| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115635 | A. Building<br>B. Wing | 04/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| River Brook Healthcare Center | 390 Sweat Street<br>Homerville, GA 31634 |

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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, the facility failed to ensure that two of three sampled residents (R) (R2 and R7) received a 30ˆday discharge notice and failed to notify the ombudsman of a facilityˆinitiated transfer or discharge.1.Review of the admission Record revealed Resident 2 (R2) was admitted to the facility on [DATE] with diagnoses including, but not limited to, hypertension, depression, diffuse traumatic brain injury with loss of consciousness, and traumatic ischemia of muscle.Review of the Progress Notes dated 01/10/2026 through 01/20/2026 revealed an entry dated 01/19/2026 indicating that R2 was accepted to an outˆofˆcounty (named) facility. The note stated that R2 and a family member were informed of the discharge, and the nurse and CNA were also notified of the transfer. Staff were informed that transport would arrive at 8:30 AM. On 01/20/2026 at 8:30 AM, R2 was transferred via EMS on a stretcher. All of the resident's belongings were packed and sent with him.Review of the Order Summary Report revealed no evidence of a physician order for discharge.There was no evidence of a 30ˆday discharge notice or a request for transfer to another Skilled Nursing Facility (SNF). There were no behaviors documented, and the ombudsman had not been notified of the discharge.Review of the Discharge Recapitulation dated 01/20/2026 revealed an incomplete form. The form contained only the resident's demographic information and name, with all other sections left blank.Interview on 03/30/2026 at 2:34 PM with Ombudsman CC revealed that R2 was discharged from the facility without notification to the ombudsman or the family. The ombudsman stated the resident did not want to move because his mother lived in the local area.Interview on 03/30/2026 at 3:27 PM with R2 revealed staff came to his room and told him to be ready the next morning because they needed to work on his room. He was told the move was temporary. Upon arrival at the receiving facility, he was informed he would not be returning.Interview on 03/31/2026 at 10:15 AM with the Maintenance Director revealed he did not perform any renovation to R2's room.Interview on 04/02/2026 at 11:05 AM with the Social Services Director revealed the resident frequently complained about being in the facility and expressed a desire to go to New York, and later to an Assisted Living Facility (ALF). She stated that some residents on A Hall had to be moved due to environmental issues, and because R2 was unhappy, she told him he would be leaving the next morning to go to a (named) facility. R2 left less than 24 hours after being informed he was moving for room renovation. She acknowledged she did not contact the ombudsman regarding his discharge.2. Review of the admission Record revealed Resident 7 (R7) was admitted to the facility on [DATE] with diagnoses including, but not limited to, endˆstage renal disease on dialysis, paraplegia, hypertensive heart and chronic kidney disease, type 2 diabetes, hypertension, and seizures.Review of the progress notes dated 11/01/2025 through 03/31/2026 revealed an entry dated 03/16/2026 documenting that an R7 family member accused the roommate of slapping R7. The roommate denied the allegation. Law enforcement was contacted due to family members attempting to fight and verbally threaten the roommate. The roommate was moved to a different room.Review of the Order Summary Report revealed no evidence of a physician order related to the discharge.There was no evidence that the resident received a 30ˆday discharge notice, and the discharge recapitulation<br>(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 |
|---|---|---|

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | summary was not completed.Interview on 03/31/2026 at 1:08 PM with Ombudsman BB revealed the resident wanted to return to the facility. She stated the resident was not given a 30ˆday notice, and the facility did not notify the ombudsman prior to the discharge. She stated the resident could have appealed with her assistance.Interview on 04/02/2026 at 11:05 AM with the Social Services Director revealed she sent a referral package to a (named) facility after speaking with corporate and the previous administrator. She stated the resident's family member had to be escorted out by law enforcement. She also stated the resident kept her television on all night and talked loudly on her phone using speaker mode. The resident was not given a 30ˆday discharge notice because she had found another facility, and the ombudsman was not notified. The resident was transferred out of the facility within 24 hours. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility policy titled, RAI/Care Planning Management, the facility failed to ensure that two of three sampled residents(R) (R2 and R7), whose care plans indicated they wished to remain in the facility, had their expressed desires honored.Findings includeReview of the policy titled, RAI/Care Planning Management revised August 2017. A discharge plan will be included in the care plan at admission. Goals will be resident specific, measurable and realistic.1.Review of the admission Record revealed R2 was admitted to the facility with diagnoses including, but not limited to, hypertension, depression, diffuse traumatic brain injury with loss of consciousness, and traumatic ischemia of muscle.Review of the care plan revealed R2's plan was to remain a longˆterm care resident. Interventions included encouraging and assisting the resident to participate in activities of choice, and for the Social Services Director to visit as needed.2. Review of the admission Record revealed R7 was admitted to the facility on [DATE] with diagnoses including, but not limited to, endˆstage renal disease on dialysis, paraplegia, hypertensive heart and chronic kidney disease, type 2 diabetes, hypertension, and seizures.Review of the care plan revealed the resident had voiced no desire to be discharged from longˆterm care and required 24ˆhour care. The family was unable to provide care at that time. The care plan also directed staff to refer to Social Services if the resident voiced or demonstrated interest in seeking outside resources to live elsewhere.Interview on 04/02/2026 at 11:02 AM with the Licensed Practical Nurse (LPN) MDS Coordinator revealed that the Social Services Director (SSD) initiates the transfer/discharge process. The LPN stated she did not know why the required process was not followed for these residents. |