STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115721	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Care Center - Brunswick	2611 Wildwood Drive Brunswick, GA 31520

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and residents' representative interviews, record review, and review of the facility's policy titled, Resident Trust Funds, the facility failed to ensure two out of three residents (R) (R135 and R139) accounts reviewed, that the resident or residents' representative received a final refund within 30 days of expiration or discharge. Findings include:Review of the policy titled Resident Trust Fund revised date [DATE] revealed, when a patient whose funds are held and managed by the facility in the Patient Trust Fund expires or is permanently discharged , the Business Office will ensure that the balance of the account is refunded, and a full accounting is provided, within 30 days of expiration or discharge (or as required by state law) to the: patient or legal representative. 1. Review of the admission record revealed R135 admitted on [DATE] and expired on [DATE].Review of R135's resident statement landscape dated [DATE] revealed the resident had a credit balance of $25.01.Interview on [DATE] at 1:28 pm with the Administrator confirmed the facility owed R135's representative $25.01. The Administrator stated that the financial services person was terminated for not issuing money back to residents and or their representatives in a timely manner. The Administrator stated that the corporate office was going to issue $25.01 back to the resident's representative. 2. Review of the admission record revealed R139 was admitted on [DATE] and discharged on [DATE].An interview on [DATE] at 11:03 am with R139's representative revealed he had not received the balance of funds from R139's trust account. He revealed it was less than $100 but that the facility kept giving him the run around to get it. Review of R139's resident statement landscape dated [DATE] revealed the resident had a credit balance of $57.66.Interview on [DATE] at 10:30 am with the Administrator confirmed the facility owed R139's representative $57.66. The Administrator stated that her financial services person was terminated for not issuing money back to residents and or their representatives in a timely manner. The Administrator stated that the corporate office was going to issue $57.66 back to the resident's representative.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, the facility failed to ensure a safe, clean, comfortable, home-like environment for one out of 29 rooms (room [ROOM NUMBER] B) located on the 200 hall. Specifically, clean bed linens were not provided for the resident in room [ROOM NUMBER] B.Findings include:An interview on 7/21/2025 at 12:48 pm with the resident in room [ROOM NUMBER] B revealed that his sheets had not been changed in a month. He showed the surveyor where he placed his initials on the underside of the sheet to track if his sheets were being changed. Observation of room [ROOM NUMBER] B's bed linens on 7/21/2025 at 12:48 pm, 7/22/2025 at 12:55 pm, and 7/23/2025 at 1:00 pm revealed the resident's initials on the underside of his sheets indicating they had not been changed.Interview on 7/22/2025 at 12:15 pm with Certified Nurse Assistant (CNA) HH working on the 200 Hall, confirmed the sheets on resident's beds did not get changed as often as they should. She revealed the resident's sheets should be changed on bath days or as needed. She stated that CNAs were too busy doing other tasks and couldn't get to the resident's rooms to change bed linens. She revealed she did not change the resident's linens and did not know when the last time they were changed.Interview on 7/23/2025 at 12:50 pm with CNA KK working on the 200 Hall revealed bed linens should be changed on bath days or as needed. She stated CNA's were responsible for changing linens. She confirmed that the resident in room [ROOM NUMBER] B had a bath sometime that morning, but she did not change his sheets and had no idea when the last time his sheets were changed. An interview on 7/23/2025 at 1:40 pm with the Assistant Director of Nursing (ADON) revealed CNA's were to ensure bed linens were changed on shower days or as needed. Observation and interview on 7/23/2025 at 1:50 pm with the Director of Nursing (DON) confirmed that the bed sheets needed to be changed and saw the resident's initials. She said she would think best practice would be for linens to be changed daily but at least on bath days or as needed. She looked at the resident's initials and stated that his sheets not being changed for a month was unacceptable. She stated that she was going to get them changed.

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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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review and review of the facility's policies Care Plans and Smoke Free Policy, the facility failed to develop and implement care plan interventions for four out of 49 sampled residents (R) (R120, R10, R16, and R26). Specifically, care plans addressing the following were not developed and implemented for R10 and R120 related to elopement, R16 related to smoking, and R26 related to diet orders. This failure had the potential to cause the residents not to receive treatment and/or care according to their needs. Findings include: Review of the facility's policy titled, Care Plan, dated 7/27/2023 under the “Policy Statement” revealed, “It is the policy of the health care center for each patient/resident to have a person-centered baseline care plan followed by a comprehensive care plan developed following completion of the Minimum Data Set (MDS) and Care Area Assessment (CAA) portions of the comprehensive assessment according to the Resident Assessment Instrument (RAI) Manual and the patient/resident choice”. Under the section titled, “Procedure: New admission Baseline Plan of Care “revealed, “2. the baseline care plan will be updated to reflect changes to approaches, as necessary, that result from significant changes in condition or needs occurring prior to the development of a comprehensive care plan. Within the first few days of admission, a Post admission Care Conference (PACC) will be held for update and review of the baseline care plan.” Under the section titled admission Comprehensive Plan of Care revealed, 2. A comprehensive person-centered care plan will be developed by the interdisciplinary team for each patient /resident within seven days after the completion of the comprehensive assessments. The patient/resident and/or the patient/resident’s representative will participate to the extent practicable in the care planning process. An explanation must be included in a patient/resident's medical record if the participation of the patient/ resident and their patient/ resident’s representative is determined not practicable for the development of the patient/ resident’s care plan. 3. The comprehensive person-centered care plan is developed to include measurable goals and timeframes to meet a patient/resident's medical, nursing, and psychosocial needs. These services are to be furnished to attain or maintain the Resident's highest practicable physical, mental, and psychosocial needs that are identified in the comprehensive assessment… 5. The comprehensive care plans will be developed electronically, printed and filed in the medical record for manual updates. For MatrixCare users, care plans are maintained and updated electronically. Review of the facility’s policy titled, “Smoke Free Policy” with a revised date 7/30/2024 under the section titled “Grandfathered in Patients/Residents: Assessment & Care Planning” revealed, (2). Grandfathered patients/resident(s) will be assessed, utilizing the Smoking Observation Form in the Electronic Health Record, by a Licensed Nurse upon admissions, re-admission, and/or with a significant change. A re-admission Smoking Care Plan shall be developed by the Licensed Nurse on the admission Interim Care Plan Form, or electronically. 1. Review of clinical records for R120 revealed diagnoses that included but not limited to dementia, with severity of other behavioral disturbances, type 2 diabetes, and major depressive disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress note dated 2/21/2025 for R120 revealed that R120 rolled out the front doors behind Emergency Medical Services (EMS); the resident was seen by housekeeping and was brought back inside but never left facility grounds. The resident was asked where she was going and stated she was going home. Review of progress note dated 4/24/2025 revealed that R120 was found sitting on the floor in her room beside a large black bag full of her belongings. The resident had packed all of her items and stated she was going home. Further review of the progress note documented that the resident did this from time to time and that this was not an abnormal occurrence for this resident. Review of R120’s Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate impairment. Section E (Behavior) revealed the presence of wandering behaviors one to three days during the assessment period. Section I (Active Diagnosis) revealed, diagnoses of Dementia, Cerebrovascular Accident, Depression, and Psychotic disorder. Review of the incident report for R120's elopement on 6/29/2025 revealed that R120 was observed outside the facility by Housekeeper TT who was dumping out water from her bucket. She looked up and saw R120 rolling down the alley road with her shower bag, headed towards [NAME] Avenue at 3:20 pm. The housekeeper alerted all the floors that R120 was getting away down the road. It was reported that staff observed R120 attempting to exit through the Turtle Cove unit's doors, but she was unable to do so because the doors were locked. Housekeeper TT was unsure how she had exited, but later discovered it was through the smoking door. After this incident, R120 was moved to the memory unit. Review of R120’s care plans revealed “ELOPEMENT: Requires admission to the specially designed secure unit R/T (related to) elopement, dementia, intermittent confusion, exit seek behavior. ” with a problem start date of 7/2/2025. There was no evidence that an elopement risk care plan had been developed prior to 7/2/2025. 2. Review of clinical records for R10 revealed diagnoses that included but not limited to autistic disorder, bipolar disorder, current episode mixed, severe, with psychotic features, and depression. Review of R10’s admission MDS assessment dated [DATE] revealed Section C (Cognitive Patterns), a BIMS score of 3 which indicated severe cognitive impairment. Review of clinical records revealed, an “Elopement Risk Observation Form” was completed on 6/30/2025 which indicated R10 was a high risk for elopement, with a score of 12. Review of the Care Plan for R10 with last reviewed/revised date of 7/22/2025 revealed that an Elopement Risk care plan had not been developed for the resident. During an interview on 7/24/2025 at 1:02 pm, the Administrator revealed she was unsure about the care plan being updated after the assessment, and that she would have to look at the clinical records. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2025 at 1:16 pm, the Nurse Consultant stated that there should be an assessment completed after each attempt, and a care plan should be in place for elopement risk. She further noted that their process involves assessing residents on admission, readmission, quarterly, and after a significant change of event. Interview on 7/24/2025 at 4:15 pm with the MDS Coordinator revealed that the Elopement Assessment was implemented for all staff once they answered the interview questions. Residents with high-risk scores are 11 and above, low-risk scores are 0-4, and moderate scores are 5-10. The MDS Coordinator revealed that CAA care assessments activate the care plan, that allows MDS to review progress notes, plan of care (POC), and the chart within a 7-day look back window. If it is missed within the seven days, she cannot code it in MDS, and it should be discussed in morning meetings. The care plan and interventions should be implemented for elopement. MDS confirmed that the Interdisciplinary team (IDT) reviews charts daily to gather reports on behaviors and that the nursing department should document information to ensure that elopement behaviors are appropriately recorded. Further interview revealed that once assessments are completed, a care plan should be updated/developed if the elopement scores are high risk or moderate. 3. Review of medical records for R16 revealed diagnoses that included but not limited to, other sequelae of other cerebrovascular disease, spastic hemiplegia affecting left nondominant side; type 2 diabetes mellitus with unspecified complications, borderline personality disorder, nicotine dependence, cigarettes, uncomplicated; and generalized anxiety disorder. Review of R16’s Annual MDS dated [DATE] for Section C (Cognitive Patterns) revealed, a BIMS of 15 which indicated the resident was cognitively intact. Review of the smoking list revealed R16 was identified as a tobacco user. Review of R16’s clinical record on 7/21/2025 revealed there was no “Smoking Observation Form “completed. Review of R16’s care plan on 7/21/2025 revealed she did not have a care plan related to smoking. Further review of clinical records revealed the care plan and the “Smoking Observation Form” was completed on 7/22/2025. Observation and interview on 7/21/2025 at 1:00 pm with Certified Nursing Assistant (CNA) LL entering R16’s room to find out if R16 to find out if she was ready to get dressed to go outside to smoke. She stated that R16’s smoke break was 2:00 pm when asked. Observation on 7/22/2025 at 2:10 pm of smoke break revealed R16 sitting outside in the designated smoke area smoking a cigarette with staff supervision. During an interview on 7/28/2025 at 3:20 pm with Unit Manager/LPN AA, revealed that the facility became a smoke-free facility after (Name of Facility) took over. She stated that R16 was smoking before she started working at the facility. She confirmed that R16 smoked and stating that R16 had been Grandfathered in. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/29/2025 at 1:05 pm with MDS coordinator revealed, there should have been a care plan and assessment completed for R16. She confirmed that there was not a care plan nor an assessment in the Electronic Health Record (EHR) before 7/22/2025. She stated that everything was electronic in February 2025 and that there should have been something in the EHR. She stated that she had been going through trying to update information on the care plan; however, she was the only MDS person and there was no one in the position for several months before she was hired. 4. Review of the medical records revealed R26 had diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, need for assistance with personal care, and dysphasia following cerebral infarction. Review of R26’s physician order dated 1/10/2025 listed a dietary order for no added salt, mechanical soft. Review of R26 's care plan with a start date of 9/30/2024 and last revised on 7/22/2025 revealed resident requires a mechanically altered and therapeutic diet related to dysphagia and hemiplegia. Interventions included Diet: mechanical soft diet. Record review revealed a progress note dated 5/21/2025 that revealed the resident had a choking incident. The note revealed the resident is on a mechanical soft diet that requires meat to be grounded and was mistakenly given a hamburger for lunch. Interview on 7/28/2025 at 2:06 pm with the Registered Dietician revealed mechanical soft meats are considered ground meats. A hamburger patty is not considered mechanical soft. Interview on 7/28/2025 with Licensed Practical Nurse (LPN) FF revealed she was the author of the progress note dated 5/21/2025. She confirmed R26 was given a meal tray that did not adhere to his prescribed diet. She revealed staff should know each residents diet because it is listed numerous places such as the resident's profile and the care plan. Interview on 7/29/2025 at 1:03 pm with the MDS Coordinator revealed the facility uses an IDT approach. Anybody can enter a care plan. They are done quarterly, annually, admission, and anytime there is a significant change. It is the supervisor’s responsibility to ensure their staff familiarize themselves with the care plan and interventions. All staff must follow the resident’s care plan. Interview on 7/29/2025 at 1:15 pm with the Director of Nursing (DON) and the Administrator revealed that care plans are implemented to provide the best care for each resident including providing and implementing interventions. The Administrator confirmed that the staff did not follow the resident’s care plan and provided a meal that was not mechanical soft.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record reviews and review of the facility's policy titled, Medication Administration: General Guidelines, the facility failed to follow professional standards of quality care for two of six residents (R) (R89 and R51). Specifically, the facility failed to ensure all medications ordered were administered and documented according to professional standards of clinical practice. Findings include: A review of the facility's policy titled, Medication Administration: General Guidelines, reviewed 7/22/2024 stated that, Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. At the end of each medication pass, the person administering the medications reviews the paper Medication Administration Record (MAR) or the electronic version of e-MAR to ascertain that all necessary doses were administered and all administered doses were documented. In no case should the individual who administered the medications report off duty without first recording the administration of any medications. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. patient/ resident not in healthcare center at scheduled dose time, initial dose of antibiotics), the space provided on the front of the paper MAR for that dosage administration is initialed and circled and for facilities utilizing the e-MAR system the NOT ADMINISTERED button will be utilized with the appropriate reason given for not administering medication at scheduled time. 1. A review of the facility's admission records for R89 revealed that the resident admitted with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD) with acute exacerbation, proximal atrial fibrillation (A-Fib), muscle weakness, pulmonary fibrosis, vascular dementia, rheumatoid arthritis without rheumatoid factor, depression, chronic kidney disease and moderate protein calorie malnutrition. A review of R89 admission Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Patterns) a Brief Interview of Mental Status (BIMS) score of 13 which indicated minimal cognitive impairment; Section N (Medications)indicated the use of antipsychotics, antianxiety, antidepressants, anticoagulant, diuretic, antiplatelet, and anticonvulsants.A review of R89's active physician's orders included acetaminophen tablet 325 milligrams (MG) two tablets (start date 7/1/2025), ascorbic acid tablet 500 MG two tablets (start date 7/2/2025) , azelastine hydrochlorothiazide 0.137 milligrams metered dose nasal spray, two sprays in each nostril (start date 7/8/2025), and cholecalciferol 1.25 MG one tablet (start date 7/1/2025). During a medication pass on 7/22/2025 at 8:35 am on Live Oak hall with Licensed Practical Nurse (LPN) CC revealed her administering medications to R89. Azelastine hydrochlorothiazide 0.137 milligrams metered dose nasal spray, one sprays in each nostril, ascorbic acid tablet 500 MG one tablet were all administered however, cholecalciferol 1.25 milligrams one tablet was not administered.Review of the MAR for R89 on 7/22/2025 at 8:45 am revealed LPN CC documented administration of all medications as administered without indicating any omissions or errors. During an interview on 7/22/2025 at 9:00 am with LPN CC, she admitted to not administering the correct dosage of azelastine hydrochlorothiazide nasal spray and ascorbic acid 500 milligrams. LPN CC admitted she only administered one spray of nasal spray in each nostril and only one ascorbic acid tablet. She also admitted to omitting one tablet of cholecalciferol 1.25 milligrams stating that she was nervous and it was an oversight. LPN CC stated that she will go back and administer the missed medications in the correct dosage of the medications given in error. 2. During a record review of R51 admission records revealed the resident was admitted to the facility with diagnosis that included but not limited to quadriplegia, peripheral vascular disease, incomplete lesion at unspecified level of cervical spinal cord, seizures, vitamin D deficiency, major depressive disorder, chronic idiopathic constipation and polyneuropathy. During a record review of R51's Quarterly MDS dated [DATE] revealed Section C (Cognitive Patterns) a BIMS score of 15 indicating no cognitive impairment and Section N (Medications) indicated the use of inside depressants, anticoagulants, opioids and anticonvulsants.A review of the active physicians orders for R51 revealed docusate sodium 100 mg oral capsule [Colace] two caps two times daily (start date 10/10/2024), vitamin b-12 1tablet daily (start date 10/10/2024), polyethylene glycol 3350 17000 mg powder for oral solution [MiraLax] 30 ml (milliliter) by mouth every three days (start date 10/10/2024), sertraline 50 mg oral tablet one tablet once a day (start date 12/20/2024), carbamazepine 200 mg extended-release oral tablet one tablet, (start date 10/10/2024) , famotidine tablet 20 mg one tablet (start date 10/10/2024) , phenytoin sodium extended capsule; 100 mg three capsules daily (start date 10/10/2024), tramadol tablet 50 mg one tab two times daily (start date 10/31/2024), apixaban five mg oral tablet; one tablet (start date

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, resident and staff interviews, record reviews, and reviews of the facility's policy titled, Medication Administration: General Guidelines the facility failed to follow the physician's orders as recommended for one resident (R) (R94) of 49 sampled residents. Findings include: Review of the facility's policy titled, Medication Administration: General Guidelines with a revision date of 4/10/2019 documented in the section Policy Statement: Medications are administered as prescribed, in accordance with food nursing principles and practice an only by persons legally authorized to do so. Personnel authorized to administer medication do so only after they have familiarized themselves with the medication. In section Procedure: (2) Medication is administered in accordance with written orders of the attending physician. If a dose seems excessive considering the patient/resident's age and condition, or a medication order seems to be unrelated to the patient/resident's current diagnosis or condition, the physician is contact for clarification prior to the administration of the medication. This interaction with the physician is documented in the nursing notes and elsewhere in the medical record as appropriate. R94 was admitted to the facility on [DATE] with a diagnosis of but not limited to presence of coronary angioplasty implant and graft (main blood vessel supplying the heart). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed R94 had a Brief Interview of Mental Status (BIMS) score of 7 indicating moderate cognitive impairment. Further review of the MDS in section (N) Medications documented he is on an antiplatelet (reducing the formation of blood clots) medication. Review of the care plan documented R94 is at risk for skin breakdown and pressure ulcers related to impaired bed mobility, fragile skin, and right-hand skin tears.Review of the Physician's order documented clean skin tear to the top of right hand with wound cleaner pat dry then apply calcium alginate (absorb wound fluid) cover with drying dressing once a day (QD). During an observation on 7/21/2025 at 12:48 pm and 7/22/2025 at 1:56 pm revealed R94 had a bandage on his right hand dated 7/18/2025.During an observation and interview on 7/23/2025 at 11:25 am with R94 stated the staff changed their bandage that morning and they change his dress every six days. During an interview on 7/23/2025 at 1:56 pm with Licensed Practical Nurse (LPN) PP confirmed she changed R94 bandage this morning because it was falling off of his hand. LPN PP continued to state the Wound Care Nurse (WCN) has been on vacation and she would be responsible for ensuring those dressings are changed based on the physician's order. She further revealed R94 dressing should be changed on Mondays, Wednesday, and Fridays or as needed. However, she was unaware R94 physicians' orders were to be cleaned and changed once a day. During an interview on 7/23/2025 at 2:04 pm with the Direct Health Service (DHS), stated the nurses on the unit are responsible for conducting treatments if the WCN is not in the facility, and they should be following the physicians' orders.

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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 observations, staff interviews, record review, and review of the facility's policies titled Occurrences and Smoke Free Policy, the facility failed to ensure the environment was free of accident hazards for one of 15 sampled residents (R) (120) reviewed for elopement and one of two residents (R16) reviewed for smoking. Specifically, the facility failed to complete an elopement assessment for R120 after an occurrence and failed to complete a smoking assessment for R16 with known tobacco use. The deficient practice created a potential risk to the safety and well-being of R120 and R16.Findings include: Review of the facility’s policy titled Occurrences revised date 1/11/2024 The health center recognizes that due to the frailty of the patients/ residents served, there is an increased risk of occurrences that may result in injury to the patient/resident and/or others. To prevent occurrences, each patient/resident will be observed and assessed for risks. Appropriate, realistic interventions will be implemented by their plan of care. Occurrence hazards are physical features in the health care center environment which may pose a risk to a patient/resident's safety, including but not limited to: Elopement from healthcare center property, regardless of weather, there was an injury associated with elopement. Review of the facility’s policy titled, “Smoke Free Policy” with a revised date 7/30/2024 documented under the section Grandfathered in Patients/Residents: (1). Patients/residents who are grandfathered in will be assessed for risk/hazards prior to smoking in designated areas and shall be supervised as necessary based on the Smoking Observation Form located in the Electronic Health Record. Under the section “Assessment & Care Planning”: (3). An assessment utilizing The Smoking Observation Form in the Electronic Health Record is completed at lease quarterly thereafter only if the answer to either of the first (2) questions indicates the resident either smokes or has a history of smoking. After completion of the assessment, the care planning team shall review and utilize the assessment when developing the resident’s care plan. 1. Review of clinical records for R120 revealed diagnoses that included but not limited to dementia, with severity of other behavioral disturbances, type 2 diabetes, and major depressive disorder. Review of R120’s Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate impairment. Section E (Behavior) revealed the presence of wandering behaviors one to three days during the assessment period. Section I (Active Diagnosis) revealed, diagnoses of Dementia, Cerebrovascular Accident, Depression, and Psychotic disorder. Review of progress note dated 2/21/2025 for R120 revealed that R120 rolled out the front doors behind Emergency Medical Services (EMS); the resident was seen by housekeeping and was brought back inside but never left facility grounds. The resident was asked where she was going and stated she was going home. Review of R120 clinical records under “Observation History” revealed an elopement risk observation form was not completed after the occurrence on 2/21/2025. (continued on next page)

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	115721	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Care Center - Brunswick	2611 Wildwood Drive Brunswick, GA 31520

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress note dated 4/24/2025 revealed that R120 was found sitting on the floor in her room beside a large black bag full of her belongings. The resident had packed all of her items and stated she was going home. Further review of the progress note documented that the resident did this from time to time and that this was not an abnormal occurrence for this resident. Review of the incident report for R120's elopement on 6/29/2025 revealed that R120 was observed outside the facility by Housekeeper TT who was dumping out water from her bucket. She looked up and saw R120 rolling down the alley road with her shower bag, headed towards [NAME] Avenue at 3:20 pm. The housekeeper alerted all the floors that R120 was getting away down the road. It was reported that staff observed R120 attempting to exit through the Turtle Cove unit's doors, but she was unable to do so because the doors were locked. Housekeeper TT was unsure how she had exited, but later discovered it was through the smoking door. After this incident, R120 was moved to the memory unit. Review of R120 clinical records under “Observation History” revealed an elopement risk observation form was completed until after the second occurrence on 6/29/2025. Interview on 7/23/2025 at 1:00 pm with Licensed Practical Nurse (LPN) CC revealed that R120 behaviors were not alarming to her because she packs her things every evening between the hours of 3:00 pm and 5:00 pm, and she attempts to exit the building; however, the doors are usually locked. She stated that she felt that resident R120 should have been on the memory lock unit, This is not the first elopement attempt. She revealed that R120 would have a bag with gowns, briefs, and other belongings and walked up and down the hall with her walker, checking exit doors, including the front exit door, attempting to elope. LPN stated that she heard a CNA on the other hall had propped the door open during a smoke break, which is how R120 exited. Interview on 7/23/2025 at 1:15 pm with Housekeeping TT revealed that she was the one who saw R120 off the facility property in the alley, by the doctor's office on 6/29/2025. She revealed she was not looking for the resident. She was outside dumping her mop bucket when she happened to see her with a bag of clothes in her hand. She explained that upon seeing her, she ran to her as quickly as possible and called for help. She stated that it was such a scary moment because she could have walked across the street, where traffic was hectic, due to the hospital directly across the facility on the opposite side of the road. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2025 at 11:00 am, the Administrator revealed that elopement refers to a situation where a resident is in an unsafe and unsupervised area. She continued to state that when an elopement is identified, they call a code. The Administrator revealed, it is expected that the team members will respond, leave the floor safely, conduct a room and facility check, and then move to the outside of the facility with the radios and continue the search. Continued with the interview, the Administrator stated that if exit-seeking behaviors are present, such as physically going to the door wanting to open it or shaking and pushing at the door handle, the staff should intervene and get them back to the unit. She continued to state that when a resident elopes, and shows elopement behaviors, the clinical team should conduct an elopement assessment, create a care plan for them, and put interventions in place. The Administrator stated she is familiar with R120 and the elopement event on 2/21/2025. She noted that the February elopement is not her first attempt and has had historical behaviors of wandering and eloping for years. She stated that she is aware of the 6/29/2025 elopement event, and an elopement assessment, care plan, and interventions were implemented. However, regarding the attempt on 2/21/2025, they did not consider this to be an elopement risk. Therefore, no elopement assessment was implemented, nor was a care plan with interventions. Nevertheless, she believes interventions should have been implemented after the 2/21/2025 incident. During an interview on 7/24/2025 at 1:16 pm, the Nurse Consultant stated that there should be an assessment done after an attempt, and a care plan should be in place. She further stated that their process for when a resident should be assessed was on admission, readmission, quarterly, and a significant change of event. 2. Review of medical records for R16 revealed diagnoses that included but not limited to, other sequelae of other cerebrovascular disease, spastic hemiplegia affecting left nondominant side; type 2 diabetes mellitus with unspecified complications, borderline personality disorder, nicotine dependence, cigarettes, uncomplicated; and generalized anxiety disorder. Review of R16’s Annual MDS dated [DATE] for Section C (Cognitive Patterns) revealed, a BIMS of 15 which indicated the resident was cognitively intact. Review of the smoking list revealed R16 was identified as a tobacco user. Review of R16’s clinical record on 7/21/2025 revealed there was no “Smoking Observation Form “completed. Review of R16’s care plan on 7/21/2025 revealed she did not have a care plan related to smoking. Further review of clinical records revealed the care plan and the “Smoking Observation Form” was completed on 7/22/2025. Observation on 7/22/2025 at 2:10 pm of smoke break revealed R16 sitting outside in the designated smoke area smoking a cigarette with staff supervision. During an interview on 7/28/2025 at 3:20 pm with Unit Manager/LPN AA, revealed that the facility became a smoke-free facility after (Name of Facility) took over. She stated that R16 was smoking before she started working at the facility. She confirmed that R16 smoked and stating that R16 had been Grandfathered in. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/29/2025 at 1:05 pm with MDS coordinator revealed, there should have been a care plan and assessment completed for R16. She confirmed that there was not a care plan nor an assessment in the Electronic Health Record (EHR) before 7/22/2025. She stated that everything was electronic in February 2025 and that there should have been something in the EHR. She stated that she had been going through trying to update information on the care plan; however, she was the only MDS person and there was no one in the position for several months before she was hired.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, residents and staff interviews, record review, and review of the facility's policy titled, Medication Administration: General Guidelines, the facility failed to ensure the medication error rate was less than five percent. There were nine errors with 56 opportunities for three of six residents (R) (R51, R89 and R92) observed for a medication administration with an error rate of 16.07 percent. This deficient practice had the potential to place all residents at risk of avoidable medical complications due to not receiving medications or receiving an incorrect dose of medication other than that prescribed by the physician. Findings include: During a review of the facility's policy titled, Medication Administration: General Guidelines, dated 7/22/2024, revealed under heading Procedure: Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the patient/ resident's age and condition, or a medication order seems to be related to the patient/ resident's current diagnosis or condition, the physician is contacted for clarification prior to the administration of the medication. This interaction with the physician is documented in the nursing notes and elsewhere in the medical record as appropriate. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. patient/ resident not in healthcare center at scheduled dose time, initial dose of antibiotic), The space provided on the front of the paper Medication Administration Record (MAR) for that dose administration is initialed and circled and for facilities utilizing the e-MAR system the NOT ADMINISTERED button will be utilized with the appropriate reason given for not administering medication at scheduled time period an explanatory note is entered on the reverse side of the record provided for as needed (PRN) indication and general medication notes and for EMR the note can be typed in the appropriate space provided within the electronic system. If more than two consecutive doses of a vital medication or refuse, the physician is notified. 1. Review of R51 admission records revealed the resident was admitted to the facility with diagnosis that included but not limited to quadriplegia, peripheral vascular disease, incomplete lesion at unspecified level of cervical spinal cord, seizures, vitamin D deficiency, major depressive disorder, chronic idiopathic constipation and polyneuropathy. A review of the active physicians orders for R51 revealed docusate sodium 100 milligram (MG) oral capsule [Colace] two caps two times daily, vitamin b-12 1tablet daily, polyethylene glycol 3350 17000 mg powder for oral solution [MiraLax] 30 ml (milliliter) by mouth every three days, sertraline 50 mg oral tablet one tablet once a day, carbamazepine tablet; 200 mg one tablet two times daily, famotidine tablet 20 mg one tablet, phenytoin sodium extended capsule; 100 mg three capsules daily, tramadol tablet 50 mg one tab two times daily, apixaban 5 mg oral tablet; one tablet, baclofen 10mg oral tablet; one tablet, and 12 HR (hour) carbamazepine 200 mg extended-release oral tablet; one tablet. During a medication pass on 7/22/2025 at 9:30 am with LPN EE on Turtle Cove hall revealed her administering medications to R51. LPN EE was observed administering docusate sodium 100 mg oral capsule [Colace] one capsule (instead of two), apixaban 5 mg oral tablet one tablet, baclofen 10 mg oral tablet one tablet, 12 HR carbamazepine 200 mg extended-release oral tablet one tablet, famotidine 20 mg oral tablet one tablet, phenytoin 100 mg capsules three capsules and tramadol hydrochloride 50 mg extended-release oral tablet one tablet. Vitamin B12 one tablet, Lactulose 10mg/15ml-30ml, polyethylene glycol 3350 17000 milligram powder 17grams nor sertraline 50 mg one tablet was administered. A review of the MAR for R51 revealed LPN EE administered the docusate sodium 100 mg capsule one cap and did not administer vitamin B12 one tablet, Lactulose 10mg/15ml-30ml, polyethylene glycol 3350 17000 milligram powder 17grams nor sertraline 50 mg one tablet. During an interview on 7/22/2025 at 10:00 am with LPN EE revealed that not only was she new to the facility, but she was also new using the current electronic medical records (EMR) system. She denied seeing the medications omitted on the MAR during her administration and acknowledged to not signing off the MAR after completing the medication administration. 2. A review of the facility's admission records for R89 revealed that the resident admitted with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD) with acute exacerbation, proximal atrial fibrillation (A-Fib), muscle weakness, pulmonary fibrosis, vascular dementia, rheumatoid arthritis without rheumatoid factor, depression, chronic kidney disease and moderate protein calorie malnutrition.A review of R89's active physician's orders included acetaminophen tablet 325 milligrams (MG) two tablets, ascorbic acid tablet 500 MG two tablets, azelastine hydrochlorothiazide 0.137 milligrams metered dose nasal spray, two sprays in each nostril, and cholecalciferol 1.25 MG one tablet. During a medication pass on 7/22/2025 at 8:35 am on Live Oak hall with Licensed Practical Nurse (LPN) CC revealed her administering medications to R89. Azelastine

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, staff interviews and review of the facility's policy titled, Medication Storage in the Healthcare Center, the facility failed to ensure that all drugs and biologicals were discarded prior to the expiration date on one of nine medication carts (Harbor Side) and two of six medication rooms (Central Supply and Ocean Breeze). This deficient practice had the potential to place residents at risk for medical complications and delayed treatment. The facility census was 126 residents.Findings include: Review of the facility's policy titled, Medication Storage in the Healthcare Center, revised 6/20/2025, under the section titled, Procedure revealed, number three, Nurses and medication aides are required to check all medications for deterioration and expiration before administration. And medication aides are also required to inspect medication storage facilities, including medication cards, routinely. Medication storage areas are to be kept clean, well lit, and free of clutter. Nursing staff and medication aides who administer medications are responsible for the cleaning and organization of medication carts and storage areas.Number12 revealed, Outdated, or deteriorated medications and those in containers, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exists. During an observation on 7/22/2025 at 12:43 pm of the medication cart on Harbor Side, revealed a bottle of Allergy Relief with expiration date January 2025 in the medication cart. During an observation on 7/22/2025 at 1:04 pm of the central supplies medication storage area revealed two bottles of aspirin 325 milligrams (mg) with expiration date June 2025. During an observation on 7/22/2025 at 2:16 pm of the medication room on Ocean Breeze, revealed two boxes of COVID-19 antigen rapid tests with a used by date 4/30/2025.During an observation on 7/22/2025 at 12:45 pm with Licensed Practical Nurse (LPN) FF revealed that she did not normally work on Harbor Side Hall and that her regular hall was Live Oak. LPN FF also revealed that did not normally administer these medications and therefore did not check the expiration date. She confirmed that she knew to check the medication cart and to remove any expired medications but, she did not do so. During an interview on 7/23/2025 at 9:54 am with LPN GG revealed that when you can't tell the expiration date you're to discard the medication and replace it. She confirmed that she did not check the medication cart for expired medications when she returned to work after her scheduled days off. During an interview on 7/28/2025 12:05 pm with LPN AA revealed that the nurses on the cart were responsible for checking and removing expired medications from the cart. LPN AA stated that the cart should be checked weekly for expired medications. She also stated that I did an inventory about four weeks ago of both the medication cart and the medication storage room and removed all expired medications. LPN AA stated that all nurses were responsible for checking all medications for expiration date before administering the medication. She also stated that It was also an oversight on my part as well. LPN AA stated that the central supply person is generally responsible for the central supply medication closet. During an interview on 7/29/2025 at 10:04 am with the Central supply manager/ Transporter revealed she was responsible for stacking and auditing supplies in the nursing supply closet in the central supply room. She stated that I order as needed with a specific amount kept in the closet, I rotate the stuff according to what's going out first meaning what's expiring sooner gets pulled to the front. I check weekly for expired medications and if expired then I pull it and dispose of it. I'm not sure if the nurses placed extra stuff found in their carts back in my storage and that's why I had expired stuff in my closet. During an interview on 7/28/2025 at 3:38 pm with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) revealed that all nurses were responsible for disposing expired medications immediately if it was expired. The DON stated that if it is a continuous medication then the nurse should reorder it or replace it if it is an over-the-counter medication. She also stated that the pharmacy comes monthly and checks everything including expired medications. The DON revealed that nurses should be checking the expiration date before administering medications as well as the managers, just as an extra set of eyes. I think it's a team effort.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure mechanical soft - chopped meats were prepared properly for one out of 36 residents resident (R) (R26) reviewed on a mechanical soft diet.Findings include:Review of the medical records revealed R26 had diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, need for assistance with personal care, dysphasia following cerebral infarction. Review of the Minimum Data Set (MDS) Annual assessment dated [DATE] revealed Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) score of nine, indicating moderate cognition impairment and Section K (Swallowing/Nutritional status) revealed, the holding of food in mouth/cheeks or residual food in mouth after meals, and received a mechanical altered diet/therapeutic dietReview of R26's physician order dated 1/10/2025 listed a dietary order for no added salt, mechanical soft.Review of R26 's care plan with a start date of 9/30/2024 and last revised on 7/22/2025 revealed resident required a mechanically altered and therapeutic diet related to dysphagia and hemiplegia. Interventions included Diet: mechanical soft diet.Record review revealed a progress note dated 5/21/2025 that revealed the resident had a choking incident. The note revealed the resident was on a mechanically soft diet that required meat to be grounded and was mistakenly given a hamburger for lunch.Interview on 7/28/2025 at 2:06 pm with the Registered Dietician (RD) revealed mechanical soft meats were considered ground meats and that a hamburger patty was not considered mechanical soft. The RD revealed that staff passing trays should be checking the resident's diet which was listed on the resident's profile, care plan, and meal ticket to the actual tray being served to the resident. Interview on 7/28/2025 at 2:44 pm with the Dietary Manager confirmed the R26 did receive a diet that was not mechanically soft. He revealed when the incident occurred, he went to the resident's room and saw that the resident had received his roommate's tray.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility failed to ensure that the dumpster area was free of debris and maintained in sanitary conditions. In addition, the facility failed to ensure the dumpsters lids for three of the four dumpsters had a secure fit and closed properly. The deficient practice had the potential to promote the harboring of pests, insects, and other organisms and create the potential for disease transmission by pest and rodents. The census was 126 residents. Findings include:During the initial tour of the outside area on 7/21/2025 at 9:30 am revealed the dumpster area had garbage and litter on the ground. Further observation revealed that the dumpsters lids for three of the four dumpsters were not secured and opened. Observation and interview on 7/23/2025 at 3:25 pm of the facility's dumpster with Dietary Kitchen Manager (DKM) revealed the dumpsters lids for three of the four dumpsters were not secured and opened. One of the four dumpster's lid was damaged, allowing it not to close properly causing the lid to lift, not having a secure fit and preventing the trash from being securely contained. Debris and used nitrile exam gloves were thrown on the ground around the dumpsters; boxes and litter were thrown behind the dumpsters. The DKM confirmed the condition of the dumpsters lids, the debris, and litter on the ground. He reported that the lids should be always closed to contain the trash. He verified that the trash should not be on the ground, nor thrown behind the dumpsters. He stated that he did not know that it was the kitchen staff's responsibility to maintain the garbage and refuse; however, all staff should take responsibility. The DKM reported being unaware of the dumpster condition. The DKM stated that he would organize a cleanup day for them to clean the dumpster area. Observation on 7/24/2025 at 11:55 am of the facility dumpster area revealed no changes in the condition of the dumpster area from the previous day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policy titled, Standard Precautions, the facility failed to ensure resident personal care items were stored in a manner to prevent cross-contamination in three of 12 bathrooms shared between rooms (216 and 218, 215 and 217, 205 and 207) on the 200 Hall. The deficient practice had the potential to expose residents to infections due to cross-contamination. Findings include:A review of the policy titled Standard Precautions last reviewed on 12/4/2023, revealed 7. Patient Care Equipment and Instrument/Devices. Handle equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of pathogens to other patients or the environment.Observations on 7/21/2025 at 12:48 pm, 7/22/2025 at 1:01 pm, and 7/23/2025 at 12:38 pm of the bathroom shared between rooms [ROOM NUMBERS] revealed a bed pan and a bath basin not bagged or labeled. Observation on 7/21/2025 at 1:11 pm, 7/22/2025 at 1:00 pm, and 7/23/2025 at 12:59 pm of the bathroom shared between rooms [ROOM NUMBERS] revealed two urinals not bagged or labeled. Observation on 7/21/2025 at 1:14 pm, 7/22/2025 at 1:05 pm, and 7/23/2025 at 1:05 pm of the bathroom shared between rooms [ROOM NUMBERS] revealed five bath basins not bagged or labeled.Interview on 7/23/2025 at 2:50 pm with Certified Nurse Assistant (CNA) KK revealed bath basins and urinals should be cleaned, bagged, and labeled with resident's name and room number. An interview on 7/23/2025 at 1:40 pm with Assistant Director of Nursing (ADON) revealed that all urinals and bath basins should be bagged and labeled. Observation and interview on 7/23/2025 at 1:50 pm with the Director of Nursing (DON) confirmed that all urinals and bath basins should be labeled and bagged to ensure no spread of disease or contamination. She confirmed the bathroom shared between rooms [ROOM NUMBERS] contained a bed pan and a bath basin not bagged or labeled, the bathroom shared between rooms [ROOM NUMBERS] contained two urinals not bagged or labeled, and the bathroom shared between rooms [ROOM NUMBERS] contained five bath basins not bagged or labeled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115721	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Care Center - Brunswick	2611 Wildwood Drive Brunswick, GA 31520

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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of the facility's policy titled Patient/Resident Rights, Accommodation of Needs, the facility failed to ensure privacy for two out of 29 resident rooms observed (room [ROOM NUMBER] A and 218 B) had privacy curtains. Findings include:Review of the facility's policy titled Patient/Resident Rights, Accommodation of Needs, revised 12/1/2023 revealed B. Privacy: 1. Patients/residents will be provided full visual privacy during routine care and treatments by means of privacy curtains and closed doors.Observation on 7/21/2025 at 1:11 pm during an initial tour shared rooms 217 A and 218 B revealed that the privacy curtains were missing. Further observations on 7/22/2025 at 11:55 am and 7/23/2025 at 12:39 pm revealed both 217 A and 218 B were still missing their privacy curtains.Interview on 7/23/2025 at 12:50 pm with Certified Nurse Assistant (CNA) KK revealed that all residents in a double room should have a privacy curtain. Interview and rounding on 7/23/2025 at 1:45 pm with the Director of Nursing (DON) revealed the facility prioritizes resident's privacy and dignity. The DON confirmed revealed that all shared rooms should have a privacy curtain for each bed. She confirmed that 217 A and 218 B did not have a privacy curtain. She stated she was going to get maintenance to hang both curtains.