, created on 02/10/26, during the survey, located in the EMR under the Care Plan tab revealed, The resident has an ADL self-care performance deficit r/t Parkinson's, decreased mobility, dementia. The goal was for the resident to maintain current level of function in ADLs through the review date. Interventions included Bathing/Showering: Resident requires extensive assistance of one staff for bathing.Review of R7's POC Response History, revealed R7 had a Scheduled bath/shower three times a week on Tuesday/Thursday/Saturday 3-11 (shift).Review of the Skin and Bath Report, revealed R7 had 42 opportunities to receive a bed bath or shower, he received a bed bath or shower eight times, and was offered a bed bath or shower 10 times since 11/01/25. He was offered and received showers on: 11/06/25, 12/06/25, 12/18/25, 01/03/26, 01/08/26, 01/22/26, 02/07/26, and 02/10/26. He was offered and refused showers on 01/17/26 and 01/31/26. During an observation on 02/10/26 at 9:15 AM, R7 was seen going through his clothes on the bed. The clothes appeared as if they had been kept in a garbage bag. R7 said he was going through his clothes. He smelled of stale urine. The clothes he pulled out of the garbage bag had a wet (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urine smell.During an observation and interview on 02/11/26 at 7:35 AM, R7 had a smell of old urine. His face had whiskers, and he had gray patches of dry skin. R7 stated he washes up in the sink and that's enough for me.During an interview on 02/09/26 at 10:28 AM, R38 stated when Resident Council is lead, residents talk a lot about not offering showers.During an interview on 02/10/26 at 2:30 PM, Certified Nurse Aide (CNA) 4 and Restorative Aide (RA1) stated they would use their assignment sheets to know who had showers during their shift. Both stated they did not receive an assignment sheet for 02/10/26, therefore they did not know who should have received a shower. Both said they were uncertain how to indicate in the computer that a shower was not given. During an interview on 02/10/26 at 2:30 PM, CNA 2 stated she knew who was scheduled for a shower based on her assignment sheet. She did not know how to document in the computer whether a resident took a shower or not.During an interview on 02/10/26 at 2:40 PM, Registered Nurse - Evening Supervisor (RN1) stated she expected the CNA to receive an assignment sheet at the start of their shift which would indicate which residents needed showers. She stated she would verify with CNAs if showers were completed. She stated if they were not completed, she instructed the CNA to contact their nurse. RN1 stated if the resident did not receive their shower during their assigned shift, she would expect the resident to receive their shower on the next shift. She stated completed shower sheets would also document areas of concern on residents' skin. This way nursing could determine the necessary treatment for any skin concerns. During an interview on 02/11/26 at 7:40 AM, CNA 9 stated the shower sheet should be completed after every shower and if there are skin concerns they should be documented on the shower sheet and the nurse should be notified. If a resident refuses a shower, then the nurse should be notified. CNA 9 stated residents who reside in even numbered rooms receive their shower during the day shift. She stated if a resident is in A bed (by the door) they receive a shower Tuesday, Thursday, and Saturday. She stated if a resident is in B bed (by the window) they receive their shower on Monday, Wednesday, and Friday. She stated R1 should receive her shower on Tuesday, Thursday, and Saturday because she is in A bed, in an even numbered room. CNA 9 stated if a resident lived in an odd numbered room, the same shower days would apply for bed A and bed B, but the showers would be given during the evening shift.During an interview on 02/12/26 at 11:45 AM, interim the Director of Nursing/ Regional Director of Clinical Operations (DON) stated it was a problem if a resident was not offered a shower or bed bath. She stated if the resident refuses the refusal needs to be documented. The DON stated, if necessary, the time needs to be changed if a resident has a different preference. 3. Review of R156's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed R156 was admitted on [DATE] with diagnoses of stroke and muscle weakness.Review of R156's annual Minimum Data Set (MDS), located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/27/26 indicated the resident was dependent for shower/ bathing.Review of R156's Care Plan, located under the Care Plan tab of the EMR revealed the dated 02/11/26 revealed R156 has an ADL self-care performance deficit related to cerebral infarction. R156 is totally dependent on staff to provide a bath/shower.Review of shower sheets provided by the facility reveal R156 was bathed on:01/27/2601/29/2602/03/2602/07/26 During an interview on 02/09/26 at 2:44 PM, R156 stated he had been showered twice. R156's hair appeared oily. During an observation on 02/10/26 at 12:21 PM, R156 was in the common area sitting in his wheelchair and his hair appeared oily. During an interview on 02/11/26 at 12:58 PM, Certified Nurse Assistant (CNA)7 was at R156's bedside and confirmed the resident's hair appeared oily and he needed a bath.During an interview on 02/12/26 at 1:53 PM, Licensed Practical Nurse (LPN)7 confirmed R156 had only received four baths since his admission on [DATE]. She confirmed R156 should be bathed two to three times per week and more if necessary to maintain proper hygiene.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, record review, and interviews, the facility failed to ensure two residents (Resident (R) 33 and R12) of two residents reviewed for activities out of a sample of 50 residents received an ongoing activities program to support their choice of activities. This failure had the potential for the residents' physical, mental, and psychosocial well-being to worsen and potentially develop a general decline in health. Findings include:1.Review of R33's Face Sheet, located in the electronic medical records (EMR) under the Profile tab indicated an admission date 01/06/22 with diagnoses of chronic systolic (congestive) heart failure and dementia.Review of R33's annual Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/07/25 indicated R33 was unable to complete the Brief Interview for Mental Status (BIMS) which indicated the resident was severely cognitively impaired. R33 had bilateral impairment of the upper extremities and on one side of her lower extremities. She was dependent on staff for all activities of daily living (ADL).Review of R33's annual MDS, located in the EMR under the MDS tab with an ARD of 12/07/25 revealed it was very important for R33 to participate in religious services or practices and somewhat important to listen to music she likes.Review of R33's Care Plan, located in the EMR under the Care Plan tab dated 01/05/26, revealed, (R33) has little or no group activity involvement at [the] time, she is on the one-to-one program. The goal was for R33 to express satisfaction with [the] type of activities and level of activity involvement. Interventions included, invite and encourage (R33) to attend group act[ivities] of her choice.post monthly calendar.praise for all efforts.provide supplies to engage (R33) with sociable activities. Continuous observations of R33 on 02/09/26 from 9:49 AM until 10:03 AM and 2:40 PM until 2:53 PM, revealed R33 was observed lying in bed. There was no music or television in the room and the lights were off.Continuous observations of R33 on 02/10/26 from 9:15 AM until 9:55 AM, 10:28 AM until 10:37 AM and 2:30 PM until 2:45 PM, revealed R33 was observed lying in bed. There was no music or television in the room and the lights were off.Continuous observations of R33 on 02/11/26 from 3:54 PM until 4:05 PM, revealed R33 was observed lying in bed. There was no music or television in the room and the lights were off.An observation of R33 revealed on 02/12/26 at 5:01 PM, R33 was observed sitting in her wheelchair along the wall next to the nurses' station.2. Review of R12's Face Sheet, located in the EMR under the Profile tab indicated an admission date of 04/14/25 with diagnosis of encephalopathy and dementia.Review of R12's annual MDS, located in the EMR under the MDS tab with an ARD of 12/06/25 indicated R12 had a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired. R33 had bilateral impairment of the upper and lower extremities. She was dependent on staff for most ADLs.Review of R12's annual MDS, located in the EMR under the MDS tab with an ARD of 06/08/25 revealed it was very important for R12 to listen to music he likes, do things with groups of people, be around animals, and participate in his favorite activities. Review of R12's Care Plan, located in the EMR under the RAI tab dated 11/01/25 revealed, (R12) [is] dependent on staff for meeting emotional, intellectual, physical and social needs due to cognitive deficits. The goal was for R12 to maintain involvement in cognitive stimulation [and] social activities as desired. Interventions included, staff converse with (R12) .introduce (R12) to residents with similar background.invite (R12) to scheduled activities . provide (R12) with materials for individual activities. The care plan did not mention one-to-one as an intervention. Continuous observations of R12 on 02/09/26 from 9:49 AM until 10:03 AM and 2:40 PM until 2:53 PM, revealed R12 was observed lying in bed with his covers pulled up over his face. There was no music or television in the room and the lights were off.Continuous observations of R12 on 02/10/26 from 9:15 AM until 9:55 AM, 10:28 AM until 10:37 AM and 2:30 PM until 2:45 PM, revealed R12 was observed lying in bed with his covers pulled up over his face. R12 was observed sitting inside the doorway of his room at 4:00 PM. There was no music or television in the room and the lights were off.Continuous observations of R12 on 02/11/26 from 3:54 PM until 4:05 PM, revealed R12 was observed lying in bed, with his covers pulled (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up over his face. There was no music or television in the room and the lights were off.An observation of R12 on 02/12/26 at 5:00 PM revealed R12 was observed sitting in his wheelchair next to the nurse's cart across from his room.During an interview on 02/11/26 at 5:10 PM, the Activity Director (AD) stated she was new to the position. She stated her plan was to set up a one-to-one program. She stated she was going to start on 02/12/26, the last day of the survey. The AD stated she did not know what she would provide because she needed to get a feel for what they (R33 and R12) liked doing. She stated both R33 and R12 would be placed on one-to-one visits three times a week. She stated she would include puzzles, aroma therapy, nail care, massage, talking, and reading the Bible during the visits. During an interview on 02/12/26 at 1:30 PM, the Director of Regulatory Compliance stated, I'll give you these (Activity Logs), but they really do not show you much. The Director of Regulatory Compliance stated he was aware there was a limited activity program since the new company had taken over and it was important to have a good program.Review of the policy tilted, Activities, revised 01/2024, revealed, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, an preferences.Each resident's interest and needs will be assessed on a routine basis.Activities may be conducted in different ways: (a) One-to-one programs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, interviews, record review, and policy review, the facility failed to ensure one resident (Resident (R) 33) reviewed for skin concerns out of a total sample of 50 residents received the proper care and monitoring to prevent an axilla rash under the left arm from worsening. This failure had the potential for R33's skin to worsen, cause pain, and potentially develop a general decline in health. Findings include:Review of R33's Face Sheet, located in the electronic medical records (EMR) under the Profile tab indicated an admission date 01/06/22, with diagnoses of chronic systolic (congestive) heart failure and dementia.Review of R33's annual Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/07/25 indicated R33 was unable to complete the Brief Interview for Mental Status (BIMS) which indicated the resident was severely cognitively impaired. R33 was dependent on staff for all activities of daily living (ADL). R33 did not have Applications of ointments/medications listed under the skin conditions in the MDS.Review of R33's Care Plan, located in the EMR under the Care Plan tab, dated 01/06/26, revealed, (R33) is at risk for chronic fungal under left arm r/t (related to) moisture. L (left) arm is contracted, and resident has a purple-reddish discoloration from previous rash. The goal included, Resident will have no s/sx (signs/symptoms) of infection of the rash through the review date. Interventions included Apply PRN (as needed) antifungal cream as needed. Interventions initiated 02/12/26, during the survey, included, Monitor skin rashes for increased spread or signs of infection. Place wedges under each arms [sic] as tolerated.On 02/11/26, the Skin and Bath Reports revealed R33 had a rash on her left Axillary/Armpit.Review of the Skin Check, located in the EMR under the Assessment tab dated 02/05/26, revealed no discoloration or rashes were previously noted. The Skin Care Plan revealed, weekly skin check, daily documentation skin notes and other skin assessments were reviewed.medical conditions/medication/risk factors were reviewed, other areas reviewed (.positioning, contractures, mobility.) and changes to plan of care were updated were blank which indicated those areas were not reviewed.Review of a [Nurse Practitioner] Progress Note, provided by the facility, dated 02/12/26, revealed She is being seen for follow up after MD (Medical Doctor) initiated Fluconazole 100 mg (milligrams) daily for seven days and topical Miconazole powder for axillary candidiasis.Skin: erythema (skin redness) and moisture present under bilateral axillary folds.ICD (International Classification of Diseases) (coding system to classify diseases), B37.2: Candidiasis of skin.Review of the Clinical Physician Orders, dated 03/15/25 through the survey, revealed:-Diflucan 100 mg (milligrams), start date of 6/25/25 through 6/30/25. -Diflucan 150 mg, start date of 09/10/25 through 09/15/25. -Diflucan 100 mg, start date of 02/12/26 through 02/19/26.-Miconazole Nitrate Powder 2%, apply to left arm topically, start date 02/12/26.-Antifungal External Powder 2%, apply to underneath left arm, start date 01/06/26 and discontinued 02/11/26.During an interview on 02/10/26 at 2:40 PM, Registered Nurse - Evening Supervisor (RN1) stated she expected the Certified Nurse Aide (CNA) to receive an assignment sheet at the start of their shift which would indicate which residents needed showers. She stated she would verify with CNAs if showers were completed. She stated if they were not completed, she instructed the CNA to contact their nurse. RN1 stated if the resident did not receive their shower during their assigned shift, she would expect the resident to receive their shower on the next shift. She stated completed shower sheets would also document areas of concern on residents' skin and nursing could determine the necessary treatment for any skin concerns. During an interview on 02/10/26 at 2:45 PM, with the Director of Rehab (DOR) and the Occupational Therapist (OT). The OT stated R33 had contractures. She stated she had worked with R33 in June 2025 for her contractures and had just recently started working with her again. The OT stated when she started working with R33 last June she also had some skin breakdown in her armpit area, which was an oozing area. During an observation and interview on 02/11/26 at 5:34 PM, the Director of Nursing - Interim Regional Director of Clinical Operations (DON), the Previous Director of Nursing (PDON) and the Former Administrator observed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the area in R33's left armpit. The DON stated she was not aware of the area and would investigate and determine if there was a current treatment. The PDON stated she remembered R33 having the area for quite some time. During an observation on 02/12/26 at 7:31 AM with a Registered Nurse (RN) from the survey team and Licensed Practical Nurse (LPN) 8, R33's was observed lying in bed, under the covers. R33 had foam wedges on both her left and right side, near her body. Both of her arms were resting on top of her chest with her arms bent at a 45-degree angle at the elbow, and her arms were lying close to her body, without her armpit exposed. Her arms were lying on her chest with both the right and left hand bent at the wrist with her fingers curled completely into her right and left hands. R33 was uncovered by LPN8 and R33's left arm was lifted and her armpit was exposed and observed. LPN8 stated the redness was yeast and R33 had had it for a long time. LPN8 stated you should have seen it a year ago, it was oozing. LPN8 stated it looked much better. The survey team RN agreed the area was a healing yeasty rash. LPN8 stated it was difficult to keep the area dry.During an interview on 02/12/26 at 11:17 AM, the OT stated she looked at R33's skin in her left armpit area and it looked better than it had last year. She stated because there were moisture and redness under both her left and right arm, R33 would benefit from using the wedges under both arms to improve the airflow and relieve the pressure. The OT stated she would educate CNAs again, so they are aware of how to position the wedges to help the area under R33's arms with air flow. She stated she also observed R33's right arm and observed the right armpit had moisture and redness. She stated the left arm required passive range of motion (PROM). During an interview on 02/12/26 at 11:33 AM, the Nurse Practitioner (NP) stated she had not been treating R33 with anything related to her skin. She stated she was not aware of any concerns until 02/11/26. She stated her expectation would have been to be made aware of any skin concerns since their practice took over in November of 2025 and see a skin assessment. The NP stated if she would have known she would have looked at R33's armpit and monitored the area. She stated if she were aware sooner, she would have had the opportunity to monitor the treatment and follow-up for effectiveness. She stated the risk of not knowing is that the skin could have gotten worse, become infected or become a systemic problem. During an interview on 02/12/26 at 11:45 AM, the DON stated she was not aware of any red areas under R33's right arm. She stated she would observe the area, monitor, and notify the doctor. Review of the Skin Integrity Prevention Policy, revised 08/2024, revealed, .Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.Repeat the risk assessment weekly and upon any changes in condition.Prevention: Keep the skin clean .Review the interventions and strategies for effectiveness on an ongoing basis.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jonesboro Center for Nursing and Healing LLC	2650 Highway 138 SE Jonesboro, GA 30236

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure two of two resident (Resident (R) 33 and R83) reviewed for range of motion (ROM) out of a sample of 50 residents received restorative services to ensure ROM did not worsen in the upper and lower extremities, splint devices were in place, and failed to ensure staff were educated on placement of splint devices. This failure had the potential for the resident's ROM to worsen, cause pain, skin break down and potentially develop a general decline in health. Findings include: 1.Review of R33's Face Sheet, located in the electronic medical records (EMR) under the Profile tab indicated an admission date of 01/06/22 with diagnoses of chronic systolic (congestive) heart failure and dementia. Review of R33's modified annual Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/07/25 indicated R33 was unable to complete the Brief Interview for Mental Status (BIMS) which indicated the resident was severely cognitively impaired. R33 had bilateral upper extremity impairments and impairments on one side of the lower extremities. She was dependent on staff for all activities of daily living (ADL). Review of R33's annual Care Area Assessment (CAA), located in the EMR under the MDS tab with an ARD of 12/07/25 did not indicate the resident had contractures. Review of R33's Care Plan, located in the EMR under the Care Plan tab did not mention R33's right hand contracture until 02/11/26, during the survey. Additionally, the Care Plan included an intervention dated 02/12/26, place wedges under each arms [sic] as tolerated. Review of a [Nurse Practitioner] Progress Note, provided by the facility, dated 02/12/26, revealed Physical Debility/Geriatric Deconditioning/Contractures-chronic, unstable: Continue PT/OT (physical therapy/occupational therapy) to meet tools for endurance, strengthening and to assess for support devices, support participation in therapy to address contractures. ICD (International Classification of Diseases) (coding system to classify diseases, M24.529: Contracture of upper arm joint, M24.561: Contracture, right knee, M24.562: Contracture, left knee. Review of R33's Occupational Therapy Discharge summary, dated [DATE], revealed Short-Term Goals: Patient will safely wear [brace] to further assess and order/fabricate on left shoulder for up to [two] hours with minimal s/s (signs/symptoms) of redness, swelling, discomfort or pain. Short-Term Goal: Patient will safely wear least restrictive splinting/orthotic device at all times except bathing and exercise without redness and skin irritation in order to improve AROM/PROM (Active Range of Motion/Passive Range of Motion) for adequate hygiene, maintain joint integrity and joint mobility and reduce abnormal tone prior to splint application. Review of R33's Clinical Physician's Orders, located in the EMR under the Orders tab reviewed from 06/25/26 to current, revealed R33 did not have orders for a splint for the left hand or a shoulder wedge for the left shoulder. Review of R33's Nursing to Therapy Screen Request, dated 01/07/26, located in the EMR under the Assessment tab, revealed, left arm contracted, possible splint request. OT to eval [evaluate]. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Summary of screening: hand contractures and decreased UE (Upper Extremity) ROM and axilla (armpit) skin breakdown. Review of R33's Occupation Therapy Evaluation & Plan of Treatment, provided by the facility, dated 01/21/26, revealed, A new goal: [R33] will safely wear a resting hand splint on the left hand for up to 2 (two) hours with minimal s/s of redness, swelling, discomfort or pain (Target 04/13/26). New goal: Patient will tolerate positioning wedge/lateral support on left shoulder to prevent axilla skin breakdown for up to [two] hours with minimal s/s of redness, swelling, discomfort or pain (Target 04/13/26). During an observation on 02/09/26 at 9:55 AM, R33 was observed lying in bed, under the covers. R33 had foam wedges on both her left and right side, near her body. Both of her arms were resting on top of her chest with her arms bent at a 45-degree angle with both the right and left hand bent at the wrist with her fingers curled completely into her right and left hands. The foam wedges were not under either her left or right arm. During observations of R33 on 02/09/26 at 10:03 AM and 2:53 PM, R33 was observed lying in bed with foam wedges next to her body. Splints were not observed on either hand. During an observation of R33 on 02/10/26 at 9:55 AM, 10:37 AM and 2:45 PM, R33 was observed lying in bed with foam wedges on both her left and right side, near her body. Splints were not observed on either hand. During an observation of R33 on 02/11/26 at 4:05 PM, R33 was observed lying in bed foam wedges on both her left and right side, near her body. Splints were not observed on either hand. During an observation on 02/12/26 at 7:31 AM, R33 was observed lying in bed with foam wedges on both her left and right side near her body. Both of her arms were resting on top of her chest with her arms bent at a 45-degree angle at the elbow, and her arms lying close to her body, without her armpits exposed. Her arms were lying on her chest with both the right and left hand bent at the wrist with her fingers curled completely into her right and left hands. During an interview on 02/11/26 at 7:40 AM, Certified Nurse Aide (CNA) 9 stated she was not aware of any type of splint for R33's hands. During an interview on 02/11/26 at 2:45 PM, with the Director of Rehab (DOR) and the Occupational Therapist (OT) the OT stated R33 has contractures. She stated if nursing sends a therapy referral for a resident, the therapy department will conduct an evaluation. She stated R33 was receiving Occupational Therapy in June 2025, and she recommended a restorative program upon discharge from occupational therapy. The OT stated they ordered a splint for R33 last year to wear on her left hand and recommended she have restorative therapy to improve R33's tolerance with the hand splint, once discharged from therapy. She stated at that time she had provided CNAs, Restorative CNAs and nurses who worked with R33, education about placement of the splint. The OT stated as of 11/01/25, the restorative program was discontinued, and she was not sure what happened with the splint and did not have documentation of previous education. The OT stated she evaluated R33 on 01/21/26, after receiving a request from nursing for the left-hand contracture. She stated once the evaluation was completed, they determined R33 would be added to their caseload. She stated they were currently working with R33 on ROM. The DOR stated they ordered a splint for R33, and the goal was to have R33 use a splint upon discharge from therapy. The OT stated when she started working with R33 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last June she also had some skin breakdown in her armpit area, with an oozing area, and she knew the wound doctor was working with her. The OT and the DOR stated the restorative program was discontinued after the Restorative Nurse resigned and the new company took over. Both stated a restorative program was important to maintain a resident's mobility and agreed it was unfortunate the facility did not have one. During an interview on 02/12/26 at 11:17 AM, the OT stated she looked at R33's skin in her armpit area and it did look better than it had last year. She stated because moisture and redness were under both her left and right arm R33 would benefit from using the wedges under both arms to improve the airflow and relieve the pressure. The OT stated she would educate CNAs again, so they would be aware of how to position the wedges. She stated that R33 had better ROM on her right side than her left side and was able to assist with ROM when she worked with her. She stated R33's needed more stability on her left side and was unable to assist with ROM. The OT stated she had not measured R33's ROM in June of last year or during her current treatment but would start. She stated she did not think the contracture had gotten worse since June of last year and had remained the same. During an interview on 02/12/26 at 2:11 PM, Restorative Aide (RA1) stated they had a good restorative program until the nurse who oversaw the program resigned in November 2025. He stated they do not have a restorative program, and he is currently the only CNA that has worked in the restorative program but is currently working as a CNA on the floor. He stated he remembered R33 used to have a splint, but he was not sure where it was. He stated he was told they were going to reorder a splint for R33. During an interview on 02/12/26 at 5:16 PM, CNA6 stated the last ROM training she received was when she started working at the facility five years ago. During an interview on 02/12/26 at 5:21 PM, CNA8 stated she last received ROM training when she was in school. She stated she had worked at the facility for several years. 2. Review of R83's admission Record, located under the Profile tab of the EMR revealed R83 was admitted on [DATE] with diagnoses which included contracture of muscle and aphasia (impaired ability to understand or produce speech). Review of R83's quarterly MDS, located under the MDS tab of the EMR with an ARD of 12/20/25 revealed a BIMS score of 13 out of 15 which indicated R83 was cognitively intact. The resident was marked as receiving no range of motion or splint devices over the last seven calendar days. Review of R83's EMR revealed no evidence of R83 receiving any restorative services to include splint devices. Review of R83's Care Plan, located under the Care Plan tab of the EMR, revealed no mention of splint devices. During an interview on 02/09/26 at 9:48 AM, R83 stated there were no splints, and the last time one was put on was from therapy. He was observed with a contracted left hand. Review of the Occupational Therapy OT Discharge Summary, signed 09/04/25, revealed Restorative Program Established/ Trained: Restorative Splint and Brace Program. Splint and Brace Program Established/ Trained: Donning/doffing [putting on/taking off] of splint to prevent further joint (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deformity. During an interview on 02/11/26 at 11:14 AM, the DOR stated they used to have a training log and would do training with the staff for about one to two weeks prior to being discharged from therapy services. She stated they had three restorative CNAs but was unsure how many there were now. She confirmed they did not have a restorative nurse and that MDS was now overseeing the program. The DOR confirmed the September discharge summary was the last time they saw this resident. She stated they did not have a restorative list, and she was unable to see anything in the resident's chart about restorative services. During an interview on 02/11/26 at 11:26 AM, the MDS coordinator (MDSC) stated there was no restorative program as of 11/01/25. She stated the restorative CNAs were working as regular CNAs, getting weights as needed. She stated if the resident had a splint, it would have been care planned and the CNAs on the floor would place it on the resident. She stated that information would also have been on the Kardex. She reviewed the care plan and Kardex for R83 and confirmed there was no mention of splints. During an interview on 02/11/26 at 11:39 AM, the previous Director of Nursing (PDON) stated they had a restorative program with a nurse and a team, but they could not have a nurse anymore. She stated they were awaiting guidance from the new company. She stated they had a list and a tracker, at the nursing station. At 11:44 AM, after looking throughout the nursing station, she stated no list was available. During an interview with the resident, alongside the PDON, R83 stated there was no splint device. During an interview on 02/11/26 at 2:11 PM, the Director of Nursing – Interim Director of Clinical Operations (DON) stated they did not have a restorative nurse but was told nurses on the floor, then the supervisors, then MDS was the one who oversaw the program. She stated she would get with the DOR to see who needed restorative services. Review of the facility's policy titled, Restorative Nursing Programs, reviewed 10/23, revealed It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.Potential candidates for restorative nursing services may be identified through one or more of the following processes.specialized rehabilitation assessments.The Restorative Nurse, or designated licensed nurse will provide oversight of the restorative aide activities, review the documentation weekly, and evaluate the effectiveness of the plan monthly. Review of the facility's policy titled, Restorative Nursing Program, revised October 2023, revealed, It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.Nursing personnel are trained on basic, or maintenance nursing care that does not require the use of a qualified therapist or licensed nurse oversight. The training may include.Assisting residents in adjustment to their disabilities and use of any assistive devices. Review of the facility's policy titled, Use of Assistive Devices, implemented February 2026, revealed, The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity. Assistive devices are . types of equipment that help individuals.Nursing.and therapy departments will work together to ensure availability of devices, such as for ordering and/or (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	replacement.Storage and maintenance of equipment is based on the determination of the department with the responsibility for oversight.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure respiratory supplies were dated and stored in a sanitary manner in accordance with professional standards for one of two residents (Residents (R)117) reviewed for respiratory care. This failure had the potential to affect infection control and had the potential to spread infection in the facility. Findings include:Review of R117's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, asthma, and obstructive sleep apnea. Review of R117's Orders, located under the Orders tab of the EMR revealed an order for Oxygen at three liters through nasal cannula (NC) for shortness of breath (SOB), monitor for SOB when resident is lying flat, if SOB when lying flat lift head of bed, document and notify medical director (MD) of any changes, every shift starting 01/14/26.During an observation on 02/09/26 at 10:57 AM, R117 had an oxygen concentrator present in her room running at one and a half (1.5) liters per minute (LPM) via NC. A storage bag was not present, and the tubing was not dated. During an interview on 02/09/26 at 10:57 AM, R117 said she has been on oxygen for a long time and that she had oxygen at home too. R117 confirmed she has a hard time breathing without it. During an observation on 02/12/26 at 7:50 AM, R117 had an oxygen concentrator present in her room running at two (2) LPM through NC. No storage bag was present, and the tubing was not dated. During an observation on 02/10/26 at 9:59 AM, R117 was out of her room, and her oxygen concentrator was turned off, oxygen tubing was laying on the bed, and no storage bag was present.During an observation on 02/12/26 at 7:50 AM, R117 had an oxygen concentrator present in her room running at two (2) LPM via NC. No storage bag was present, and the tubing was not dated. During an interview on 02/12/26 at 8:01 AM, Licensed Practical Nurse (LPN)7 confirmed R117 was on oxygen and the concentrator was set on two LPM and should be set on three LPM per the physician order. LPN7 confirmed no storage bag was present and confirmed a storage bag was used to avoid contamination and bacteria when R117 leaves her room and uses portable oxygen. LPN7 also confirmed R117's oxygen tubing was not dated and should be dated to know when it should be changed for sanitary purposes.During an interview on 02/12/26 at 1:54 PM, the Director of Nursing-Interim Regional Director of Clinical Operations (DON) confirmed R117 uses oxygen, and a physician order was documented on admission. The DON confirmed that R117 should be administered oxygen at three LPM, tubing should be dated, and a storage bag should be present to avoid contamination.The facility provided a policy titled, Oxygen Administration, with a revision date of 04/25 that indicated Policy:.Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. 5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include:.b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.e. Keep delivery devices covered in plastic bag when not in use.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and a review of the facility policy titled Hospice Services Facility Agreement, the facility failed to ensure comprehensive fall assessments were completed after a fall, and implement appropriate, individualized fall interventions, placing residents at risk for falls and fall-related injuries for one of five (Resident (R) 68) residents reviewed for falls and also failed to ensure the medical record was complete and accurate for two of three hospice residents (R14 and R36) out of the total sample of 50 residents. This failure placed residents at risk for unmet care needs. Findings include: Review of the facility's policy titled, Hospice Services Facility Agreement, reviewed 09/23, revealed d. Obtaining the following information from the hospice. i. The most recent hospice plan of care specific to each resident.e. Ensuring that the facility provides orientation to hospice staff of the following.iv. Record keeping requirements. 1. Review of R68's Progress Notes, located under the Progress Notes tab of the electronic medical record (EMR) dated 12/14/25 at 4:31 PM revealed R68 had an unwitnessed fall and was found lying on the floor on his back. R68 was sent to the hospital and left the facility via stretcher. Review of R68's discharge return not anticipated Minimum Data Set (MDS), located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/20/26 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the resident is cognitively intact. Review of R68's Care Plan, located under the Care Plan tab of the EMR revealed R68 was at risk for falls and related injuries due to generalized weakness, psychotropic drug use and had an actual fall on 12/14/25. Review of R68's Fall Assessment, located under the Assessments tab of the EMR dated 01/13/26 indicated the resident had not had a fall in the last 90 days. Review of Facility Reported Incident (FRI), provided by the facility, dated 12/14/25 at 3:30 PM, revealed during rounds, two nurses heard yelling from the resident's room, responded quickly, and found R68 on the floor, beside his bed, on his back. When asked what happened the resident stated that he was trying to go to the bathroom by himself. R68 informed the nursing staff that he recently had neck surgery, and complained of back pain on a scale of 7/10, and requested to go back to the hospital. At 4:30pm on 12/14/25, R68 was transferred to the hospital via stretcher for further evaluation and treatment. On 12/15/25, while at the hospital, R68 stated that he fell because of no assistance from the staff despite multiple attempts to use his call light. R68 stated that he believes the staff only came to check in on him because he fell. R68 sustained no injury related to the unwitnessed fall. During an interview on 02/12/26 at 1:54 PM, the Director of Nursing – Interim Director of Clinical Operations (DON) confirmed that R68's fall assessment was inaccurately completed on 01/13/26 because the resident had a fall in the facility on 12/14/25. During an interview on 02/12/26 at 2:19 PM, the Regional Director of Operations confirmed R68's fall assessment was inaccurate when it was completed on 01/13/26 because the resident had a fall in (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility a month prior. 2. Review of R14's admission Record, located under the admission tab of the EMR revealed R14 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia, and hypertension. Review of R14's admission MDS, with an ARD of 11/12/25, revealed that R14 was assessed with a BIMS score of 8 out of 15, indicating that R14's cognitive function is moderately impaired. Review of R14's Order Audit Report, located under the Orders tab in the EMR dated 02/09/26, revealed that the physician order for hospice services was entered on 02/09/25 and was confirmed on 02/10/25. Review of an admission Progress Note, dated 11/11/25, and located under the Progress Note tab in the EMR, written by Licensed Practical Nurse (LPN) 9 indicated, Received hospice resident via stretcher accompanied by two hospice personnel. The resident was living in the facility's assisted living. Review of page two of the document titled, Hospice Care Communicator, and located under the MISC tab of the EMR dated 11/11/25, revealed R14 was admitted to the nursing facility on 11/11/25 with hospice services as of 11/11/25. During an interview on 02/11/26 at 12:40 PM, LPN1 stated, I called the assisted living 15 minutes ago. The nurse said the hospice staff will bring the hospice binder and documents to the facility later because when this resident was admitted , she was already on hospice services. On 02/12/26 at 12:00 PM, LPN1 brought the hospice binder with hospice documents to the conference room. During an interview on 02/12/26 at 10:31 AM, the previous DON (PDON) stated, We require a hospice binder that has the active orders, code status, care plans, and certificate of terminal illness. This should be on the unit where the resident resides. 3. Review of R136's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed R136 was admitted on [DATE] with diagnoses which included dementia and hemiplegia [paralysis on one side of the body] and hemiparesis [weakness on one side of the body] following cerebral infarction affecting left non-dominant side. Review of R136's quarterly MDS, with an ARD of 12/18/25 and located under the MDS tab of the EMR, revealed a BIMS score of zero out of 15 which indicated R136 was severely cognitively impaired. The resident was marked as receiving hospice services. Review of R136's Physician Orders, located under the Orders tab of the EMR revealed an order for admission to hospice on 09/08/25. Review of R136's Care Plan, located under the Care Plan tab of the EMR, revised on 02/04/26, revealed the resident was on hospice due to a terminal condition. [The terminal condition was not listed]. Interventions included: Center staff will notify hospice of significant changes, clinical complications needing POC [plan of care] change.Assess for pain, restlessness, agitation.Hospice to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115545	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jonesboro Center for Nursing and Healing LLC	2650 Highway 138 SE Jonesboro, GA 30236

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide over and beyond services other the SNF [skilled nursing facility] which includes but not limited to spiritual counseling, increased social services and increased clinical visits, expanded pain/comfort control.Provide emotional support to patient and family. Review of the hospice documentation provided by the facility revealed one page located in a folder at the nursing station. The form titled, admission Orders/Hospice Certification, dated 09/07/25, revealed the level of care was routine home care nursing home. Initial weekly staff frequency included: Nurse, Social Work (SW), Chaplain per protocol. Primary diagnoses included cerebral atherosclerosis. The form included a list of medications. The interval of plan of care renewal and care plan update: at least biweekly. The file did not contain any additional documentation from hospice. During an interview on 02/11/26 at 8:41 AM, LPN stated R136 was the only one using this hospice service. She confirmed there was only one document located in the hospice folder for this resident. She confirmed there was no documentation in the EMR from hospice services. She stated she knew a nurse came and a Certified Nurse Aide (CNA) came but was unable to report anything additional. During an interview on 02/11/26 at 11:44 AM, the previous Director of Nursing (PDON) stated the Unit Managers oversaw obtaining the documentation from hospice.