STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115679	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Comfort Creek Nursing and Rehabilitation Center	10200 U.S. Hwy 1 South Wadley, GA 30477

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family and staff interviews, record review, and review of the facility policy titled, Discharge Plan/Transfers and policy titled, Instructions for Conduction BIMS (Brief Interview for Mental Status), the facility failed to notify the responsible party of the discharge and transfer to a Personal Care Home for one out of eight sampled residents (R) with moderate cognitive impairment. Findings included:Review of the facility's policy titled Discharge Plan/Transfers, with a revised date of 10/20/2025, revealed under the Procedure section: 3. When the facility anticipates a resident's discharge to a private residence or to another nursing care facility, a post-discharge plan will be developed which will help the resident adjust to their new living environment. 4. The post discharge plan will be developed by the care team with the assistance of the resident and his/her family. 6. As a minimum the post discharge plan will include: a. A description of the residents's and family's preference of care. d. A description of specific resident needs after discharge. e. A description of how the resident and family need to prepare for the discharge. f. Social Services will review the plan with the resident and family 24 hours before the discharge is to occur.Review of the Clinical Resident Profile for R E revealed the resident's sister was the resident's responsible party and financial power of attorney.Review of the clinical record revealed that R E had an initial admission date of February 2018 and a discharge date of 2/11/2026. Diagnoses included, but were not limited to, asthma, schizophrenia, schizoaffective disorder, alcohol dependence in remission, intellectual disabilities, and major depressive disorder recurrent.Review of the Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview of BIMS score of 07, indicating severe cognitive impairment.Review of the Discharge Return Not Anticipated MDS assessment dated [DATE] revealed Section C (Cognitive Patterns) documented BIMS score of 05, indicating severe cognitive impairment.Review of the care plan, dated 01/12/2026, revealed a focus area of the resident and his family wish for him to be discharged to a facility closer to them. Interventions included establishing a discharge plan with the resident and family as needed.Review of a Progress Note-Discharge Evaluation dated 02/11/2026 for R E, documented Patient has a planned discharge today to a personal care facility in [named city] at his request. Prescriptions signed and to be sent with patient. He is ambulatory, continent, and independent with all ADLs. Patient continues to experience paranoia and did not allow physical exam today. He did state that feels fine and is ready to go. He voices no concerns at this time. {sic} The Discharge Evaluation was signed by the FNP-C (Family Nurse Practitioner-Clinician).Review of multiple progress notes over the course of R E's stay at the facility documented that the primary RP was notified for consent or notification of changes or new issues. Consent and/or notifications documented in the clinical record included, but were not limited to, psychoactive medication consent, bed hold notification, flu shot consent, COVID vaccine consent, and care conference invites.Review of Discharges for the past three months revealed R E was discharged on 2/11/2026 to [Named] facility.In an interview on 04/02/2026 at 1:13 PM, the Social Services Director (SSD) revealed that R E was alert and oriented, with no signs of confusion or dementia. The SSD stated she was unaware that she should have notified the RP about the discharge (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the Personal Care Home.In an interview on 04/08/2026 at 10:03 AM, the Director of Nursing (DON) confirmed R E was discharged and that his family was not notified. She confirmed the RP should have been notified before discharge. The DON stated that the expectation for a resident with a BIMS score of 05 or 07 to be discharged was that the family should be notified and involved.In an interview on 04/08/2026 at 10:15 AM, the Administrator confirmed that she knew R E was being discharged and that she did not notify the RP. She revealed she thought the SSD had notified the RP that R E was being discharged , and that the RP should have been called that same day.In an interview on 04/08/2026 at 4:00 PM, the Nurse Practitioner revealed she was not aware that R E's family was not notified and not involved in his discharge. She revealed that a BIMS score of 05 indicated severe cognitive impairment, and the RP should have been notified of the discharge.