STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Health and Rehabilitation	433 North McGriff Street Whigham, GA 39897

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
	115607	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Health and Rehabilitation	433 North McGriff Street Whigham, GA 39897

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records review, staff interviews, and the facility policy titled Fall Prevention Policy, the facility failed to ensure that one Resident (R1) with a history of multiple falls and receiving Plavix daily had accurate and complete neurological checks for a head injury on [DATE] and a second fall on [DATE] resulting in an acute bilateral tentorial subdural hemorrhage to the left side of the head with a right-to-left midline shift. The resident expired on [DATE] with an immediate cause of death determined to be a subdural hematoma. The facility census was 60. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Interim Director of Nursing, Director of Nursing, MDS (Minimum Data Set) Coordinator, and Registered Nurse Wound Care were informed of the Immediate Jeopardy on [DATE], at 4:07 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on [DATE]. An Acceptable IJ Removal Plan was received on [DATE]. Based on observation, record reviews, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on [DATE]. The facility remained out of compliance while the facility continues to develop and implement a Plan of Correction (POC). This oversight process includes analyzing the facility's staff's conformance with the facility's policies and procedures related to ensuring resident safety, including staff education, care plan review and interventions, fall risk assessments, resident neurological checks, and quality assurance. Findings include:Review of the policy Fall Prevention Policy dated [DATE]. Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.Policy Explanation and Compliance Guidelines: 9. When any resident experiences a fall, the facility will a. Assess the resident. b. Complete a post-fall assessment. f. Document all assessments and actions. h. Initiate neurological checks (if unwitnessed or witnessed and the resident hit their head).Review of the Electronic Medical Record (EMR) for R1 revealed the following diagnoses that included but were not limited to traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, type 2 diabetes mellitus, and hypertension.Review NBC (nonspecific tool by name)-Fall Risk Assessment dated [DATE] revealed a score of 16, indicating high risk.Review of progress notes dated [DATE] to [DATE] revealed a history of multiple falls. An entry dated [DATE] at 1:47 pm revealed R1 was found lying on the floor on his back with his walker rollator next to him. R1 sustained a hematoma to the top of his head. It was noted that the physician was notified of the fall, and neurological checks were started per fall protocol.Review of the Neurological Assessment Flowsheet dated [DATE] revealed the flowsheet was to be completed for each fall with a head injury or any unwitnessed fall. The parameters listed on the flowsheet are to Complete Every 15 minutes x 2 hours, Every 30 minutes x 2 hours. And the instructions: Document the date and time of each assessment, proceed as follows. Level of Consciousness, Pupil Response, Motor Functions - Hand grasp, extremities. Pain Response, Vitals and Observation.There was a discrepancy in time intervals between the last 15 minutes and the beginning of the 30-minute neurological checks for R1. There was no evidence that the neurological check assessments were completed for the [DATE] night shift (11:00 pm to 6:00 am), [DATE] for each of the three shifts, and [DATE] day shift (7:00 am to 3:00 pm).The progress note (nursing) dated [DATE] revealed R1 was noted to be on the floor in his room. R1 had discoloration from a previous fall ([DATE]). The nurse noted she attempted to notify the physician and the emergency contact. She returned to R1's room to do neurological checks, and R1 was not responding to commands. The resident was in a state of sleep, and she was unable to get the resident to respond. R1 was sent out via Emergency Medical Services (EMS) for an evaluation. The nurse noted that she had received a call from the hospital that his diagnosis was a brain bleed with a midline shift. On [DATE], R1 returned from the hospital on hospice care. Review of the Medication Administration Record (MAR) for R1, dated [DATE] through [DATE], revealed an order for clopidogrel bisulfate [generic Plavix (a medication used to prevent blood clotting)] oral tablet 75 milligrams (mg) by mouth one time a day related to essential primary hypertension. Further review revealed the medication was documented as administered daily as ordered. Review of the Medication Administration Record (MAR) dated [DATE] through [DATE] revealed R1 received clopidogrel bisulfate (Plavix) oral tablet 75 mg by mouth one time a day. He was administered Plavix on [DATE] through [DATE] as indicated by initials on the MAR.Review of the hospital emergency room (ER) documentation dated [DATE] revealed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Health and Rehabilitation	433 North McGriff Street Whigham, GA 39897

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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Health and Rehabilitation	433 North McGriff Street Whigham, GA 39897

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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, the facility failed to ensure that staff nurses assessed and completed neurological checks for one of 10 Residents (R1) who had a fall (5/15/2025) with a head injury and sustained a hematoma. The census was 60. On August 12, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Interim Director of Nursing, Director of Nursing, MDS (Minimum Data Set) Coordinator, and Registered Nurse Wound Care were informed of the Immediate Jeopardy on August 12, 2025, at 4:07 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on May 15, 2025. An Acceptable IJ Removal Plan was received on 8/14/2025. Based on observation, record reviews, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on 8/15/2025. The facility remained out of compliance while the facility continues to develop and implement a Plan of Correction (POC). This oversight process includes analyzing the facility's staff's conformance with the facility's policies and procedures related to ensuring resident safety, including staff education, care plan review and interventions, fall risk assessments, resident neurological checks, and quality assurance. Findings include:Review of the medical record for R1 revealed diagnoses that included, but were not limited to, traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, dated 5/23/2025.Review of the Medication Administration Record (MAR) dated 5/1/2025 through 5/31/2025 revealed an order for clopidogrel bisulfate [generic Plavix (a medication used to prevent blood clotting)] oral tablet 75 milligrams (mg) by mouth one time a day related to essential primary hypertension. Further review revealed the medication was documented as administered daily as ordered. Review of the Progress Notes for R1 revealed an entry dated 5/15/2025 at 1:47 pm documented that R1 was found lying on the floor on his back with his walker (rollator) next to him. R1 had a hematoma [a localized collection of blood outside of a blood vessel caused by trauma or injury] to the top of his head. It was noted that the physician was notified of the fall, and neurological checks (neuro checks) were started per the facility's fall protocol. Continued review revealed an entry dated 5/21/2025 at 7:43 pm that R1 was noted to be on the floor in his room. The resident was unable to give a description of the incident and was assisted to a chair via a two-person assist. The nurse returned to the room, and the resident was not responding to commands. Staff were unable to get the resident to respond to any commands. The resident was sent out via Emergency Medical Services (EMS) for evaluation. Review of the facility-provided document titled Neurological Assessment Flow Sheet for R1 indicated the neuro checks were to be completed every 15 minutes for two hours, every 30 minutes for two hours, and every shift for 72 hours. Further review of the document revealed that the neuro checks were initiated on 5/15/2025 at 1:30 pm. Continued review revealed no evidence that the neurological checks were completed on the 5/17/2025 night shift (11:00 pm to 6:00 am), 5/18/2025 for each of the three shifts, and 5/19/2025 day shift (7:00 am to 3:00 pm). The Vitals section of the document revealed a blood pressure of 99/58 on 5/15/2025 at 2:30 pm, 104/58 at 3:30 pm, and 108/58 at 4:30 pm. There was no documented evidence that the physician was notified of the blood pressure readings. Review of the Georgia Death Certificate for R1 revealed the Immediate Cause of death was a Subdural Hematoma, and the approximate interval between onset and death was weeks. date of death [DATE].In an interview on 8/5/2025 at 1:14 pm, Licensed Practice Nurse (LPN) AA revealed that she came to work on 5/21/2025, and that she received a report that R1 had a previous fall on 5/15/2025. She noticed that the resident had a knot on his head that was getting larger, and his head looked warped. She stated that the Director of Nursing (DON) was aware of the knot. She further stated that R1 was more confused. He had a fall in his room and was placed in his bed. She stated she left the room to call the physician, returned to R1's room, saw him unresponsive, and sent him to the hospital via EMS services.In an interview on 8/5/2025 at 2:02 pm, Registered Nurse (RN) BB revealed the R1 fell on 5/15/2025. She stated that the resident stood and tumbled while going into his room and fell backward. His head hit the door as he was falling. In an interview on 8/6/2025 at 9:52 am, Certified Nurse Aide (CNA) DD revealed that before his fall with injury, R1 was able to go to the shower, dress, and feed himself. He was ambulatory with a walker and would place his clothes over the walker. He had a walker with wheels (rollator). She stated that he was still his usual self and was not a bed person. CNA DD further stated that R1 changed after the fall and before he had the last fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Health and Rehabilitation	433 North McGriff Street Whigham, GA 39897

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Health and Rehabilitation	433 North McGriff Street Whigham, GA 39897

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and a review of the facility-provided Administrator and Director of Nursing (DON) Job Description, the Administration failed to provide oversight and supervision related to assessments of post fall monitoring and neurological checks by licensed nurses and failed to ensure safety measures implemented were effective for R1, who suffered head trauma after a fall, resulting in death.On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Interim Director of Nursing (DON), Director of Nursing, MDS (Minimum Data Set) Coordinator, and Registered Nurse Wound Care were informed of the Immediate Jeopardy on [DATE], at 4:07 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on [DATE]. An Acceptable IJ Removal Plan was received on [DATE]. Based on observation, record reviews, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on [DATE]. The facility remained out of compliance while the facility continues to develop and implement a Plan of Correction (POC). This oversight process includes analyzing the facility's staff's conformance with the facility's policies and procedures related to ensuring resident safety, including staff education, care plan review and interventions, fall risk assessments, resident neurological checks, and quality assurance. Findings include: Review of the Administrator job description dated [DATE]. Purpose of Your Job Position. The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to ensure that the highest degree of quality care can be provided to our residents at all times. Duties and Responsibilities. Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities in accordance with guidelines issued by the governing board. Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the facility. Review of the Director of Nursing job description dated [DATE]. Position Purpose. Planning, organizing, developing, and directing the overall operations of the Nursing Service Department in accordance with local, state, and federal standards and regulations, established facility policies and procedures, and as may be directed by the Administrator and the Medical Director, to provide appropriate care to the residents. Major Duties and Responsibilities. Interprets and communicates policies and procedures to nursing staff, and monitors staff practices and implementation. Participates in daily or weekly management team meetings to discuss census changes, resident changes in status, complaints or concerns. Performs rounds to observe residents and ensure nursing needs are being met. Facility Administration, specifically the Administrator and DON, failed to ensure resident safety and effectively oversee areas of the facility that were included in their job descriptions. 1.The facility Administration failed to provide supervision and oversight of R1, who had a history of multiple falls; failed to ensure monitoring of R1, who was on Plavix and had a head trauma from a fall on [DATE] and a second fall on [DATE] with head trauma resulting in death on [DATE]. Cross-reference F689 2.The facility failed to ensure safety measures implemented were effective for R1 who had a head trauma from a fall on [DATE] and [DATE].Cross-reference F689, 726, F835 3.The facility failed to ensure R1 had accurate and completed neurological checks post-fall ([DATE]) protocol for head injury. R1 had a hematoma located on the left side of the head and was receiving Plavix daily.Cross-reference F835 4.The facility failed to ensure that staff nurses assessed and completed neurological checks for R1, who was on Plavix and had a fall ([DATE]), which resulted in a hematoma to the left side of the head.Cross-reference F689, F835 Review of R1's fall history for 2025 revealed he had had a total of 10 falls prior to his death. A previous fall on [DATE] resulted in a compressed fracture of the lumbar spine. R1 fell on [DATE], revealing a hematoma (nurse's note) to the top of his head. And on [DATE], a fall that put R1 in a state of unconsciousness and expired on [DATE]. A review of the progress note (nursing) dated [DATE] revealed R1 was noted to be on the floor in his room. R1 had discoloration from a previous fall ([DATE]). The nurse noted she attempted to notify the physician and the emergency contact. She returned to R1's room to do neurological checks, and R1 was not responding to commands. The resident was in a state of sleep, and she was unable to get the resident to respond. R1 was sent out via Emergency Medical Services (EMS) for an evaluation. The nurse noted that she had received a call from the hospital that his diagnosis was a brain bleed with a midline shift. On [DATE], R1 returned from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Health and Rehabilitation	433 North McGriff Street Whigham, GA 39897

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	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, staff and resident interviews, and review of the facility policy titled Documentation in Medical Record, the facility failed to ensure the medical record documentation was complete and accurate for one of 10 sampled residents (R) (R5). Specifically, staff documented the presence of maggots between the left great toe and the second toe for R5.Findings include:Review of the facility policy titled Documentation in Medical Record, dated 1/13/2025, revealed: Policy Explanation and Compliance Guidelines: 4. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident-centered.Review of the admission record revealed that R5 was admitted to the facility with diagnoses including, but not limited to, type 2 diabetes mellitus, unspecified dementia, peripheral vascular disease, and severe morbid obesity.Review of the 6/30/2025 Wound Care Physician note indicated the resident had a wound to the left medial leg that was being treated with medical-grade honey and a two-layer compression wrap every Monday, Wednesday, and Thursday.Review of the 7/2/2025 Wound Care Physician note indicated the order was changed to cleanse with wound cleanser, pat dry, apply collagen, and cover with ABD [abdominal] pad every Monday, Wednesday, and Thursday.Review of the 7/17/2025 progress notes documented the Wound Care Nurse and the Wound Care Nurse Practitioner (NP) were in the resident's room for weekly rounds. It was noted the left foot was noted to have non-skin abnormalities. There was no redness or open areas noted. The Physician and the Director of Nursing were notified.Review of the Physician's Order for R5 revealed an order dated 7/17/2025 to cleanse the left foot with normal saline, pat dry, soak in Dakin's solution for five to ten minutes, pat dry, apply calcium alginate to left foot digits, and apply nystatin powder. Remove calcium alginate in the am. One-time, only for one day order.During an interview with Registered Nurse (RN) EE on 7/23/2025 at 3:37 pm, she stated that she had seen maggots between the resident's left foot toes. She stated that there was no open area between her toes. She stated there were about 10 maggots for about two to three days. She also stated she did not document the maggots on the resident's foot because she was instructed not to write maggots in her documentation.During an interview with the NP Wound Consultant on 8/5/2025 at 10:55 am, she stated the resident had maggots between the toes, and she did not document the maggots in her report because the maggots were not in the wounds. She stated she was seeing the resident for wounds.During an interview with RN BB on 8/5/2025 at 11:08 am, she stated that the Wound Care NP told her that the resident had maggots between her toes and feet. The Wound Care NP asked her if she had seen the maggots. She stated that if she had seen the maggots, she would have documented that in the resident's chart.During an interview with Licensed Practical Nurse (LPN) GG on 8/5/2025 at 12:39 pm, she stated the maggots were in the resident's left toes and that she was standing near RN BB and RN EE and overheard the conversation about the resident having maggots.