| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115727 | A. Building<br>B. Wing | 04/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Jeffersonville Care Center LLC | 113 Spring Valley Road<br>Jeffersonville, GA 31044 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled Abuse, Neglect and Exploitation, the facility failed to protect one of two residents (R) (R31) right to be free from physical abuse by R73. Actual Harm was identified to have occurred on March 29, 2026, when R73 physically assaulted R31, causing a laceration to his scalp and faint bruising to the right rib area.Findings include:Review of the facility policy titled Abuse, Neglect and Exploitation, revised 3/5/2024, documented under III. Prevention of Abuse, Neglect and Exploitation-The facility will implement polices and procedure to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.1. Record review revealed R73 was admitted to the facility on [DATE] with diagnoses including, but not limited to, schizophrenia, mental disorders, severe intellectual disabilities, and personal history of traumatic brain injury.Review of the Quarterly Minimum Data Set (MDS) for R73, dated 03/30/2026, revealed section C (Cognitive Patterns) documented that R73 had a Brief Interview of Mental Status (BIMS) of 00, indicating severe cognitive impairment. Section E (Behaviors) documented the following: Physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Behavior of this type occurred 1 to 3 days during the assessment period. Verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others. Behavior of this type occurred 1 to 3 days during the assessment period. Other behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds. Behavior of this type occurred 1 to 3 days during the assessment period.Review of the care plan for R73, dated 07/23/2025, revealed a focus area of the resident is at risk for behavior problems related to a history of traumatic brain injury and schizophrenia. The resident yells/cries out at times, refuses care, lab draws, and has verbal behaviors and aggression. The goal was for the resident to have no complications related to behaviors by the review date. Interventions included administering psychotropic medications as ordered, providing opportunity for positive interactions, minimizing the potential for disruptive behaviors by offering tasks that divert attention, and providing a program of activities that is of interest to the resident. Continued review revealed that the resident uses antipsychotic (psychotropic) medication related to behavior management and schizophrenia. The goal was that the resident would remain free from psychotropic medication-related complications, including movement disorders, discomfort, hypotension, gait disturbance, constipation/impaction, and cognitive or behavioral impairment through the review date. Interventions included observing and documenting the occurrence of target behavioral symptoms, including pacing, wandering, disrobing, inappropriate responses to verbal<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | communication, and aggression or violence toward staff or others, in accordance with facility protocol.Review of the progress notes for R73 revealed an entry dated 03/29/2026 at 7:17 AM documenting that the nurse heard a loud noise and yelling. Upon responding, R73 was noted to be involved in an altercation with another resident (R31). The nurse noted R31 sitting on the floor and R73 standing over R31, flailing his arms. The note documented that R31 incurred injuries.2. Record review revealed R31 was admitted to the facility on [DATE] with diagnoses including, but not limited to, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and delirium due to known physiological condition.Review of the Quarterly MDS for R31, dated 03/05/2026, revealed section C (Cognitive Patterns) documented a BIMS of 00, indicating severe cognitive impairment. Section E (Behaviors) documented that behaviors were not exhibited during the assessment period.Review of the progress notes for R31 revealed an entry dated 03/29/2026 at 7:17 AM documenting that the nurse heard a loud noise and yelling. Upon responding, R31 was noted as involved in an altercation with another resident (R73). R31 was noted to have a laceration on the scalp, red discoloration around the right eye, and complained of right side pain. The Nurse Practitioner (NP) was notified, and the resident was sent to the emergency room (ER). Continued review revealed an entry dated 3/29/2026 at 1:29 PM documenting that the resident returned to the facility via Emergency Management Services (EMS), and the hospital diagnoses were laceration of the scalp and a contusion of the right rib. Further review revealed an entry dated 03/30/2026 at 10:17 AM documenting that the resident had a dressing on the scalp with two intact Steri-Strips applied to the laceration, the resident complained the right rib area was tender to touch, and there was faint bruising noted to the area.During an interview on 04/09/2026 at 12:34 PM, the Director of Nursing (DON) reported a previous incident between R73 and R31, and stated R73 had received Geodon (a medication used to treat schizophrenia and bipolar disorder). She stated that she did not initially recognize the severity of the incident until she reviewed documentation later. The DON stated that R73 was not placed on 1:1 supervision; instead, the resident was placed on behavioral monitoring with a 72-hour observation period based on staff reports indicating the resident had calmed following medication administration. The DON stated that R73 remained on behavioral monitoring and that staff had been advised to monitor him closely for any signs or changes in his behavior, report any changes to the charge nurse, and administer medications as ordered. |