STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115709	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Care Center LLC	1400 Hogansville Road Lagrange, GA 30240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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 observation, staff interview, record review, and review of the facility's policy titled Fall Prevention Program, the facility failed to provide an environment free from accident hazards for one of three Residents (R) (R1) reviewed for accidents. On 11/18/2025, actual harm occurred when R1 attempted to use her bathroom, which was under renovation, and her sock became stuck to the glue on the bathroom floor, resulting in an unwitnessed fall. R1 sustained a right humerus shaft fracture, right open distal femur fracture, and a hematoma over the right inferior frontal scalp. R1 was hospitalized on [DATE] and underwent an operative fixation (a surgical repair for broken bones) on 11/20/2025 as a result of the fall.Findings include:Review of a facility's policy titled, Fall Prevention Program, with an implemented date of 1/8/2025 revealed, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 5. Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of resident falling including, but not limited to: i. A clear pathway to the bathroom and bedroom doors. b. Implement routine rounding schedule.Review of the facility's five-day report revealed on 11/18/2025, R1 fell in the restroom, and stated her arm hurt and that she could not move. R1 was sent to the Emergency Room. R1 received Cat Scans (CT) and x-rays, indicating an acute comminuted displaced fracture of the distal diaphysis of the right femur and a comminuted displaced fracture of the mid diaphysis of the right humerus with displacement measuring greater than one shaft length. R1 had surgical repair and is doing well. This incident of an unwitnessed fall with major injury is substantiated as R1 has sustained two fractures.Review of the Emergency Medical Service (EMS) report dated 11/18/2025 for R1 revealed employees stated she went into the bathroom where her socks got stuck on glue that was spread on floor and came out of them falling on arm. Patient complaint was right arm pain and right leg pain. The right upper arm had obvious deformity. Right leg was noted to be shorter then her left leg with noted pulse. Patient stated it was in position of comfort and didn't want us to move it. The patient also had a hematoma above the right eye.Review of hospital records dated 11/18/2025 revealed R1 arrived at the hospital after a fall. Her foot got stuck in glue, she fell face-first, and it was an unwitnessed fall. R1 had x-rays completed and a diagnosis of displaced fracture of shaft of humerus, closed fracture of right femur, contusion of knee, and facial swelling. R1 was transferred on 11/18/2025 to a hospital for higher level of care.Review of hospital Discharge summary dated [DATE] revealed R1 was transferred and admitted after a fall resulting in a right humeral shaft fracture and a right open distal femur fracture confirmed through radiograph on 11/18/2025. R1 underwent operative fixation on 11/20/2025 for both fractures, and postoperative imaging confirmed improved alignment and intact hardware. R1 was discharged on hospital day 14 to a subacute rehabilitation facility.Review of the Electronic Medical Record (EMR) revealed that R1 was admitted with diagnoses that included but not (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 0689 Level of Harm - Actual harm Residents Affected - Few	limited to Alzheimer's disease, other symptoms and signs involving cognitive functions and awareness, dementia in other diseases classified elsewhere, severe, with anxiety, parkinsonism, and unspecified osteoarthritis. Review of the most recent Quarterly Minimum Data Set (MDS) for R1, dated 9/17/2025, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, indicating moderately cognitively impaired. R1 was independent for toileting and did not use a wheelchair or walker.An interview on 12/1/2025 at 2:34 pm with Licensed Practical Nurse (LPN) LPN AA stated that on 11/18/2025, she was sitting at the nursing station when a Certified Nursing Assistant (CNA) DD jumped up, and she did as well and went behind CNA DD to R1's room. LPN AA saw R1 lying on the floor on her back, to her right. She stated that she completed an assessment and neuro-check as well. LPN AA stated that R1 complained of pain in her arm and leg and stated she couldn't move her arm. She stated that she called 911, notified the Nurse Practitioner (NP), and either the Director of Nursing (DON) or the Assistant Director of Nursing (ADON). She stated that she could not remember what the floor looked like because she was focused on the resident. R1 revealed that she hit her head and nose. LPN AA stated that R1 was wearing one sock when they found her after the fall.An interview on 12/1/2025 at 1:05 pm with the DON revealed that she was informed by the nurse and the unit manager that R1 had a fall in the bathroom. The DON stated that the nurse revealed that R1 went to use the bathroom, which was her normal routine. She stated that remodeling was underway at the facility. The DON stated that they were putting new floors in the bathroom and remodeling the patient rooms, including the floor. The DON stated that rooms [ROOM NUMBERS] (R1 room) share a bathroom and couldn't say whether the bathroom floor was completed at the time of R1's fall, but the bathroom and room [ROOM NUMBER] were complete by the end of the day.An interview on 12/1/2025 at 1:43 pm with the Director of Maintenance (DOM) revealed that the contractors were remodeling R1's room and the adjoining bathroom floors. He revealed that R1's bathroom floor was not completed prior to the fall. He stated that R1's room and bathroom floor was completed a couple of hours after R1 fell. The DOM stated there was still glue on part of the bathroom floor prior to R1 falling. He stated that after the fall, furniture was used as a barrier, and caution tape was placed before the furniture. The DOM revealed that he is familiar with R1 and that she wears socks. He stated that R1's socks got stuck to the bathroom floor glue. An interview on 12/2/2025 at 11:02 am with CNA DD revealed that she was at the nurses' station and saw someone (one of the contractors remodeling the residents' floor and bathroom floors) waving at her. CNA DD stated that she approached the contractor, who pointed at room [ROOM NUMBER]'s bathroom door shared by room [ROOM NUMBER] (R1's room). She stated that she went into room [ROOM NUMBER], and the contractor pointed at the bathroom shared by rooms [ROOM NUMBERS]. She stated that the bathroom door was half open, and the resident was lying on the floor on her side. She stated that the bathroom floor was under construction and was not completed when she saw the resident on the floor. CNA DD stated that R1 was ambulatory and did not use a wheelchair or walker prior to the fall. An interview on 12/2/2025 at 11:20 am with Registered Nurse (RN) CC, and the Unit Manager on duty revealed that LPN AA called her to report a fall. RN CC stated that she went into the bathroom with a male nurse, LPN BB, where R1 was on the floor. She stated that she asked R1 what happened, and R1 stated that she was toileting. She stated that R1 was lying on her left side, guarding her right arm. She stated that R1 stated that she hit her head when asked. RN CC stated R1 had a skin tear on her right thigh and was complaining of right leg pain. RN CC stated that the bathroom floor was under construction and not completed prior to R1 falling. She stated that R1 had a goose egg on her forehead. She stated that R1 was not at risk for falls and was ambulatory. She stated that R1 has not had a fall in over two years. RN CC revealed that R1 does not require assistance with toileting; the most they do is (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	place her clothes on the bed. An interview on 12/2/2025 at 11:45 am with LPN BB revealed that he was on break when the floor nurse called for assistance with R1. He stated that R1 was on the bathroom floor when he arrived. He stated that R1 said she had fallen, and they were more concerned about her head. LPN BB revealed they completed an assessment and vital signs, and made R1 comfortable, while the other nurses called the ambulance and completed paperwork. He stated that the contractors were still working on the bathroom floor, and it was not completed prior to R1's fall. LPN BB stated that R1 was ambulatory.An interview on 12/8/2025 at 11: 39 am with the DON revealed residents were not reassigned rooms during the remodeling of their rooms and bathrooms. She stated that staff assisted residents who needed to use the restroom during rounds. The DON revealed that R1 was not assisted to the restroom because she was independent and cognitively fit and did not require assistance. The DON stated that, moving forward, the facility will have a better-planned approach to ensure resident safety and education for both residents and staff, and will take into account residents' cognitive levels.