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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jeffersonville Care Center LLC	113 Spring Valley Road 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 Level of Harm - 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 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 (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 - Actual harm 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.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review and staff interview, the facility failed to provide financial statements related to resident fund bank statements and resident trust accounts. The deficient practice had the potential to affect residents with trust funds managed by the facility. The facility census was 91 residents.Findings include:Review of the facility-provided documents revealed, there was no record of the residents' financial statements within the requested documents.Interview with the Administrator on 4/9/2026 at 2:00 pm revealed she did not know the number of residents who had their funds managed by the facility. She explained that her company acquired the building on 4/1/2026 and did not have access to financial information. She revealed that the current corporate office was in the process of trying to gain access to the financial information. She revealed that she nor anybody else has knowledge of the resident trust accounts or the balances. She also confirmed that residents were not currently receiving money.A request for the resident's financial statements from the Administrator was made but was not received prior to exit.

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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 policy titled Food Safety Requirements, the facility failed to label, store, prepare and discard food under sanitary conditions. The deficient practices created an unsanitary kitchen environment that increased the potential for cross contamination and foodborne illness for 86 of 91 residents receiving an oral diet from the kitchen.Findings include:Review of the facility's policy titled, Food Safety Requirements, revised on 1/4/2024, under Policy Explanation and Compliance Guidelines revealed, Number 3.(iv) Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers so it is used by its use-by date, or frozen (when applicable)/ discarded.During the initial observation tour of the kitchen on 4/7/2026 beginning at 9:11 AM with the Food Service Director (FSD), the following concerns were identified and confirmed:- In Freezer one revealed, one bag of opened frozen cookie dough and one bag of French fries that was unlabeled and not dated.-In Freezer two revealed, an opened blue bag of frozen bananas and six bags of frozen pancakes that was unlabeled and not dated-In Freezer three revealed, six packages of frozen biscuits without an open or end date-In Refrigerator one revealed, two large containers of [Name] Classic Italian Pasta Salad, sausage patties wrapped in clear plastic wrapping, and a bag of [Name] Classic Orange Gelatin without an open or end date. During the kitchen tour, the FSD confirmed and verified all identified concerns and revealed that the staff needed additional education on labeling, dating, and discarding items. The FSD removed some of the items and discarded them as they were identified. She confirmed that all items should be discarded in the trash bin. Interview conducted on 4/9/2026, at 1:01 PM with the Director of Nursing (DON) revealed that it was her expectation that all food items must be clearly labeled with both the open and discard dates. She revealed that staff were expected to consistently follow established policies for proper labeling and storage.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record reviews, and the facility policy titled Resident Assessment-Coordination with PASARR Program, the facility failed to ensure submission to the state-designated authority for a Preadmission Screening and Resident Review (PASRR) Level II for two of two residents (R) (R4 and R3) reviewed for PASRR. This deficient practice increased the potential to place R4 and R3 at risk of not receiving services and/or care according to their needs.Findings include: Review of the facility's policy titled, Resident Assessment-Coordination with PASARR Program, dated 12/24/2023 revealed, 1(a) PASARR Level I initial pre-screening that is completed prior to admission (i) negative level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. 3. A record of the pre-screening shall be maintained in the resident's medical record. 5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: (a) the facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID, or a related condition to the appropriate state designated authority for a Level II PASARR evaluation and determination. B. The Level II resident must be completed within 40 calendar days of admission. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 1. Review of the electronic health record (EHR) under the Diagnosis tab for R4 revealed, the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition, other symptoms and signs involving appearance and behavior. Review of the quarterly Minimum Data Set (MDS) assessment for R4, dated 2/27/2026, revealed that Section C (Cognitive Patterns) documented that R4 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition; Section I (Active Diagnosis) revealed a diagnosis of psychotic disorder. Review of the PASRR Level I Assessment and DMA 6 for R4, dated 11/15/2024 revealed that the diagnosis of other psychotic disorder was not marked. Review of the clinical record for R4 revealed no submissions for a PASRR Level II after admission. In an Interview on 4/8/2026 at 2:00 pm with the Social Services Director (SSD) revealed she was responsible for the submissions of PASSR Level IIs. She revealed that she had attempted to get PASSAR Level II services for the resident but was told the resident did not have a qualifying diagnosis. She did not have any documentation of proof that she had applied for PASSAR Level II services. 2. Review of the EHR under the diagnosis tab for R3 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment for R3, dated 2/11/2026, revealed that Section I (Active Diagnosis) revealed a diagnosis of schizophrenia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the PASRR Level I Assessment for R3, dated 8/12/2020, revealed that the diagnosis of schizophrenia was not marked. Review of the clinical record for R3 revealed no submissions for a PASRR Level II after admission. In an interview on 4/8/2026 at 10:00 am with the SSD, she confirmed that the resident did not have a PASSAR Level II evaluation nor did she have any documentation of proof that she had applied for PASSAR Level II services. She confirmed that the resident had a qualifying diagnosis and that applying for PASSAR Level II services was on her list of tasks to complete.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, staff interviews, record review, and review of the facility's policy titled Medication Storage, the facility failed to ensure that a controlled substance was locked in the permanently affixed compartment in the refrigerator in one of two medication storage rooms. In addition, the facility failed to ensure that one of four medication carts was locked and secured when out of a nurse's sight. These deficient practices had the potential to place residents at increased risk of medical complications and give unauthorized staff, residents, and visitors access to medications and controlled substances.Findings include:Review of the facility's policy titled Medication Storage, revised February 14, 2024, revealed that It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The policy further stipulates that all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls and only authorized personnel will have access to the keys to locked compartments. Additionally, during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Further review revealed, Schedule II drugs and back-up stock of Schedule III, IV, and V medications are stored under double-lock and key and Schedule II controlled medications are to be stored within a separately locked, permanently affixed compartment. During an observation on 04/06/2026 at 10:56 AM of the medication storage room for the 100, 200, and 300 Halls, with Unit Manager (UM)/Licensed Practical Nurse (LPN) LL, observation revealed that one Ativan liquid was stored in the medication refrigerator on a shelf and not in a permanently affixed compartment. Further observation revealed the permanently affixed lockbox was empty, and the refrigerator did not have an additional lock. In an interview, UM/LPN LL stated that the Ativan should have been secured in the locked, permanently affixed compartment in the refrigerator. Observation on 04/08/2026 at 9:10 AM revealed one medication cart unlocked and unattended on the 200 Hall. Continued observation revealed that a resident in a wheelchair was sitting directly next to the unlocked cart. Observation at 9:12 AM revealed LPN AA walking out of a resident's room toward the unlocked cart. She confirmed the cart was unlocked, stating she thought she had pushed the lock in, but must not have done so all the way. She confirmed the cart should be locked anytime she walked away from it. During an interview on 04/08/2026 at 9:17 AM, the Director of Nursing (DON) revealed that medication carts should never be left unlocked and unattended. The DON stated the nurse was an agency nurse and confirmed she should not have left the cart unlocked. During a concurrent interview on 04/09/2026 at 11:30 AM, the Administrator and DON revealed that they were aware of the medication storage concerns. They stated it was their expectation that all medications be secured per facility policy, including double-locking controlled substances and keeping medication carts secured at all times to prevent unauthorized access.