STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115684	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Care Center - St Marys	805 Dilworth Street Saint Marys, GA 31558

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the facility's policy titled Abuse Prevention and Reporting, the facility failed to ensure three of 15 residents (R) (R1, R2, and R3) were protected from verbal and/or physical abuse by staff. This deficient practice had the potential to affect the quality of life for all residents reviewed.Findings included:Review of the facility's policy titled Abuse Prevention and Reporting, revised June 20, 2025, documented Definitions: Abuse: Any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a resident, including but not limited to, assault or battery, failure to provide treatment or care, or sexual harassment of the resident. Verbal Abuse: Any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents regardless of age, ability to comprehend, or disability. Policy: This assisted living center will not tolerate abuse, neglect or exploitation of its residents by anyone. Such incidents will be reported to all appropriate authorities, agencies and registries and a written copy as such reports maintained in a central file and the resident's file.1. R1 was a [AGE] year-old (y/o) female who was admitted with a primary admission diagnosis of cerebral infarction. Other diagnoses included, but were not limited to, Alzheimer's disease, generalized muscle weakness, history of falling, overactive bladder, irritable bowel syndrome with constipation, shortness of breath, diaper dermatitis, vitamin B12 deficiency anemia, and malignant neoplasm of the cranial nerve.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R1 reported Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) score 08, indicating moderate cognitive impairment. Indicators for mood or behaviors in sections D (Mood) and Section E (Behaviors) identified during the assessment period. GG-R1 required a wheelchair for mobility, had lower extremity impairment on one side, and required supervision/touch assistance for eating, oral hygiene, dressing, footwear, personal hygiene, rolling in bed, lying to sitting, sit to lying, moderate assist for toilet transfer & tub/shower, and dependent for toileting, partial/moderate assistance for toilet, bed-to-chair, tub/shower transfer, walking 10 feet, wheeling 50 feet with two turns. H-R1 was frequently incontinent of bladder, and occasionally incontinent of bowels. No training program. M-Risk of developing pressure ulcers/injuries.Review of the care plan, last reviewed/revised on 04/09/2026, revealed R1 had a risk for skin breakdown related to (r/t) bladder and bowel (B/B) incontinence, need for ADL (Activities of Daily Living) assistance, impaired mobility, risk for impaired mobility/ weakness, risk for falls r/t impaired mobility and weakness associated with CVA (cerebrovascular accident/stroke), is an ADL decline r/t CVA, reduced mobility, and impaired vision.Review of wound history revealed R1 had a rash in the perineal area that was not there on admission, and it was first identified on 01/13/2026. The color is pink, localized, warm, circular, and itchy. Orders for butt cream back to 09/23/2025 for diaper dermatitis, and po meds and prescription ointments started in January 2026.An interview on 05/05/2026 at 1:45 PM with R1 revealed she had a bowel problem, and when she needed help, she pushed the button. R1 revealed that Certified Nursing Assistant (CNA) UU spoke to her in a mean manner, mistreated her, and would not help or change when needed. CNA UU yelled (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and told me to get up and go by myself. CNA UU did not want to change her wet pants. R1 stated CNA UU had no business talking to her that way.An interview on 05/05/2026 at 2:40 PM with Registered Nurse (RN) LL revealed she usually worked on A hall and confirmed several residents reported abuse by CNA UU. RN LL revealed CNA UU was terminated in the last few weeks because of the mistreatment/abuse/neglect reported by several residents. A phone interview on 05/05/2026 at 1:55 PM with the family of R1 confirmed that the CNA UU yelled at R1, refused to change or provide care for R1, or help her to the bathroom.2. R2 was a 50-y/o female admitted with primary/admission diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Other diagnoses included, but were not limited to, cerebral infarction, insomnia, constipation, chronic candidiasis, muscle weakness, diarrhea, and major depressive disorder.Review of the Quarterly MDS assessment dated [DATE] reported Section C-BIMS score 13, indicating little to no cognitive impairment. GG-Impairment on one side, upper and lower extremities, required partial/moderate assistance for rolling side to side in bed. Maximum/ substantial assistance for sit-to-lying or lying-to-sitting, transferring from bed to chair, and toilet & tub/shower transfer. Dependent for toileting hygiene, bathing, dressing, footwear, and personal hygiene. H-R2 was always incontinent with bladder and bowels, and not on a toileting training program. M-Risk of developing pressure ulcer/injury.Review of the care plan, last reviewed/revised 04/13/2026, revealed R2 required training and skill practice in bed mobility-start date 11/10/2025, had CVA(Cerebrovascular Accident) with left hemiparesis, left foot drop and left hand contracture and needs extensive to total help in ADLs-start date 09/02/2024, risk for pressure ulcers related to impaired mobility, risk for contracture r/t CVA w/left hemiparesis-apply palm guard left hand, risk for skin breakdown r/t bladder and bowel (B/B) incontinence, need for ADL assistance, impaired mobility.Interview on 05/05/2026 at 2:10 PM with R2 confirmed the abuse by a staff. R2 revealed it was a CNA named [CNA UU], on the night shift. R2 stated CNA UU took off her gown and snatched it, yanked it, and pulled her left shoulder, and then wiped her private (labia) hard, and where she wiped me, it hurt badly. R2 stated that she told CNA UU, and she didn't care; she didn't slow down or stop; she kept on. R2 reported it to my night nurse. R2 confirmed that the police spoke with her. R2 was not sure whether CNA UU was still employed at the facility and hoped she was not, and stated that CNA UU had not returned to provide care for her.3. R3 was a 75 y/o female admitted with primary/admission diagnosis of Alzheimer's disease. Other diagnoses included but not limited to orthopedic aftercare, hypothyroidism, glaucoma, major depressive disorder, muscle weakness (generalized), insomnia, protein-calorie malnutrition, osteoarthritis, pain, acute embolism and thrombosis of deep veins of left lower extremity, localized swelling, mass and lump left lower limb, adult failure to thrive, diarrhea, severe protein-calorie malnutrition, cutaneous abscess of buttock, local infection of the skin and subcutaneous tissue, anxiety disorder, depression.Review of Physician orders included pain evaluation every shift, Treatments: Non-Rx: Clean area to coccyx with normal saline (NS) and pat dry, apply hydrocolloid as needed, start date 04/22/2026, Treatments Non-Rx: Clean area to coccyx with normal saline(NS) and pat dry, apply dry Optiview dressing once a day every three days, start date 04/24/2026, weekly skin assessment.Review of the Quarterly MDS assessment dated [DATE] for R3 reported Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) score 12, indicating little to mild cognitive impairment. D-Felt down/depressed/hopeless 7-11 days and poor appetite 12-14 days of the seven-day look-back period. E-No behaviors exhibited. GG-R3 had impairment on both sides in upper & lower extremities, no device for mobility (R3 rarely got out of bed). R3 required substantial/maximum assistance for bathing self, dressing, footwear, rolling left to right in bed, and was dependent for toileting, personal hygiene, sit to lying (ability to move from bed), lying to sitting on side of bed, chair/bed-to-chair transfer, toilet and shower transfer, and walking was not attempted due to medical reasons. H- Always incontinent of B&B and no toileting program. M-R3 had a risk for pressure ulcer/injury.Review of the care plan, last reviewed/revised on 04/21/2026, revealed R3 had a risk for ADL functional status/rehabilitation potential. Has a decline related to neuralgia and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alzheimer's disease with a start date of 09/03/2024. Risk for falls r/t impaired mobility and cognition, start date 09/03/2024. Interventions: Place the call light within reach, keep the environment safe. Impaired skin integrity: small open area on her coccyx, start date 04/21/2026. Interventions dated 04/21/2026 included wound care as ordered, turn and reposition, and observe for /report s/s of infection. Risk for skin breakdown r/t impaired mobility and bowel and bladder incontinence. Interventions: Keep skin as clean and dry as possible, minimize skin exposure to moisture, start date 3/6/25, verbal education given to the resident on changing positions and getting out of bed to prevent skin breakdown-12/17/25, encourage changing positions and getting out of bed-12/18/2025. Mobility: has impaired mobility r/t weakness and impaired cognition, start date 09/03/2024.An interview on 05/05/2026 at 1:55 PM, R3 confirmed being treated roughly by [Named CNA UU]. She revealed she had a hip replacement and a blood clot in her leg, and CNA UU was pulling her leg hard, and she would not stop when she told her it hurt. She revealed that R1 family member had called the police, and that the officer had spoken with several residents in B hall, including R3 and her roommate, R9.An interview on 05/05/2026 at 1:55 PM with R9 revealed her roommate, R3, needed her catheter emptied so it would drain properly and not back up. R9 revealed that she reminded CNA UU the night before to please empty it the next morning before leaving, so it would drain properly. CNA UU did not empty her catheter drainage bag. R9 confirmed that the police officer came in and spoke with her and R3 about CNA UU, and they told the police officer how rough she was with R3. R3 and R9 revealed the facility was short-staffed, or they just won't do their job. Often, it takes a long time for staff to answer call lights, especially on the night shift.Review of a Police report dated 04/11/2026 for Abuse, Neglect or Exploitation of a disabled or elderly person confirmed that the police investigated an incident at the facility and talked to the nurse, Director of Health Services (DHS), a family member, and three residents. The Officer documented that he was dispatched to the facility regarding neglect.Review of Police Report case number 2026-00011423, with date of occurrence 04/11/2026, revealed that the local police were called and dispatched to the nursing home. They made a report that included the Police officer talking with a family member, residents, two hall nurses, and the Director of Nursing (DON) related to the offense of abuse, neglect, or exploitation of disabled or elderly persons by a staff member. The DON revealed to the Police officer that CNA UU would be placed on administrative suspension. She also said that prior to my involvement, CNA UU had been removed from the wing where the reporting residents were. When the Police officer gave the description and name of the CNA UU to the DON, she nodded to indicate she knew who he was talking about.Review of Facility Reported Incident (FRI) 202604212 dated 04/10/2026 for abuse. Details of the incident were documented on 04/10/2026 at approximately 2:52 PM. The facility was notified that a resident reported to her granddaughter that a CNA had handled her roughly during care. The granddaughter contacted local law enforcement, who responded to the facility to investigate the allegation. Education on abuse and neglect was initiated by the DHS. R1 stated that the CNA entered her room using a loud-voiced tone and spoke to her in an inappropriate manner. Documentation revealed that the CNA was immediately suspended, and the family and physician were notified. Further review of facility documentation also revealed that after investigation of the incident, which included interviewing staff and residents, the CNA who was involved in the allegation was terminated, but not reported to the licensure boardA review of a Notification-Allegation of Abuse and Neglect to the Ombudsman by the Director of Health Services (DHS) documented that the facility became aware that a resident had reported to her that a family member had handled her roughly while providing care. The granddaughter contacted law enforcement, and an officer responded. Measures have been implemented to ensure the resident's safety, and the CNA involved has been removed from the resident's care duties pending the outcome of the investigation.Review of the documentation revealed that, in the Status of Employee dated 04/21/2026, the CNA remained suspended during the investigation. Upon completion of the investigation, the facility attempted to contact CNA UU to schedule a meeting, review the findings, and complete the required re-education prior to the CNA's (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	return to work. After multiple attempts without response, the facility determined the CAN UU had abandoned her position (job abandonment) in accordance with facility policy.A review of the Investigation Summary dated 05/16/2026 revealed that, during the investigation, other residents in the same unit were interviewed. Four residents expressed concerns about CNA UU's manner of providing care, describing CNA UU as rough and/or rushed; however, none reported any specific incidents of injury, neglect, or harm. No resident provided sufficient detail to establish that abuse as defined by regulation occurred. CNA UU reported she provided care in accordance with training and facility policy. Based on information obtained, abuse was unsubstantiated as there is no evidence to support that abuse or neglect occurred.Review of the documents revealed that during interviews with residents, law enforcement noted that the CNA UU was rude, yelled, and failed to provide requested care. The officer interviewed other residents who reported similar concerns involving the same CNA UU as being rude and speaking in a yelling/angry tone.Review of witness statements revealed that CNA SS documented, Residents c/o (complained of) CNA talking and shouting at them. The complaint was reported to the supervisor from 3:00 PM to 11:00 PM. The CNA was (CNA UU), and the residents' c/o (complaining) were R2 and R3.An interview on 05/07/2026 at 2:05 PM with the Administrator confirmed the abuse allegation of CNA UU by R1, revealed that it was investigated and reported, and she was terminated. The incident with R1 was reported to her by staff after R1 called her family, who overheard the CNA on the phone with R1. The Administrator provided the state report of the incident for review and confirmed that CNA UU immediately left the facility and was suspended pending investigation. R1 had no history of reporting false allegations against staff. The Police were called and interviewed by R1's family member, and afterward interviewed other cognitively impaired residents who resided in A-hall, where CNA UU was assigned. It was reported that there had been other incidents of CNA UU speaking inappropriately to residents, neglecting residents by refusing to provide needed care, or physically being rough with residents during care. The Administrator also revealed all staff had been in-service on abuse and reporting abuse. The Administrator revealed she did not have an incident report on any other residents, but others were identified through the investigation.An interview on 05/13/2026 at 2:55 PM with the DHS OO revealed that she participated in the investigation into R1 abuse. The facility called her and the Administrator, and she came to the facility that day, one to two hours after they called. CNA UU was not at the facility when she arrived. The plan was to suspend her pending an investigation. CNA UU was scheduled to work that night, but DHS OO spoke with her and told her she could not work. She wanted to know what the problem was and why she could not work. DHS OO spoke with CNA UU, who denied any wrongdoing. DHS OO spoke with all residents CNA UU had cared for; she was only in A hall, so she focused on that hall. Residents complained about the way CNA UU spoke to them and how she responded when they asked or spoke to her. It was just verbal; they were complaining about it. CNA UU left and never came back. The DHS OO revealed she tried to call her, but CNA UU did not answer any of her calls. DHS OO revealed the incident was not reported on CNA UU's license. It was reported to law enforcement and the Ombudsman. DHS NN revealed the incident was unsubstantiated. It was only CNA UU being loud, talking to the roommate; she is mean and rude and told R1 to get up and go to the bathroom on her own, but there was no physical contact, no abuse. The Police came, spoke with several other residents, and were still at the facility when DHS arrived. The other residents reported the same thing. The CNA was mean talking but she never responded. It was all verbal. When asked, DHS OO stated she did not feel that being mean, talking, and being loud was verbal abuse. DHS OO felt like it was her tone of voice.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record reviews, and review of the facility's policies titled Restorative Nursing Program and Therapy Evaluations, the facility failed to ensure that restorative nursing services were consistently provided following the completion of therapy for four of eleven residents (R) (R12, R13, R14, and R15) reviewed for restorative nursing services. Specifically, the facility failed to provide required restorative interventions, including transfer assistance for R12; ambulation/walking programs for R13 and R14; and Range of Motion (ROM) exercises for the upper or lower body for R12, R13, and R14. This deficient practice has the potential to diminish residents' quality of life.Findings included:Review of the facility's policy titled Therapy Evaluations, revised May 13, 2020, documented the following procedures: 5. The evaluation will include recommendations for treatment and followˆup as clinically indicated. 12. Therapy will foster an interdisciplinary approach to care by educating departments on safe transfer techniques, environmental adaptations, and patient/residentˆspecific restorative nursing programs as indicated.Review of the facility's policy titled, Restorative Nursing Program, revised November 4, 2021, documented Policy Statement: It is the policy of this healthcare center to provide restorative nursing which actively focuses on achieving and maintaining optimal physical, mental, and psychological functioning and wellbeing of the patient/resident. Restorative Nursing Program is under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) and restorative nursing services are provided by Restorative Nursing Assistants (RNAs) and other qualified staff. Definitions: Restorative nursing program refers to interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. Passive Range of Motion (PROM)-movements in order to maintain flexibility and useful motion in the joints of the body. Active Range of Motion (AROM)-exercised performed by the resident, with cueing, supervision, or physical assistance by the staff. Documentation: 1. Restorative nursing care will be documented in the EHR (Electronic Health Record) or paper form. 2. The nurse will evaluate the patient's progress. Document in resident's care plan.1. R12 was an [AGE] year-old (y/o) admitted to facility 10/28/2025 with primary/admission diagnosis of chronic obstructive pulmonary disease. Other diagnoses included, but were not limited to, Vitamin B12 deficiency anemia, muscle weakness, difficulty in walking, muscle spasm of the calf, hypothyroidism, osteoporosis, and constipation.Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R12 reported Section C-Cognitive Patterns BIMS (Brief Interview for Mental Status) score of 15, which indicated little to no cognitive impairment. I-Active diagnoses: Debility, cardiorespiratory conditions. Section O-Special Treatments and Therapies revealed that the resident did not receive any therapies and received restorative nursing services for transfer and active and passive range of motion on one day during the seven-day look-back period.Review of the care plan, last reviewed/revised date 03/13/2026, revealed that R12 had a problem with ADLs (Activities of Daily Living) functional status/rehabilitation potential and required training and skill practice in transfers and active range of motion for the bilateral upper and lower extremities six days per week. Interventions: Follow treatment guidelines of PT (Physical Therapy) . RNP (Restorative Nursing Program) once a day for transfer and AROM (Active Range of Motion).Review of PT Discharge Summary dated 12/04/2025 for R12 under Discharge Recommendations and Status documented Discharge Recommendations: Restorative Range of Motion Program and Restorative Transfer Program. The prognosis to maintain CLOF was good with consistent staff follow-through. There was no documentation of restorative nursing services for review. An interview on 05/13/2026 at 12:22 PM with R13 revealed that the only exercises she received were those Certified Nursing Assistant (CNA) QQ gave her, and they might be once a week or not at all. R13 stated she asked CNA QQ if she could do her exercises while working on the floor and was told she couldn't do both. R13 revealed that the frequency of exercise depended (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on whether CNA QQ was working on the floor. The problem is they don't have enough help. R13 was concerned and stated that she would not improve by exercising only once a week. R13 continued to reveal staffing issues and said residents are at their mercy. R13 2. Review of the medical record revealed R13 was a 66 y/o who was admitted with a primary/admission diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Other diagnoses included, but were not limited to, respiratory syncytial virus as of 03/21/2026, acute bronchitis due to respiratory syncytial virus, muscle weakness, hypothyroidism, difficulty in walking, and peripheral vascular disease.Review of Quarterly MDS assessment dated [DATE] for R13 reported Section C-Cognitive Patterns BIMS score 14, which indicated little to no cognitive impairment. I-Active diagnoses: Stroke. Section O-Special Treatments and Therapies revealed the resident did not receive restorative nursing services during the seven-day look-back period. Section O-reported R13 received OT and no RNP in the past seven-day look-back period. Review of the care plan, last reviewed/revised date 04/21/2026, revealed that R13 had a problem with ADLs' functional status/rehabilitation potential and required training and skill practice in walking and active range of motion for the bilateral lower extremities (BLEs) six days per week. Interventions: Follow treatment guidelines of PT. RNP once a day ambulation and AROM.Review of Physical Therapy PT Discharge Summary dated 12/30/2025 for R13 under Discharge Recommendations and Status documented, Discharge Recommendations: RNP for Restorative Ambulation Program, Restorative Range of Motion Program. The prognosis to maintain CLOF was excellent with consistent staff follow-through. There was no documentation of restorative nursing services for review.Interview on 05/13/2026 at 2:25 PM with R13 revealed that CNA QQ did exercises at the same time as her roommate, focusing on her legs, ankles, and arms. She did not get therapy every day, only about once or maybe twice a week. 3. Review of the medical record revealed R14 was an 86 y/o who was admitted with a primary/admission diagnosis of dementia. Other diagnoses included, but were not limited to, hypothyroidism, type 2 diabetes mellitus, osteoarthritis, weakness, constipation, age-related osteoporosis, and disorders of bone density and structure.Review of Quarterly MDS assessment dated [DATE] for R14 reported Section C-Cognitive Patterns BIMS score 12, which indicated moderate cognitive impairment. I-Active diagnoses: Non-traumatic brain dysfunction. Section O-Special Treatments and Therapies revealed R14 received restorative nursing services for AROM and walking one day during the seven-day look-back period.Review of the care plan, last reviewed/revised date 03/24/2026, revealed that R14 had a problem with ADLs' functional status/rehabilitation potential and required training and skill practice in walking and active range of motion to BLEs (Bilateral Lower Extremities), six days per week. Interventions: Follow treatment guidelines of PT. RNP once a day ambulation/walking and AROM.Review of Physical Therapy PT Discharge Summary dated 11/12/2025 for R14 under Discharge Recommendations and Status documented, Discharge Recommendations: RNP for Restorative Ambulation Program, Restorative Range of Motion Program. The prognosis to maintain CLOF was good with consistent staff follow-through. There was no documentation of restorative nursing services for review.Interview on 05/13/2026 at 12:20 PM with R14 revealed that CNA QQ performs leg exercises. She does not come every day. She does it one to two times a week. R14 revealed she did not have restorative today, and there is only one girl for a lot of people. 4. Review of the medical record revealed R15 was admitted with a primary/admission diagnosis of nondisplaced fracture of the second cervical vertebra dated 09/04/2025. Other diagnoses included, but not limited to, disease of the upper respiratory tract-03/04/2026, muscle weakness (generalized), chronic obstructive pulmonary disease with acute exacerbation, presence of right artificial knee joint, idiopathic gout, spinal stenosis lumbar region with neurogenic claudication, wedge compression fracture of third thoracic vertebra, wedge compression fracture of first lumbar vertebra, fracture of left acetabulum.Review of Annual MDS assessment dated [DATE] for R15 reported Section C-Cognitive Patterns BIMS score 15, which indicated little to no cognitive impairment. I-Active diagnoses: Medically Complex conditions. Section O-Special (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatments and Therapies revealed R15 did not receive restorative nursing services during the seven-day look-back period.Review of the care plan, last reviewed/revised date 04/21/2026, revealed R13 had a problem with ADLs' functional status/rehabilitation potential and required training and skill practice in walking, and active range of motion to BLEs six days per week. Interventions: Follow treatment guidelines of PT. RNP once a day walking and AROM.Review of Physical Therapy PT Discharge Summary dated 10/31/2025 for R15 under Discharge Recommendations and Status documented, Discharge Recommendations: RNP for Restorative Ambulation Program, Restorative Range of Motion Program. The prognosis to maintain CLOF was Other prognosis: Factors impacting prognosis-consistency/follow-through with recommendations. There was no documentation of restorative nursing services for review.A review of the staffing schedule dated 04/11/2026, for the 7:00 AM to 7:00 PM shift showed that CNA UU was marked out, and a name was written in. DON OO confirmed that the name listed for the other CNA on B hall was not a CNA; it was LPN KK, who worked as a CNA. DON OO revealed that the other nurse covered LPN KK's rooms.An interview on 05/12/2026, from 12-12:25 PM with R15 revealed that she had fallen a while back and had been hospitalized for two days. She got therapy way back, and CNA QQ worked with her about a month ago, but she was not getting therapy now. CNA QQ was the restorative aide but has not had restorative care in three to four weeks. R15 confirmed that no one does range of motion, walking, transfer, or exercises with her.During the survey, no observations of R12, R13, R14, or R15 receiving restorative services for walking, transfers, or ROM exercises were made from 05/05/2026 to 05/13/2026.Interview on 05/13/2026 at 2:04 PM with Occupational Therapist (OT) staff. OT PP revealed that both Physical Therapy (PT) and OT can recommend a restorative nursing program (RNP) after completion of therapy. The therapy discharge evaluation documents whether RNP is recommended, but it is very basic; the primary communication to the nurse includes all the details in the electronic medical record (EMR). It will be an order or a teaching record. OT PP revealed there should be an RNP care plan for residents on restorative care. OT PP revealed that if she discharged a resident with a recommendation for RNP, she would expect it to be five days a week, Monday through Friday, because that is what therapy did, and she felt the resident needed to maintain and/or prevent decline. She confirmed CNA QQ was the staff member who did restorative but was not certain whether restorative was done every day. OT PP saw CNA QQ in the facility, but did not know in what role, whether she provided restorative care or floor CNA. OT PP confirmed that R12, R13, R14, R15, and R16 were recommended for Restorative and should be on it.Interview on 05/13/2026 at 2:17 PM with CNA QQ revealed that she had been a restorative aide for 2 years. She started as a CNA on the floor in February 2024 and became a Restorative CNA in June 2024. She does not do restorative nursing on the days she is pulled to work as a CNA on the floor because she cannot do both. She revealed that she worked Monday-Friday and that there was no restorative care on weekends. The interview revealed that, over five days, she may be on the floor two to three days each week. She revealed they were usually short-staffed, and the first people they pull to go to the floor are the restorative staff. Last week, she was on the floor Monday, Tuesday, and Wednesday, and did restorative Thurs and Friday. Interview on 05/13/2026 at 10:40 AM with Director of Health Services (DHS) NN who was from a sister facility and was at this facility assisting the Administrator and interim DHS OO during the complaint investigation revealed the facility did not have a restorative nursing program (RNP) but had a functional Restorative CNA who did range of motion and walking, to keep residents where they are and try to prevent a decline.Interview on 05/13/2026 at 2:55 AM with DHS OO revealed the facility did not have an RNP but had someone who does restorative exercises. She revealed that as soon as the resident finished therapy, an assessment would be done. If the resident needs functional restorative they put them on restorative, but it is not consistent because if the restorative CNA is needed on the floor, she does not do restorative. If we don't need her on the floor, she does restorative exercises. DHS OO revealed she did not know how long it had been since they last had a restorative program, and that restorative exercises are done occasionally. DHS OO (continued on next page)

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Senior Care Center - St Marys	805 Dilworth Street Saint Marys, GA 31558

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed that CNA QQ is the restorative aide and is scheduled for restorative care as much as possible, but if they have callouts, she is pulled. DHS OO expectation was to have restorative daily and not have to pull the restorative aide to work on the floor.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the facility's policy titled Occurrences, the facility failed to provide protective oversight and supervision to prevent elopement and ensure resident safety. This deficient practice resulted in one of four sampled residents (R) (R1 and R10) exiting the facility and remaining unaccounted for by staff for over one hour, and in R10 experiencing a fall with major injury in the shower, resulting in a subarachnoid hemorrhage. Findings included:A review of the facility's policy titled, Occurrences, with a revised date of January 11, 2024, revealed under Policy Statement: .To prevent occurrences, each patient/resident will be observed and assessed for risks. Definitions: Occurrence hazards are physical features in the healthcare center environment which may pose a risk to a patient/resident's safety, including but not limited to: Any event, accident, or incident, on or off healthcare center property which results in an injury or has the potential for injury. Elopement from healthcare center property regardless of whether there was an injury associated with the elopement. 1. Review of R4's clinical record revealed R4 was an [AGE] year-old male admitted with primary/admission diagnoses of multiple fractures of ribs, left side, fracture of first thoracic vertebra, fracture of scapula, left shoulder, subsequent encounter for fracture with routine healing. Additional diagnoses included, but were not limited to, muscle weakness, need for assistance with personal care, dementia with behavioral disturbance, pain, stroke, and non-Alzheimer's Dementia.Review of Physician orders include, but are not limited to, behavior monitoring; Wander Guard to left ankle; check functioning and placement every shift; start date 03/11/2026.Review of the admission five-Day Minimum Data Set (MDS) assessment dated [DATE] reported Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) score of 02 indicating severe cognitive impairment, Section E (Behaviors) wandering behavior occurred one to three days, wandering placed the resident at significant risk of getting (outside the facility), and the wandering behavior is worse compared to prior assessment. Section GG (Functional Abilities and Goals) R4 was coded as independent for self-care, indoor mobility, and functional cognition. No impairment in upper or lower extremities, and no device used for mobility, and Section P documented that a wander/elopement alarm was used less than daily.Review of the care plan included Behavioral symptoms: Presence of Behavioral Symptoms-wanders unsafely, start date 03/05/2026. Interventions included assessing the appropriateness of the Wander guard start date (03/09/2026) and moving the resident closer to the nurses' station start date (03/11/2026).A review of the room census revealed that R4 was in room A/14-b from 03/05/2026 to 03/11/2026. Room A-14 was the last room on the right at the end of Hall A, next to the door that exited the facility.The review of the assessment for elopement, titled Elopement Risk Observation Form, dated 03/07/2026, was completed after R4 eloped from the facility on 03/07/2026 and revealed a 0-4 Low Risk. 5-10 Moderate Risk. 11 or Greater - High Risk: Interventions for high risk included but are not limited to: 3-day monitoring and Wander guard Program. R4's elopement risk score was 17.0, indicating high risk. Review of progress notes documented, 03/07/2026 5:22 PM: Resident is an [AGE] year-old male, who is alert/confused and wears a wander guard for being in unfamiliar surroundings. On 03-07-2026, the resident escaped from [Named] facility and walked to his previous residence, where he contacted his family to inform them about his location. The family member contacted the police department, and the resident was brought back to the facility unharmed and assessed by the nurse for injuries that may have occurred while he was away from the facility.Review of Facility Incident Report(FRI) dated 03/07/2026 documented, Elopement resident [R4] 03/07/2026 at 4:45 PM, Resident reported to have left the facility without signing out. Whereabouts are unknown. Elopement education was provided to all staff. All doors were checked to ensure they were locked. Resident count was completed to ensure all residents were accounted for. A copy of a Police Officer's card was with the report, Case number (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026-7627, Officer [Name].Review of form titled, SBAR (Situation, Background, Assessment, Recommendation) Communication Form (undated) documented, Post elopement started on 03/07/2026, the new environment made the condition or symptoms worse.Review of Event Note dated 03/07/2026 documented, Wander guard to left ankle #A02253145. The resident is an [AGE] year-old male who is alert/confused and wears a wander guard due to unfamiliarity with the nursing environment. On 03/07/2026, the resident escaped from [Named] facility and walked to his previous residence, where he contacted his family to inform them about this location. The family contacted the police department, and the resident was brought back to the facility unharmed and assessed by the nurse for injuries that may have occurred while he was away from the facility.A review of the two-week staffing grid for the date of the elopement, March 7, 2026, revealed that the PPD (per patient day) ratio of staff to residents was 1.87, as confirmed by the DHS (Director of Health Services).A review of the staff assignment for 03/07/2026 revealed that two nurses and two Certified Nursing Assistants (CNAs) initialed the assignment sheet to confirm their presence. For the night shift (7:00 PM to 7:00 AM), the two-week staffing had 12 RN (Registered Nurse) hours. The initial nurse scheduled was marked out, and the DHS was assigned for 7:00 PM to 5:00 AM, although on the two-week grid, it showed 12 RN hours.2. R10 was a [AGE] year-old male with most recent readmit on 03/24/2026. Diagnosis: acute bronchiolitis due to respiratory syncytial virus (RSV)-Primary/admission diagnosis (dx) as of 03/24/2026. Additional diagnoses included, but were not limited to, chronic obstructive pulmonary disease, malignant neoplasm of unspecified part of bronchus or lung, chronic kidney disease, stage 4, difficulty in walking, muscle weakness (generalized), and nontraumatic subarachnoid hemorrhage-admit dx on 02/12/2026.Review of the MDS assessment dated [DATE] reported a BIMS score of 14, indicating little to no cognitive impairment. GG-documented impairment on both sides in lower extremities, and used a wheelchair for mobility, independent for sit to stand (the ability to transfer to and from a bed to a chair or wheelchair), and supervision for toileting, dressing, footwear, toilet chair/bed transfer, and walking 10 feet.Review of the care plan included Falls: R1 had a risk for falls related to unsteady gait.Review of the witness statement documented that CNA stated that, while starting to shower, R10 turned his head to close the door, and when he turned back, R10 began to fall backward and hit his head on the shower room wall.Review of Progress Note dated 02/09/2026 11:48 AM documented, Resident ambulated with the assistance of two to the shower room and was seated in the shower chair. The resident pushed himself back in the chair, causing it to flip backward and hit his head on the back of the ceramic wall. EMS (Emergency Medical Services) was contacted, and the resident was transported to the hospital for further evaluation. Daughter and physician both notified via phone call.Review of SBAR Communication Form dated 02/09/2026 documented date admitted was 02/06/2026, and reason for transfer was a fall. It was signed by LPN TT.Review of Fall Event' dated 02/11/2026 documented a fall in the shower room. The resident was sitting in a shower chair waiting to be showered. The resident exhibited a complaint of pain related to the fall, rated five on the pain scale, 0-10. The location of the injury was the occipital part of the head.Review of Associated FRI 202601687 dated 2/18/2026. R1 had a witnessed fall with major injury in the shower room when a staff person was about to give the resident a shower. The resident was sitting on a shower bench, the staff member turned to provide privacy, and R1 attempted to move to his wheelchair. The wheelchair rolled. R1 was wet, started slipping, fell, and hit his head. The resident was sent to the hospital for evaluation and diagnosed with a subarachnoid hemorrhage. Interview with R1, interview with staff, review of clinical records, and review of facility documentation. Education for staff was given, and an associated FRI #202601687 was submitted to the State Survey Agency. The final investigation for incident, FRI 202601687, dated 02/18/2026, documented, Resident was assisted to the shower room by the CNA. While the CNA turned to shut the door, the patient was sitting on a shower bench. CNA states that when he turned back around, he noticed the patient leaning backward, falling, and hitting his head. Patient was assessed by staff and DHS; no bleeding or lumps noted. Per (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protocol, the patient was sent to the hospital. When they called to check on the resident, they were informed of the subarachnoid hemorrhage and were transferred to [Named] hospital in [Named] city for further evaluation. On 02/12/2026, the patient returned to the facility. The resident was interviewed, and he revealed that he was attempting to sit when he fell backward. Neglect was not substantiated.An interview on 05/05/2026 at 12:35 PM with R10 revealed he liked it at the facility, that it was alright, as good as can be expected, and that when he needed help, he hit the call light. R10 revealed that it sometimes takes 30-40 minutes, sometimes an hour or longer, for staff to come when he uses the call light, if at all. R10 revealed his urinal had sat on his over-the-bed table for over half an hour. He would need to use it and wait so long that, by the time they came, he no longer needed it because he had wet himself and the bed, and they had to change the bed sheets. He revealed yesterday, the day before our interview, that he was constipated and finally had to go. He called for help, and it took so long that he got up unassisted, used his wheelchair, and was on the toilet by the time they finally came. Staff told him not to do that anymore because he could slip and fall. He revealed that if he had not, they would have to change a dirty bed.An interview on 05/05/2026 at 2:40 PM with RN LL confirmed R4 eloped from the facility and walked all the way to his house, down by the waterfront, approximately two miles. R4 was gone long enough for the neighbor to call the nursing home to report it. The facility did not know until they got a call. RN LL revealed that two other residents, R5 and R6, also left through the front door and went to the parking Lot. RN LL confirmed education in-service on elopement and the wander guard after the incident. Review of the staff assignment with RN LL; she confirmed they had initialed their names to confirm they were present.An interview on 05/05/026 at 3:11 PM with Housekeeping (HK) Aide MM revealed she was aware of one elopement about four weekends ago. R4 lived close to the facility, and the neighbor saw him and brought him back.An interview on 05/05/2026 at 3:21 PM with Licensed Practical Nurse (LPN) KK confirmed there was an elopement several weeks ago, the weekend after the prior Director of Health Services (DHS) quit. R4 got out and walked to his home. LPN KK revealed that there have also been times when R5 and R6 went out the front door and reached the parking lot. They followed a visitor or someone out. There is now an alarm on the front door. She confirmed they did in-services, but not in person. They posted a paper, and the staff was supposed to read and sign it. She revealed that staff are instructed to keep a close eye on R5 and R6. They both have a Wander guard, but the alarm is only on the front door. Review of the staff assignment with LPN KK; she confirmed that the initials by their name confirmed they worked.An interview on 05/05/2026 at 4:25 PM with CNA BB revealed that she had heard about a resident who eloped from the building. It was a weekend, and she was off, but she heard staff talking about it. It was a male (R4). The family member brought him back from his house. She revealed that she did not know which door he had gotten out of and said there was an alarm on the front door. All other doors require a badge swipe to open. There are exit doors on A, B, C, and D hall, and in the Activity room at the end of D hall.An interview on 05/05/2026 at 5:00 PM with the Administrator confirmed that R4 exited the facility through the door at the end of A hall, which did not close properly. R4 left the property and walked to his nearby home. He was seen by a neighbor who called his family. The family called the police, and he returned. R4 was in the room at the end of A hall, next to the door. He had not been here long, and he wanted to go home. The Administrator confirmed R4's elopement but denied that any other residents had left the property.An interview on 05/13/2026 at 9:00 AM with the Maintenance Director revealed a resident elopement through the door at the end of A hall. He revealed that the door frame appeared to have several coats of paint and a thick buildup that may have prevented the door from being locked. He revealed he worked on the door, ground down the paint, checked the lock, and it has worked properly ever since. He revealed he checks all doors twice a day and checks the Wander guard alarm on the front door to make sure the door locks when you go out. He confirmed that there have been no problems with the doors since R4 eloped.A follow-up interview on 05/13/2026 at 10:30 AM with R10 revealed that when he fell in the shower, a staff member was present but had stepped away from him. There were two (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stalls, and R10 was sitting on the shower chair/stool in one stall. The staff turned to check on the person in the other stall. R10 got up to get to his wheelchair. He tried to get into his wheelchair on his own, and it was not locked. He revealed that the wheelchair started rolling, he was wet, and he started sliding. He also revealed that the wait time for staff answering the call light can sometimes be one, two, or three hours, if it gets answered at all.An interview on 05/13/2026 at 2:55 PM with the DHS confirmed R4's elopement. She revealed she could not tell me the exact time he left, but it was documented. It was early in the morning. It happened on the 7 AM to 7 PM shift. They notified the Administrator first, then notified the DHS, and started the investigation. R4 was brought back unharmed. She revealed they did education with all staff. The interview further confirmed that R10 had a fall in the shower, that staff were present, and that he was sent out for evaluation and treatment. He returned to the facility; he sustained a subarachnoid hemorrhage. The DHS revealed they have staffing issues at times, but that was not why R10 fell. Her expectation was that staff would always stay close to residents in the shower and closely monitor all residents, especially those who wander.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, review of facility documents titled, PBJ (payroll-based journal) Staffing Data Report, and review of the policy titled, State Minimum Staffing for Healthcare Centers, The facility failed to ensure adequate nursing staff to meet residents' needs in a timely manner. This failure delayed the provision of care, increased the risk of elopement and falls resulting in major injury, and could have decreased the quality of life of 61 residents residing in the facility. Findings included:Review of the facility's policy titled, State Minimum Staffing for Healthcare Centers, last reviewed November 2, 2025, documented Policy Statement: The facility will maintain the minimum staffing hours in accordance with federal law and the respective state's rules and regulations. Staff shall be sufficient to meet the healthcare needs of each patient/resident as identified in the patient/resident's plan of care.Review of the Facility Assessment for the period May 12, 2026 - May 11, 2027, with last activity on May 12, 2026, revealed that the number of licensed beds was 78, and the current census was 67. Overall staffing was documented as sufficient, for contractures-sufficient, for Rehabilitative Services (for those receiving therapy), documented In Progress, and Recreational Therapy documented In Progress.The Facility assessment dated [DATE] documented a request for the prior Facility Assessment, which revealed that neither documented the average daily census in the facility, nor the average hourly staffing needs per day for licensed nurses providing direct care, nor the hours for nurse aides. Review of the PBJ Staffing Data Report FY (fiscal year) Quarter 1 2026 (October 1- December 31) revealed, based on the data submitted, the facility triggered excessively low weekend staffing.Review of Grievances/Complaint Log Form for the past seven months, from 09/02/2025 to present, revealed the following complaints reported:On 02/04/2026-Spouse reports a delay in care caused the resident distress and worry about the adequacy of the resident's medical management. A Foley catheter was inserted for a full bladder but not done in a timely manner; the spouse reports it took over 20 hours to receive medical attention. Spouse requested that care be provided more promptly to avoid prolonged discomfort and potential complications.On 03/06/2026-More than one incident of not being helped with toileting, sat in wet clothes and bedding for four hours after calling for help (03/02/2026), and on 03/06/2026, the resident called for help at 11:30 AM, and at 3:00 PM, still nobody came to help her. Family visits ended up helping the residents.On 03/13/2026-Complaint of Certified Nursing Assistant (CNA) ignoring residents when they asked for something, bad behavior, ignoring and not providing care when requested, not putting a dependent resident to bed until 11 PM, even when asked several times earlier.On 10/09/2025-Not getting showers and staff being rough with residents during transfer.Review of Resident Council minutes for the past eight months revealed the following:On 10/07/2025, residents complained that the response time to call lights is unacceptable; the wait time is long when residents call the CNA; they are not getting showers on scheduled days; and residents are left alone in the shower.On 11/11/2025, CNAs walked past the lights without checking.On 12/09/2025-Response time is long when a resident calls for help. Three residents have not showered in three days. The board in the room is not updated daily (with date, nurse, and CNA name). No restorative care is provided after being discharged from therapy. Housekeeping is changing residents due to understaffing.On 01/13/2026-Understaffed on the weekends, no one checks on residents at night, call lights are not being answered, and staff scolds residents for needing to be changed.On 02/10/2026-Need more CNAs and nurses on weekends, phones not being answered at the front desk, call lights are still not answered in a timely manner, all staff can answer call lights when available but don't, nurses need to assist with getting residents up, changing, and putting to bed, one resident reported witnessing a CNA push items off a resident's desk, eating residents food, and placing items out of residents reach.On 04/07/2026-Response time is 45 mins before anyone answers. One resident (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she never gets a response on the intercom. When [NAME] is not here, no one answers phone calls. (R9) reported that one nurse was rude when called to use the restroom and scolded her. One resident reported she did not have a shower, and no one was in the dining room when serving trays.Review of the two-week staffing grid for the date of the elopement, March 7, 2026, revealed the ppd (per patient day) ratio for staff to residents was 1.87, confirmed by the DHS (Director of Health Services).Review of the two-week staffing grid for March 1 to March 14, 2026, revealed a 1.87 ppd (per patient day) staff-to-resident ratio on March 7; 1.77 ppd on March 8, 2026; 2.0 ppd on March 10, 2026; 2.05 ppd on March 11, 2026; and 2.06 ppd on March 12, 2026.Review of the staff assignment for Saturday, 03/07/2026, revealed that two nurses and two Certified Nursing Assistants (CNAs) had initialed the assignment sheet to confirm their presence. For the night (7p-7a shift), the two-week staffing had 12 RN (Registered Nurse) hours. The original nurse scheduled was marked out, and the DHS was assigned for 7 PM to 5 AM, although on the two-week grid, it showed 12 RN hours.Interviews with every cognitive resident during the seven-day survey period reported insufficient staffing and untimely, unacceptable call-light responses. Many residents reported they were not getting restorative care after completion of therapy because the restorative aide had to work as a floor CNA two to four days a week, and she cannot do both. One resident was very concerned that she would decline due to not receiving restorative exercises/training. Four residents reported verbal, physical abuse, and/or neglect by CNA UU. Some residents had diaper dermatitis, developed wounds, and were not receiving restorative nursing services after completion of therapy. One resident eloped and went two miles from the facility for several hours, and the staff was not aware until someone called to notify the facility. One resident fell in the shower and sustained a major head injury.An interview on 05/05/2026 at 1:45 PM, R1 revealed they needed more help. She revealed she had a bowel problem, and when she needed help, she pushed the button. R1 confirmed CNA UU talked mean to her, mistreated her, and refused to help or change her or assist her with going to the bathroom. R1 confirmed verbal abuse and neglect.An interview on 05/05/2026 at 1:55 PM with R9 revealed her roommate, R3, needed her catheter emptied so it would drain properly and not back up. R9 revealed that she reminded CNA UU the night before to please empty it the next morning before leaving, so it would drain properly. CNA UU did not empty her catheter drainage bag. R9 confirmed that the police officer came in and spoke with her and R3 about CNA UU, and they told the police officer how rough she was with R3. R3 and R9 revealed the facility was short-staffed, or they just won't do their job. Often, it takes a long time for staff to answer call lights, especially on the night shift.An Interview on 05/05/2026 at 2:28 PM with a Dietary Aide EE revealed that she started in March 2026, and her training consisted of shadowing someone who no longer works here, observing, and being told things. She revealed she felt they needed at least two more staff because if someone was off, they would be short. She revealed she was one of the staff members who worked several 16-hour days due to being short-staffed. They had four kitchen staff in total. They would rotate with only one cook and one aide for the whole day. The next day, the other two would work: one cook and one aide. She revealed they did 16-hour days every other day for a month.An Interview on 05/05/2026 at 2:40 PM with RN LL confirmed R4 eloped on March 7 and confirmed they were short-staffed. Review of the two-week staffing grid revealed a 1.87 ppd (per patient day) staff-to-resident ratio on March 7, 2026.An Interview on 05/05/2026 at 2:52 PM with the Dietary Aide HH revealed that the facility had been running a skeleton crew, sometimes with only two CNAs for the whole building. She used to be in the laundry department but transferred to the kitchen. She revealed that there were supposed to be two cooks, one staff member to handle tickets, one to handle mechanical diets and related tasks, and one to wash dishes. She revealed that she had little training, having started in the kitchen.An interview on 05/07/2026 at 2:05 PM with the Administrator confirmed the PBJ data for Q1 (October 1 to December 31, 2025), showing low weekend staffing.An interview on 05/13/2026 at 10:40 AM with RN LL, and review at that time of the nurse staffing assignment dated April 11, 2026, that showed CNA AA was a C/O (call-out) and the name unknown was written in her place to cover B hall. RN LL (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115684	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Care Center - St Marys	805 Dilworth Street Saint Marys, GA 31558

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that there were only two nurses and two CNAs in the facility that day.An interview on 05/13/2026 at 10:45 AM with LPN (KK)/Charge nurse, and review at that time of the nurse staffing assignment dated April 11, 2026 that showed CNA AA was a C/O (call-out) and a name written in her place to cover B hall, LPN KK confirmed that it was her, she had to do her nursing duties plus CNA duties because there was only two CNA's in the building. Another person came in to help out but did not do hardly anything.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policies titled, Foodborne Illnesses, and Food Ordering, Receiving, and Storage, the facility failed to ensure food for residents was stored, prepared, and served in a sanitary manner in the kitchen. Specifically, the facility failed to label and date food in the freezer, the refrigerator/walk-in cooler, and the dry storage pantry, with a received by date, open date, expiration, and/or use-by date, failed to discard food by the expiration or use-by date, and failed to ensure meat was thawed properly and in a sanitary manner. This deficient practice could have affected 62 of 65 residents receiving an oral diet.Findings included:Review of the Facility's policy titled, Foodborne Illnesses, with revised date October 18, 2017, documented. Procedure: 2. Foods will be used before the expiration date, use by date, best by date, and sell by date, as indicated on the food item. Foods not used prior to the expiration date, us by date, best by date, or sell by date must be discarded. 7. Meats will be thawed and cooked to appropriate internal temperature to prevent foodborne illnesses. Thaw meats under refrigeration at or below 41 degrees Fahrenheit in a drip proof container or submerged in a solid bottom pan under cold running water.Review of the facility's policy titled, Food Ordering, Receiving, and Storage with revised date October 23, 2025, documented, . Storage and Rotation Guidelines: Date all stock items with delivery date.During a tour and observation of the dietary department on 05/06/2026, starting at 12:15 PM, five staff members were working: Dietary Manager JJ, Dietary Aide EE, Dietary [NAME] FF, Dietary [NAME] GG, and Dietary Aide HH. During the tour, observations, and interview with dietary staff, revealed expired food, food with no label/dates, no label/dating system, and meat improperly thawed as follows: Observation in the twoˆcompartment sinkOne large roll of ground beef was submerged in water on the left side of the twoˆcompartment sink, with a peelˆandˆstick label with Ground Meat and a prep date of 4/24/26. No other date or label was on the item.One large roll of ground beef was submerged in water on the left side of the twoˆcompartment sink, with a peelˆandˆstick/sticker label with Ground Meat and a prep date of 4/17/26. No other date or label was on the item.Observation inside the doubleˆdoor freezer in the dietary departmentA bag of French Toast had a prep date of 5/1/26 on the sticker label. No other dates were on the item.A bag of Breaded Zucchini slices was out of date, with a prep date of 1ˆ2 and a useˆby date of 2ˆ2 on the label. No other dates were on the item.A bag of Okra was out of date, with a useˆby date of 4/3/26 on the label.A bag of Mixed Vegetables was out of date, with a prep date of 4ˆ20ˆ26 and a useˆby date of 4ˆ23ˆ26 on the label.A bag of Field Peas with Snaps had a prep date of 3'/6/26. No other date was on the item.A bag of Vegetable Blend had a prep date of 3/27/2026. No other dates were on the item.Two bags of Breaded Squash had no labels or dates on themA bag of (broccoli/cauliflower) Vegetable Blend had a prep date of 3/27/26. No other dates were on the item.A bag of Garlic Bread had no label or date on it.A box containing individual bags of frozen, mashed Sweet Potatoes had no labels or dates on the bags or the box.Observation on a spice rack revealed: A large container of opened Light Chili Powder was out of date, with an expiration date of 4/11/2026.A large container of opened Granulated Onion had no label or date on it.A large container of opened Lemonˆ Pepper Seasoning had no label or date on it.A large container of opened [Brand name] Chicken Seasoning had 1ˆ31 op, 7ˆ31 ex {sic}. No other dates were on the item.A large container of [Brand name] Seasoning Salt was open and had no label or date on it.An opened container of Instant Food Thickener had 3ˆ20 written on the container. No other dates or label were on the item.A large box of Granulated Chicken Bouillon had been opened and was out of date, with 6/20/25 written on the container. No other date or label was on the item.A large container of opened Oregano Leaves was dated 9/9/24, written in Sharpie/marker, and had a sticker label with op 1ˆ11ˆ26, Exp 7ˆ11ˆ26.Two opened containers of [Brand name] Chicken Flavored Base had no label or dates on either item.An opened box of Raisins was dated 6/20/25. No other dates (continued on next page)

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	115684	A. Building B. Wing	05/13/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were on the item.Observation of the pantry revealed:A zipˆlock bag of loose Pinto Beans had the labels Pinto Beans and was dated 5ˆ22ˆ25.An open bag of Northern Beans was inside a zipˆlock bag. No label or dates were on the item or the bag.A large, open bag of Sugar Frosted Flakes cereal was held closed with a binder clip. No label or dates were on the item.A large, unopened bag of generic-brand [NAME] Krispies cereal dated 10/24.A large, open bag of Raisin Bran cereal had a sticker label dated 10/24.A large, open bag of Froot Loops cereal was dated 10/24 and was held closed with a binder clip. Seven large bags of Croutons were dated 10/24.Eleven boxes of [Named brand] starch dated 8/22.Four bags of Instant Gravy Mix were dated 4/13/26.Four bags of Turkey Gravy were dated 4/13/26.Several bags of Chickenˆflavored Gravy Mix had two dates, 3/ 21 and 5/2/26.A large, open bag of dry spaghetti noodles was rolled up with plastic wrap around it but was not sealed completely closed. Three opened packages and two unopened packages of Taco Seasoning had no labels or dates on them. One opened bag was held closed with a binder clip, and one with a rubber band.A large tub of Peanut Butter was opened on 5/6/26. No useˆby or expiration date was on the item.Two large dry-ingredient bins, one labeled Sugar and one labeled Flour, contained white substances. No dates or other labels were on the bins.One large dry-ingredient bin containing a white substance had no label or date. Interview with Dietary [NAME] FF revealed it was a thickener. Dietary [NAME] FF stated he did not know when the thickener was received, opened, or put inside the bin. Dietary [NAME] FF then obtained a label and placed it on the bin with prep date 5/6/26 and use by date 7/6/26.A gallon container of BBQ Sauce was dated 4/13/26. A gallon container of Tartar Sauce was dated 1/21. A gallon container of Creamy Italian Dressing was dated 1/21. A gallon container of Creamy Italian Dressing was dated 3ˆ21ˆ26, prep date of 3ˆ13, and use by date 5ˆ13.A large container of Worcestershire Sauce was dated 2/13. No label or other date was on the item.A gallon container of Soy Sauce was dated 3ˆ21ˆ26.A large container of Lime Gelatin had a date of 3ˆ21ˆ26.A large plastic tub of individual packages containing two Saltine crackers had no label or date on the container or the individual crackers. Dietary [NAME] FF confirmed the foods in the Pantry were not labeled or dated with received, open, and/or expiration dates.Observation inside the walkˆin cooler/refrigerator, outside, and behind the dietary department revealed: A large, open bag of whipped topping had the tip still in the piping bag, with no label or dates on the item.Two large containers of Cottage Cheese were on the top shelf, and one box with two 5ˆlb containers of Cottage Cheese was inside the box. No label or date was on the box or the individual containers.A gallon container of Balsamic Vinaigrette had a useˆby date of [DATE]. A gallon container of [Name brand] Balsamic Vinaigrette had no label or date. The printed date on the container was 26 [DATE].Two gallons of Milk were dated 4/24/26, and one gallon of Milk was dated 5/4/26.Two large/gallon unopened bags of Shredded Hash Browns had no labels or dates on them.Ten to twelve unopened bags of hamburger buns had no labels or dates.Several packages (at least 20) that appeared to be bologna had no labels or dates.Two large-gallon bags of shredded cabbage for slaw had no labels or dates.One large/gallon bag of lettuce, some of which was brownish, had no label or date on the item.One large gallon tub of Cherry filling had no label or date on it.One large, square, white tub of Hardˆ Cooked Eggs contained eggs in a blue bag submerged in a liquid. The blue bag was inside the tub, and there was liquid around its outside. There was also an unusual, bad smell. The item was dated D/C 3/21. No other date or year was listed.The tour of the kitchen also revealed two large, round rolls of ground meat in the two-compartment sink, now in a large pan of water. An interview with a dietary cook revealed that the meat should be thawed under running water, but they did not know that it should not be left submerged. Dietary cook FF and DM confirmed the expired food items, confirmed foods in the Pantry were not properly labeled and dated with received, open, and/or expiration dates, were not able to provide the date when the items were delivered, and confirmed meat was thawing submerged in water in the sink and now submerged in a large pan.Interview on 05/08/2026 at 3:02 PM with Dietary Manager (DM) JJ confirmed expired and past-use-dated food, no proper labeling/dating system, and improper thawing of meat.