STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115308	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Place at Martinez, The	409 Pleasant Home Road Augusta, GA 30907

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, staff interviews, and policy review, the facility failed to maintain a safe, functional, and sanitary environment in the main dining room where 14 out of a total of 85 residents ate their meals. This failure had the potential to lead to the spread of infection or feelings of discomfort and dissatisfaction among residents. Findings include: Review of the undated policy titled, The Place Facilities Safe and Homelike Environment, revealed, Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. During initial observations of the main dining room on 11/18/25 at 9:11 AM, four of five observed ceiling vents were covered with fuzzy dust and dirt. These vents were located above residents' dining tables. The wall below the pass-through window to the kitchen had spilled liquid or food debris running down the length of the wall and onto the floor below. During observation of lunch in the main dining room on 11/18/25 beginning at 12:07 PM, 14 residents were seated at the tables eating lunch. The ceiling vents above the residents were observed with caked-on fuzzy dust and dirt. The wall and floor below the pass-through window continued to have the same liquid spills and food debris. During a concurrent observation and interview on 11/21/25 at 9:50 AM, the Director of Maintenance (DOM), who also served as the Director of Housekeeping, observed the ceiling vents caked with dust and dirt and stated they were dirty and needed to be cleaned. The DOM stated the dust was a concern because it was directly above where residents ate. The DOM stated the housekeeping department was responsible for cleaning the ceiling vents and stated they should be cleaned about every two weeks, but did not have documentation of the cleaning. He stated the vents needed to be cleaned immediately. The DOM also observed the wall and floor under the pass-through window to the kitchen and agreed it was soiled with food or liquid spills. The DOM stated the housekeeping staff cleaned the floor in that area, but he felt the kitchen staff should be responsible for cleaning the wall under the pass-through window. The DOM stated the wall needed to be cleaned.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, staff interviews, and document review, the facility failed to ensure that eight of the eight residents who received pureed diets out of a total of 85 residents received the foods as called for in the menus. These failures placed the eight residents at risk for weight loss, malnutrition, or dissatisfaction with their meals.Findings include: Review of a handwritten, undated document titled Texture Count, provided by the Dietary Manager (DM), revealed the facility had eight residents who received a pureed diet. 1. During interview and concurrent observation of breakfast service in the kitchen on 11/20/25 at 7:34 AM, Dietary Aide (DA) 2 stated she prepared pureed eggs, pureed waffles, and cream of wheat for the pureed meals. She was observed serving pureed meals consisting of pureed eggs, waffles, and cream of wheat. Review of the Diet Extensions: Thursday, Week 1, Menu, provided on paper by the Dietary Manager (DM), revealed that the pureed breakfast meal should have consisted of pureed oatmeal, pureed banana, pureed sausage patty, and pureed waffle. During an interview on 11/21/25 at 1:47 PM, the DM stated she had never prepared pureed oatmeal before and had never heard of it being done. She stated she did not know the menu called for pureed oatmeal. The DM stated she did not know why pureed eggs were served instead of pureed sausage or why cream of wheat was served instead of pureed oatmeal. The DM stated she did not know why the pureed banana was not served. The DM stated DA2 probably overlooked it on the menu. The DM placed a call to DA2 for an interview; however, there was no response prior to survey exit. The DM stated she expected staff to serve food as called for on the menu. 2. During interview and concurrent observation of breakfast service in the kitchen on 11/21/25 at 7:35 AM, DA1 stated she had prepared pureed eggs, cream of wheat, and pureed oatmeal for the pureed meals. She was observed serving pureed meals consisting of pureed eggs, cream of wheat, and pureed oatmeal. Review of the Diet Extensions: Friday, Week 1, Menu, provided on paper by the DM, revealed the pureed breakfast meal should have consisted of pureed banana, pureed eggs, pureed diced potatoes, and pureed wheat bread. During an interview on 11/21/25 at 1:47 PM, the DM stated she was unaware that the menu was not followed at breakfast. She stated she did not know why pureed banana was not served, or why pureed oatmeal was served in place of pureed diced potatoes. During an interview on 11/21/25 at 1:50 PM, DA1 stated she did not puree potatoes as the shipment had not come in. She confirmed she did not serve pureed banana.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, document review, policy review, and review of McGeer's criteria, the facility failed to have an Antibiotic Stewardship Program that followed current standards of practice for prescribing an antibiotic for five of five residents (Resident (R) 25, R62, R63, R46, and R50) reviewed for antibiotic stewardship out of total sample of 27 residents. This failure had the potential for residents to be prescribed unnecessary antibiotics.Findings include: Review of the undated facility's policy titled, The Place Antibiotic Stewardship Program indicated, The program includes antibiotic use protocols and a system to monitor antibiotic use. The facility uses the (CDC [Centers for Disease Control] NHSN [National Healthcare Safety Network] Surveillance Definitions, updated McGeer's criteria, or other surveillance tool) to define infections. Review of McGeer's Criteria dated 11/05/24 revealed, . Table 2. Urinary Tract Infection (UTI) Surveillance Definitions Syndrome: UTI without indwelling catheter Criteria: 1. At least one of the following sign or symptom: Acute dysuria or pain, swelling, ., Fever or leukocytosis, and one or more of the following: acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency. If no fever or leukocytosis, then greater than 2 of the following: suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency 2. At least one of the following microbiologic criteria greater than or equal to 100,000 Colony Forming Units (CFU) per milliliter (mL) of no more than 2 species of organisms in a voided urine sample greater than or equal to 100 of any organism(s) in a specimen collected by an in-and-out catheter . 1. Review of R25's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR), indicated R25 was admitted to the facility on [DATE] with the diagnosis of renal insufficiency and diabetes mellitus. Review of R25's Physician Orders, located in the hard copy of R25's medical record, indicated an order dated 01/19/25 to obtain UA [urinalysis] C&S [culture and sensitivity]. Review of the Nursing Progress Notes, located under the Progress Note tab in the EMR, revealed there was no documentation to indicate R25 signs and symptoms to warrant a UA and C&S to be ordered. During an interview on 11/21/25 at 2:15 PM, the Infection Preventionist/Wound Care Nurse (IP/WCN) reviewed the Infection Control Report for R25. In this report, the IP/WCN confirmed there was no documentation to indicate any signs and symptoms R25 was experiencing at the time the UA C&S was ordered. This report also indicated that the Nurse Practitioner ordered Omnicef (an antibiotic) 300 mg (milligrams) by mouth two times a day for 10 days on 01/21/25 for R25. The C&S report was reviewed by the IP/WCN, and she confirmed the results of 10,000 – 49,000 CFU/ml (colony-forming units per milliliter) Proteus mirabilis. The IP/WCN confirmed this result did not meet McGeer's criteria of At least 100,000 cfu/ml or no more than 2 organisms or microorganisms in a voided urine sample, even though the IP/WCN documented on the Infection Control Report the infection did meet criteria for a UTI (Urinary Tract Infection). Copies of the physician's orders for the antibiotic and nursing documentation to reflect the signs and symptoms that R25 was experiencing prior to the order of the UA C&S on 01/19/25 were requested. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further documentation was received prior to the exit conference on 11/21/25. 2. Review of R62's Face Sheet, located under the Profile tab in the EMR, indicated R62 was admitted to the facility on [DATE] with the diagnosis of coronary artery disease and renal insufficiency. Review of R62's Physician Orders, provided by the facility, indicated an order dated 08/19/25 for Doxycycline Hyclate (antibiotic) 100 mg by mouth two times a day for 10 days for infection. Review of R62's Progress Note, provided by the facility, revealed the Nurse Practitioner documented, Chief Complaint: cough. Patient [R62] states that her cough today seems worse. She [R62] denies fever, sore throat, runny nose, body aches/chills. chest pain, shortness of breath. Today Oxygen [sic] saturations noted to be 95% on room air. Vital signs noted to be stable. Review of R62's Chest X-Ray Results dated 08/19/25 and provided by the facility indicated No pleural effusion. No acute cardiopulmonary process. During an interview on 11/21/25 at 2:25 PM, the IP/WCN reviewed the Infection Control Report for R62 and confirmed that this did not meet McGeer's criteria due to R62 not having a fever, and the x-ray results on 08/19/25 did not reveal pleural effusion or any acute cardiopulmonary processes, and R62's oxygen saturations were 95% on room air. 3. Review of R63's Face Sheet, located under the Profile tab in the EMR, indicated R63 was originally admitted to the facility on [DATE] with the diagnosis of Alzheimer's Disease and traumatic brain injury. Review of R63's Physician Orders, provided by the facility and dated 04/23/25, indicated Zithromax Z-Pak [antibiotic] 250 mg [milligram] po [by mouth] give 500 mg on day 1 [sic], then 250 mg po on day 2-5 [sic] then stop for cough/congestion. During an interview on 11/21/25 at 2:35 PM, the IP/WCN confirmed that R63 did not meet McGeer's criteria for the diagnosis of congestion. The IP/WCN confirmed the Infection Control Report was not filled out completely to reflect any signs and symptoms the resident was experiencing at the time the antibiotic was ordered on 04/22/25. Nursing progress notes for R63 were requested regarding what signs and symptoms R63 was experiencing prior to the order of the Azithromycin on 04/22/25. No further information was provided by the IP/WCN prior to the exit conference on 11/21/25. During an interview on 11/21/25 at 4:55 PM, the Director of Nursing (DON) stated, [IP/WCN] went over this. We review it together. [IP/WCN] fills out the form, then we bring it to a clinical meeting to discuss with the team. Our NP [nurse practitioner] is also involved in this process. Our biggest thing is to make sure we follow and meet McGeer's criteria for antibiotic use. 4. Review of R46's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE]. Review of R46's Acute Care Note, dated 11/05/25 and located under the Progress Notes tab of the EMR, revealed, Staff states that resident is noted with some increased confusion . Assessment/Plan: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R41.0 - Disorientation, unspecified - New order: UA/CS [urine analysis with culture and sensitivity]. Review of R46's Order Note, dated 11/05/25 and located under the Progress Notes tab of the EMR, documented that a new order was received for a UA/CS due to confusion. Review of R46's EMR under the Orders tab revealed a physician's order, dated 11/10/25, for Macrobid (an antibiotic), 100 milligrams (mg) twice daily for 10 days for a urinary tract infection (UTI). Review of R46's Lab Report, dated 11/06/25 and located under the Miscellaneous tab of the EMR, revealed a result of 40,000 - 50,000 colony-forming units per milliliter (cfu/mL) of Enterococcus faecalis was reported, which was susceptible to Macrobid. Review of R46's paper Infection Report Form, dated 11/11/25 and provided by the IP/WCN, revealed that none of the criteria listed to determine if a UTI was present were checked, but confusion was written in. The form instructed that acute dysuria, fever or leukocytosis, and/or symptoms of suprapubic pain, hematuria, new or increased incontinence, urgency, or frequency must be noted along with at least 1,000,000 cfu/mL of microorganisms detected. The form documenting R46's symptoms did not meet the criteria of a UTI. The form also documented that Macrobid was prescribed. Review of R46's Acute Care Note, dated 11/12/25 and located under the Progress Notes tab of the EMR, revealed, Patient seen today due to being place [sic] on ABT [antibiotic] r/t [related to] UTI. Patient placed on Macrobid 100mg po [orally] BID [twice a day] x10 days. She is tolerating well with no adverse reactions noted. Vital signs [were] noted to be stable. She remains afebrile. She denies chest pain, shortness of breath, headaches, lightheadedness, nausea, vomiting and dizziness. Patient denies urgency, back pain, frequency, and dysuria. 11/5 UA: 40,000 - 50,000 enterococcus faecalis, susceptible nitrofurantoin [Macrobid]. Review of R46's EMR and hard chart did not reveal any documentation that the physician was notified that the infection did not meet criteria for antibiotic use. There was no documented rationale for the continuation of the antibiotic without meeting criteria for a UTI. During an interview on 11/21/25 at 1:29 PM, the IP/WCN stated that if a resident's symptoms and lab values did not meet the criteria of a true infection, she would speak to the physician and try to get the antibiotic discontinued, as it was not necessary. The IP/WCN was unable to provide evidence that the physician was contacted to discuss the findings and the appropriate course of treatment. During an interview on 11/20/25 at 6:31 PM, the Medical Director stated his expectation was to determine whether symptoms and lab values met the criteria of an actual infection prior to treatment with antibiotics or for the discontinuation of an antibiotic if already started when the lab results were received, and the facility determined the criteria were not met. The Medical Director stated there should be a discussion with the physician to determine the proper course of treatment. 5. Review of R50's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE]. Review of R50's Order Note, dated 10/13/25 and located under the Progress Notes tab of the EMR, revealed, Macrobid Oral Capsule, Give 100 mg by mouth two times a day for dysuria [pain on urination] for 10 days. Review of R50's EMR did not reveal any documentation prior to the above Order Note regarding dysuria or any other symptoms. Review of R50's 10/14/25 Infection Note, dated 10/14/25 and located under the Progress Notes tab of (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the EMR, revealed, Resident remains on abt [antibiotic] Macrobid. Resident remains afebrile. Review of R50's EMR and hard chart revealed no order for a UA/CS or lab results related to administration of Macrobid. Review of R50's Infection Report Form, provided on paper by the IP/WCN, revealed that none of the criteria listed to determine if a UTI was present were checked. The form instructed that acute dysuria must be accompanied by at least 1,000,000 cfu/mL of microorganisms detected. The form documenting R50's symptoms did not meet the criteria of a UTI. The form also documented that Macrobid was prescribed. Review of R50's EMR and hard chart did not reveal any documentation that the physician was notified that there was no criteria documented for antibiotic use. There was no documented rationale for the continuation of the antibiotic without meeting criteria for a UTI. During an interview on 11/20/25 at 6:19 PM, the IP/WCN stated that to determine whether a UTI met criteria for treatment, there must be a UA/CS performed. She stated R50 did not have a UA/CS ordered or performed because she was on hospice, and the hospice physician initiated the Macrobid order as a prophylactic. The IP/WCN stated, Hospice does that a lot. The IP/WCN was unsure if she provided any education to the hospice physician regarding antibiotic stewardship and the criteria to meet before initiation of antibiotic treatment. The IP/WCN stated the Medical Director was aware of this issue, but the Hospice had its own Medical Director who took care of all the residents in hospice. She stated she did not know if the facility's Medical Director provided any education to the hospice staff. During an interview on 11/20/25 at 6:31 PM, the Medical Director stated the hospice physician managed care for residents on hospice. He stated the hospice takes the patients as their own, they do what they want to do. The Medical Director stated the hospice did not allow a facility physician to oversee medical care for the residents on hospice. The Medical Director stated his expectation was to typically perform a UA/CS, even for his patients on hospice, prior to treatment with antibiotics. He stated there could be instances where it was impossible to get a urine sample, and treatment would be initiated without a UA/CS; however, this was rare. The Medical Director stated the hospice physician typically treated residents on hospice with antibiotics without first ordering a UA/CS. The Medical Director stated this was the way the hospice physician practiced, but he did not practice that way, and it was not the way it should be done.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, policy review, and the review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer or provide documentation of consent or refusal for pneumonia vaccines for two of five residents (Residents (R)25 and R63) and/or their resident representatives (RR) out of 27 sampled residents. This failure had the potential to put these residents at increased risk of developing pneumonia.Findings include: Review of the CDC website page titled Pneumococcal Vaccine Timing for Adults, dated March 2025 and located at https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf, revealed the CDC recommended pneumococcal vaccination for all adults [AGE] years of age or older. A PCV20 or PCV21 (types of pneumonia vaccines) should be administered greater to or equal to one year after PPSV23 given at any age. 1. Review of R25's Face Sheet, located under the Profile tab in the electronic medical record (EMR) indicated R25 was admitted to the facility on [DATE] with the diagnosis of diabetes mellitus and was [AGE] years old upon admission. Review of R25's Immunizations, located under the Immunization tab in the EMR, indicated R25 received Pneumovax 23 on 05/21/22. There was no documentation of R25 receiving or refusing any pneumococcal vaccinations that were recommended a year after the initial Pneumovax vaccine was given to R25. 2. Review of R63's Face Sheet, located under the Profile tab in the EMR, indicated R63 was originally admitted to the facility on [DATE] and was currently [AGE] years old. Review of R63's Immunizations, located under the Immunization tab in the EMR, indicated no documentation to reflect that R63 was offered or refused the Pneumovax vaccination. During an interview on 11/21/25 at 2:15 PM, the IP/WCN stated she did not keep up with vaccinations and that they were being completed by Licensed Practical Nurse (LPN4). During an interview on 11/21/25 at 4:15 PM, LPN4 was notified of the missing documentation for R25 regarding being offered or refusing the Pneumovax vaccination. R63 had missing documentation to reflect being offered or refusing the Pneumovax vaccinations. LPN4 stated she would gather this information and bring it to the surveyor. During an interview on 11/21/25 at 4:45 PM, the Director of Nursing (DON) stated, Upon admission, we review with the resident their immunizations. Our expectation is to check and see if the resident is in the GRITS system [Georgia Registry of Immunization Transactions Services]. We started consents for flu vaccines in September, and we also revisited the residents' Pneumovax vaccines. No further information was provided to the survey team prior to the exit conference.