STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Health and Rehabilitation	176 Lincoln Ave Fitzgerald, GA 31750

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 0656 Level of Harm - Actual harm 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and review of the facility's policy titled Comprehensive Care Plans, the facility failed to follow the care plan interventions related to falls for one of four Residents (R) (R1) Actual harm occurred on 10/2/2025 when R1 who required two person assist with Activities of Daily Living (ADL) care rolled out of bed onto the floor during incontinent care that was being provided by one Certified Nursing Assistant (CNA). As a result of the fall, R1 sustained a distal fracture of left femur and a fracture of the lower end of the right tibia Findings include:A review of the facility's policy titled Comprehensive Care Plan dated 6/2/2025 under Policy revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Under the section titled Policy Explanation and Compliance Guidelines revealed, 3.(f) Resident specific interventions that reflect the resident's and preferences .A review of the electronic medical record (EMR) under the Medical Diag tab revealed R1 was admitted to the facility with a diagnosis that included but was not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture to right and left knee, transient alteration of awareness, other seizures, cerebral infarction due to embolism of left posterior cerebral artery, alcohol dependence with withdrawal, other epilepsy, intractable, without status epilepticus, unspecified, memory deficit following cerebral infarction, anxiety disorder, unspecified dementia, with other behavioral disturbance. Further review of the list of diagnoses revealed, other fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing was added on10/3/2025 and unspecified fracture of lower end of right tibia, subsequent encounter for closed fracture with routine healing was added on 10/6/2025.A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for R1 under Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score indicated the resident was rarely/never understood; Section GG (Functional Abilities) revealed that R1 was dependent on staff for all activities of daily living (ADL) care and for chair/bed-to chair transfer that indicated assistance of two or more staff was required for the resident to complete the activity. A review of R1's care plan revealed, a focus that indicated Mr. [R1's Name] is at risk for Falls R/T(related to) CVA (cerebral vascular accidents) with right side weakness. Needs extensive assistance with bed mobility and transfers and has Seizure d/o (disorder) and altered mental status at times. Confusion and incontinent of bowel and bladder. He has h/o (history of) having delusions that he can walk, trying to scoot out of bed to get up. He has contracture of bilateral knees. Interventions included but not limited to: Two person assist with ADL care as needed.A review of R1's nurse's note dated 10/2/2025 at 7:15 am revealed, Writer was alerted to resident's room by staff. Staff reported that during incontinent care, resident rolled out of bed onto the floor. Resident was assessed for injury with no visible injuries noted. Resident was two person assist with use of Hoyer lift off of the floor and back into the bed. Incontinent care was provided by staff. Director of Nursing (DON), Administrator, Nurse Practitioner (NP), and RP was notified. Will continue to observe.Interview on 10/30/2025 at 1:05 pm with the Corporate MDS nurse revealed that the nursing staff do not update the Care Plans for the residents. She stated that during the Interdisciplinary Team (IDT) meetings they talk about if there needs to be changes/updates to residents' care plans. She revealed that she was currently working to get all of the care plans corrected.Interview on 10/30/2025 at 2:30 pm with the Administrator revealed that she expects staff to follow the residents' care plan when providing care. She also revealed that she expect the residents needs be reflected in the care plan interventions and for all staff to follow the care plan. [Cross Reference - F689]

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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 0689 Level of Harm - Actual harm 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)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and review of the facility's policy titled Incident and Accidents, the facility failed to provide adequate supervision to prevent accidents for one of four residents (R) (R1) reviewed for falls. Actual harm occurred on 10/2/2025 when R1 who required two person assist with Activities of Daily Living (ADL) care rolled out of bed onto the floor during incontinent care that was being provided by one Certified Nursing Assistant (CNA). As a result of the fall, R1 sustained a distal fracture of left femur and a fracture of the lower end of the right tibia.Findings include:A review of the facility's policy titled Incidents and Accidents dated 4/1/2025 under Policy revealed, It is the policy of this facility for staff to utilize the Risk Management porta [sic] to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involved a resident. Under the Compliance Guidelines section revealed, .6. In the event of an accident, immediate assistance will be provided or securement of the area will be initiated, unless it places one at risk of harm. A review of the electronic medical record (EMR) under the Medical Diag tab revealed R1 was admitted to the facility with a diagnosis that included but was not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, contracture to right and left knee, transient alteration of awareness, other seizures, cerebral infarction due to embolism of left posterior cerebral artery, alcohol dependence with withdrawal, other epilepsy, intractable, without status epilepticus, unspecified, memory deficit following cerebral infarction, anxiety disorder, unspecified dementia, with other behavioral disturbance. Further review of the list of diagnoses revealed, other fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing was added on10/3/2025 and unspecified fracture of lower end of right tibia, subsequent encounter for closed fracture with routine healing was added on 10/6/2025.A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for R1 under Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score indicated the resident was rarely/never understood; Section GG (Functional Abilities) revealed that R1 was dependent on staff for all activities of daily living (ADL) care and for chair/bed-to chair transfer that indicated assistance of two or more staff was required for the resident to complete the activity.A review of R1's undated care plan revealed, a focus that indicated Mr. [R1's Name] is at risk for Falls R/T(related to) CVA (cerebral vascular accidents) with right side weakness. Needs extensive assistance with bed mobility and transfers and has Seizure d/o (disorder) and altered mental status at times. Confusion and incontinent of bowel and bladder. He has h/o (history of) having delusions that he can walk, trying to scoot out of bed to get up. He has contracture of bilateral knees. Interventions included but not limited to: Two person assist with ADL care as needed.A review of R1's nurse's note dated 10/2/2025 at 7:15 am revealed, Writer was alerted to resident's room by staff. Staff reported that during incontinent care, resident rolled out of bed onto the floor. Resident was assessed for injury with no visible injuries noted. Resident was two person assist with use of Hoyer lift off of the floor and back into the bed. Incontinent care was provided by staff. Director of Nursing (DON), Administrator, Nurse Practitioner (NP), and RP was notified. Will continue to observe.A review of R1's progress note titled eINTERACT Situation, Background, Assessment, and Recommendation (SBAR) Summary for Providers dated 10/2/2025 at 7:38 am revealed Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Fall at the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 138/78 - 10/2/2025 7:39 Position: Lying left/arm - Pulse: P 83 - 10/2/2025 7:40 Pulse Type: Regular - RR: R 19 - 10/2/2025 7:40 - Temp: T 98.2 - 10/2/2025 7:40 Route: Forehead (non-contact) - Weight: W 201.2 lb (pound) - 9/5/2025 12:52 Scale: Mechanical Lift - Pulse Oximetry: O2 97 % - 10/2/2025 7:41 Method: Room Air; Skin Status Evaluation: No changes observed - Pain Status Evaluation: Does the resident/patient have pain? No - Neurological Status Evaluation: No changes observed; Nursing observations, evaluation, and recommendations are: Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: initiate neuro checks observe for any c/o (complaints of) pain or discomfort, B. New Testing Orders: C. New Intervention Orders:A review of R1's progress note dated 10/2/2025 6:45 pm revealed, a late entry that indicated Resident resting in bed throughout shift. Noted requesting bed repositioning several times after lunch to time of shift. Verbally denies pains, but voices overall being uncomfortable. Voices appreciation with repositioning and bed adjustment. No falls noted this shift. Will observe for any changes A review of R1's progress note dated 10/2/2025 at 6:45 pm revealed, a late entry