STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115566	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Towne Center	5131 Warm Springs Rd Columbus, GA 31909

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, and review of the facility policy titled, Medication Therapy, the facility failed to ensure residents or resident representatives were informed in advance of the risks and benefits of a prescribed psychotropic medication or an alternative treatment for two of three residents (Resident (R) 46, and R61) reviewed. This failure had the potential for residents to receive the medication without informed consent or understanding of the treatment, and/or alternative treatment available. Findings include: Review of R46's admission Record, in the electronic medical record (EMR), under the Admissions tab revealed R46 was initially admitted to the facility on [DATE]. Review of R46's annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 12/20/25 and located under the MDS tab of the EMR, revealed R46 had a Brief Interview for Mental Status (BIMS) score of nine of 15, indicating she had moderately impaired cognition. Review of R46's Resident Medication Summary, dated March 2026 and located under the Orders tab of the EMR, revealed R46 had a physician's order for two psychotropic medications, Bupropion and Effexor, prescribed for her diagnosis of depression disorder. Review of R46's EMR revealed no documentation of any informed consent documentation reviewed/signed by the resident or the resident's representative, in advance of administering the psychotropic medication. 2. Review of R61's admission Record, located under the Admissions tab of the EMR, revealed R61 was initially admitted to the facility on [DATE]. Review of R61's MDS, with an ARD of 02/19/26 and located under the MDS tab of the EMR, revealed R61 had a BIMS score of zero of 15, indicating he had severe cognitive impairment. Review of R61's Resident Medication Summary, dated March 2026 and located under the Orders tab in the EMR, revealed R61 had a physician's order for two psychotropic medications, Sertraline and Trazodone, prescribed for his diagnosis of depression disorder. Review of all documents in the EMR under the Documents tab revealed R61 had no documentation of any informed consent document reviewed/signed by the resident or the resident's representative, in advance of administering the psychotropic medication. During an interview on 03/30/26 at 11:24 AM, Social Service Director (SSD) 1 stated she was not familiar with a document required prior to administering a high-risk medication/psychotropic and was not responsible for obtaining a document of informed consent for any prescribed medication. During an interview on 03/30/26 at 1:45 PM, Unit Manager (UM) 2 stated she was not familiar with a document required prior to administering a high-risk medication/psychotropic and was not responsible for the document. She stated she thought the Director of Nursing (DON), the Physician, or Nurse Practitioner (NP) was responsible for obtaining informed consents for high-risk medications. During an interview on 03/31/26 at 12:48 PM, the DON stated she had only been in the facility for a week and assumed the charge nurses were responsible for obtaining informed consents for high-risk medication. She said she would expect informed consent to be obtained when the prescriber wrote the medication order. During an interview with the Administrator on 03/31/26 at 3:10 PM, he stated he would expect the nurse manager to confirm that an advance signed consent had been acquired prior to administering high risk medications. Review of the undated policy titled, Medication Therapy, revealed, . All medication orders would be supported by appropriate care processes and practices. The subtitle named Policy Interpretation and (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
	115566	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Towne Center	5131 Warm Springs Rd Columbus, GA 31909

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implementation revealed.All decisions related to medications shall include appropriate elements of the care process, such as each resident's wishes, values, goals, condition, and prognosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115566	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Towne Center	5131 Warm Springs Rd Columbus, GA 31909

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, and facility policy review titled Environment, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for one of one kitchen affecting 103 residents who consume food from the kitchen. This failure had the potential to contribute to contamination and infection control concerns. During a kitchen observation, alongside the Dietary Manager (DM), on 04/01/26 at 6:02 AM, a large section of non-slip flooring in front of the steam table was worn through to show the underneath tile, and some missing grout for the tile.-Two sections of non-slip flooring in front of the three-pan sink were worn through, showing the underneath tile and concrete. The sections were flooded with standing water.-Underneath the steamer, there was broken and worn non-slip flooring to reveal exposed tile.-A long section of broken, worn-through non-slip flooring at the drink station revealed rocky concrete/ tile areas and was flooded with water.-The non-slip flooring in front of the dish machine had broken, worn sections revealing the underneath concrete.-The non-slip flooring to the left side of the stove revealed open/worn/broken/cracked, and buckled areas. The DM acknowledged that the floor was not a cleanable surface.-The dry storage area, lower right-side wall, revealed drywall debris coming down onto the floor.-The entrance to the walk-in refrigerator revealed that the non-slip flooring was worn through, which revealed the underlying tile.-The back side of the hood filter revealed broken slats on the left side.-The piping underneath the three-pan sink was observed as rusted through, exposed to the inside.-The walls throughout the kitchen were dirty with food spatter, including behind the prep station, behind the hand-washing sink, behind the three-pan sink, and surrounding the clean knife storage container.-The clean knife storage was located on the left side of the three-pan sink on the wall. The unit was dirty with spatter and lint along the outside, top, and behind the storage box.-The oven was dirty with grime; food spattered on the outside windows and sides.During an interview on 04/01/26 at 6:13 AM, the DM stated there were holes in the metal ramp for the dish machine, so the water went down to the floor. He acknowledged that the flooring needed to be repaired. At 6:17 AM, after observing the flooring, he confirmed that the flooring was a non-cleanable surface. At 6:22 AM, the DM stated he thought the walls had been cleaned about two to three months ago. At 6:43 AM, the DM confirmed the dirty knife rack.During an observation on 04/01/26 at 6:30 AM, Dietary staff (D) 1 was preparing pureed bread. He laid the measuring spoons on top of the dirty microwave. There was a paper attached to the top of the microwave, and food spatter along the outside top and sides of the microwave. The microwave was located on the left side of the puree prep table and the blending machine. He added thickener to the pureed mixture using the measuring spoons and placed it back on top of the dirty microwave. At 6:53 AM, the DM confirmed the microwave was dirty and proceeded to clean it.During an interview on 04/01/26 at 7:43 AM, the Administrator stated they were looking at the cost for the flooring, but did not have any estimates. He stated the hood vent needed to be replaced.Review of the facility's policy titled, Environment, revised June 2025, revealed . All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115566	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Towne Center	5131 Warm Springs Rd Columbus, GA 31909

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the facility's policy titled, Administering Medications, the facility failed to administer medications timely for one of six residents (Resident (R) 141) reviewed for medications out of a total sample of 38 residents. This failure had the potential to alter the effectiveness of the medication with the potential for overdosing if medications were given too close together. Findings include: Review of R141's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was admitted on [DATE] and discharged on 06/21/25. The resident had diagnoses which included anemia, encounter for orthopedic aftercare following surgical amputation, and muscle weakness. Review of R141's discharge Minimum Data Set (MDS), with an assessment reference date (ARD) date of 06/21/25 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) was not conducted and the staff assessment for mental status indicated the resident had moderately impaired cognition. During an interview on 03/30/26 at 1:56 PM, the Resident Representative (RP) 1 stated she did not think the resident received any medications for the first 24 hours. Review of the Medication Admin [Administration] Audit Report, scheduled for 06/18/25-06/21/25 and provided by the facility, revealed the following: -Omeprazole DR [delayed release] 20 MG [milligram] Capsule- give one capsule by mouth one time a day for GERD [gastroesophageal reflux disease] was scheduled for 06/19/15 at 09:00 [9:00 AM] and was documented as administered on 06/19/25 at 14:33 [2:33 PM]. -Losartan Potassium 100 MG tab- give one tablet by mouth one time a day for HTN [hypertension] was scheduled for 06/19/25 at 09:00 and was documented as administered on 06/19/25 at 14:33. -Oxycodone-Acetaminophen oral tablet 5-325 MG- give one tablet by mouth every 8 [eight] hours for Pain was scheduled for 06/21/25 at 0800 [8:00 AM] and was documented as administered on 06/21/25 at 13:01 [1:01 PM]. Review of the Omnicell inventory list, located in the printer room on the wall, revealed the above medications were listed as available. During an interview on 03/30/26 at 2:53 PM, Unit Manager (UM) 2 stated for medication pass, they had one hour before and one hour after the designated time to administer the medication. She stated she did not audit the medication administration times and was unaware there were late meds. During an interview on 03/30/26 at 3:41 PM, UM1 stated for medication pass, they had one hour before and one hour after the designated time to administer the medication. She stated she did not audit the medication administration times and was unaware there were late meds. During an interview on 03/31/26 at 10:09 AM, the Administrator stated they had one hour before and one hour after the designated times to administer the medication. He stated they should have pulled the medication from the Omnicell. He said nobody was auditing for late medication administration. Review of the facility's policy titled, Administering Medications, revised December 2012, revealed . Medications should be administered within one (1) hour of their prescribed time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115566	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Towne Center	5131 Warm Springs Rd Columbus, GA 31909

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility pharmacy services failed to ensure medication irregularities were identified and addressed when ordered medications were not available for administration for one resident (Resident (R) 147) out of four newly admitted residents reviewed for medication irregularities. This failure had the potential to result in a decline of the resident's condition due to missed medication. Findings include: Review of R147's Admissions Record, located under the Admissions tab of the electronic medical record (EMR), revealed R147 was initially admitted to the facility on [DATE] and expired in the facility on [DATE], with diagnoses to include acute respiratory failure with hypoxia, hyperlipidemia, and tracheostomy. Review of R147's Physician Orders, dated [DATE] and located under the Orders tab of the EMR, revealed R147 was prescribed Budesonide Inhalation Suspension 9.5 via trach two times a day for the diagnosis of respiratory failure. The physician orders also revealed that R147 was prescribed Naloxegol Oxalate Oral tablet 12.5 via feeding tube one time a day for constipation, and Latanoprost Ophthalmic Solution for glaucoma in both eyes. Review of R147's Medication Administration Record (MAR), located under the Orders tab of the EMR, revealed R147 did not receive the ordered Budesonide Inhalation Suspension, the Naloxegol Oxalate tablet, Isosorbide Dinitrate oral tablet, or the Latanoprost Ophthalmic Solution during her three day stay in the facility. Review of R147's Progress Notes, dated [DATE] at 8:59 AM and located under the Progress Notes tab of the EMR, written by Licensed Practical Nurse (LPN) 8, documented the facility was awaiting delivery of Budesonide Inhalation Suspension, the Naloxegol Oxalate tablet, Isosorbide Dinitrate oral tablet, and the Latanoprost Ophthalmic Solution. Review of R147's Progress Notes, dated [DATE] at 2:02 PM and located under the Progress Notes tab of the EMR, documented R147 was missing the Latanoprost eye drops, budesonide inhalant, and Naloxegol tablets. The writer documented how she spoke with the pharmacy and was told the medications were on back order. Review R147's Nursing Progress Notes, dated [DATE] at 2:22 PM and located under the Progress Notes tab of the EMR, documented R147 had been assessed for shortness of breath and indicated her vital signs were checked and recorded at baseline, before and after respiratory assessments every shift. The progress notes documented that R147 had a lot of anxiety, pulling on lines and devices. Review of R147's Progress Notes, dated [DATE] 10:37 AM and located under the Progress Notes tab of the EMR, documented the missing medications were on back order and may arrive [DATE]. Review of R147's MAR, dated [DATE] and located under the Orders tab of the EMR, revealed R147's respiratory assessments were documented every shift, and her vital signs were checked and recorded every shift before and after respiratory assessments and appeared normal for her baseline vital signs. During an interview on [DATE] at 10:30 AM, LPN8 stated that she was consistent to document that R147's missing medications were on back order but that she failed to look in the Omnicell for the medication and failed to call the prescribing physician regarding the status of the unavailable medication for an update to the order or for an available substitute. During an interview with the Director of Nursing (DON), she stated she was a new employee to the facility since [DATE] and was not aware of any previous medication issues. She stated the previous DON was on maternity leave. During an interview with the Administrator on [DATE] at 11:58 AM, he initially stated he had stepped into the role of DON during the previous DON's maternity leave on [DATE] and was not aware of the missing medications that had been ordered for R147. He stated his expectation for the nursing staff was to inform the physician of any medications that were not available within the initial 12 hours of admission to the facility. He said if the ordered medications have not arrived within 12 hours of a new admission, the nurse should check the Omnicell for the medication and then notify the physician for a change in the order for similar medications that were readily available. Review of the undated policy titled, Administering Medication, revealed, . The DON supervises and directs all (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115566	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Towne Center	5131 Warm Springs Rd Columbus, GA 31909

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personnel who administer medications and/or have related functions, and that medications are administered in accordance with prescriber orders, including any required time frame.