STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115115	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tower Road Post Acute, LLC	26 Tower Rd Marietta, GA 30060

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility policies titled, Abuse, Neglect and Misappropriations, the facility failed to protect residents by not reporting verbal abuse to the State Agency (SA) for one of 38 sampled residents (R) (R11). The deficient practice had the potential for other residents to experience verbal abuse.Findings include:Review of the facility policy titled Abuse, Neglect and Misappropriations, revised 1/1/2025, policy statement revealed: It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law. The organization will include screening, training, prevention, identification, investigation, protection, and reporting to provide protection for the health, welfare, and rights of each resident residing in the facility.The organization's policy is that the Facility Administrator, or his or her designee, will conduct a reasonable investigation of each such alleged violation unless he or she has a conflict of interest or is implicated in the alleged violation. The Facility Administrator is responsible for reporting all investigations' results to applicable State agencies as required by Federal and State law. In the case of a suspected crime as defined in the Elder Justice Act, refer to the applicable Elder Justice Act policy and procedure. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Verbal abuse is defined as the use of any oral, written, or gestured language that includes any threat, or any frightening, disparaging or derogatory language, to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability. Immediately is defined as alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than two hours after the allegation is made. If a state reporting requirement establishes a longer reporting time for certain unusual incidents other than abuse or neglect, that reporting time applies only to such incidents. In other words, all allegations and incidents of abuse or neglect, as defined in this policy, will be reported immediately, as defined in this paragraph.Review of the electronic medical record (EMR) revealed R11 was with pertinent diagnoses including but not limited to metabolic encephalopathy, depression, muscle weakness (generalized), and anxiety disorder, unspecified.Review of R11's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates R11 is cognitively intact. Section D, Mood, revealed R11 feeling down, depressed, or hopeless 2-6 days (several days). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section E, Behavior, revealed no behaviors not exhibited during review period. Section GG, Functional Abilities and Goals, revealed R11 has impairment on one side upper extremity. She is dependent for toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, chair/bed-to-chair transfer. Supervision or touching assistance when rolling left and right, and substantial/maximal assistance for sit to lying, lying to sitting on side of bed. Section H, Bowel and Bladder, revealed frequent urinary and bowel incontinence.Review of R11's care plan indicated a problem of resident at risk for falls related to deconditioning. Goals included but not limited to resident will be free from falls through review period. Interventions included but not limited to anticipate and meet resident's needs, be sure call light is in reach and encourage resident to use it when assistance is needed, and resident sent to hospital for evaluation. The care plan also indicated R11 has a behavior problem related to refusing care (showers and peri-care). The goal is that resident will have fewer episodes of behavior by next review date. Interventions include administer medications as ordered and monitor/document side effects and effectiveness, discuss resident behavior and explain/reinforce why behavior is inappropriate, and praise the resident progress/improvement in behavior.Review of the Physician's Orders for R11 included but was not limited to:DuLoxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG (Duloxetine HCl), Give 1 capsule by mouth two times a day for DepressionoxyCODONE-Acetaminophen Oral Tablet 10-325 MG (Oxycodone w/ Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for severe pain 5-10 on scale 0-10Review of a striked out Progress Note dated 12/16/2025 at 10:26 am revealed, During morning medication pass at approximately 0900, resident advised this writer that overnight or early this morning she fell onto the floor. Resident stated that a nurse found her on the floor and instructed her to get up. This writer observed redness to the resident's left eye and asked if she had hit her head. Resident reported that when she fell, she hit her side.table and then fell to the floor. This writer reported observations to management at approximately 0945. Resident will continue to be monitored.Strike Out Reason: Duplicate OrderStrike Out Date: 12/16/2025 18:27 (6:27 pm)[(electronically) e-SIGNED] by Licensed Practical Nurse (LPN) GGReview of a Progress Note dated 12/16/2025 at 11:00 am revealed, Writer and DON (Director of Nursing) spoke with resident and sister about incident; resident gave 3 different stories about what happened then refused all interventions. Resident refused to let nursing evaluate her and get vitals. Resident stated she was fine and it wasn't a big deal. Resident ordered staff out of her room and stated she wanted nothing but to be left alone.[e-SIGNED] by UM (Unit Manager) FFReview of a Progress Note dated 12/16/2025 at 12:03 am revealed, this writer, accompanied by the Unit Manager, visited the resident's room to discuss allegations that the night nurse spoke harshly to her following a fall. The resident reported that she fell, first hitting her overbed table and then the wall, striking her head. She initially stated that the nurse told her to get up off the floor. Upon further discussion, R11 clarified that the nurse actually told her to get up out of bed. After additional conversation, R11 returned to her original statement. R11 expressed dissatisfaction with the staff and stated that she feels she is not being properly cared for. Her sister was present during the entire conversation, and R11 consented to speak with her sister present. R11 is fully functional and capable of transferring into the community independently, home with her sister or to an assisted living setting. Her sister stated she cannot provide care for her. It was explained that R11 does not require continuous care and is able to care for herself as she is functionally able to perform all ADLs independently. Social Services was contacted to provide available resources. Because R11 reported hitting her head during the fall, she was offered transfer to the Emergency Department for evaluation. She declined, stating she had no injuries. Fall protocol was implemented, and the MD was notified.[e-SIGNED] by (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DONObservation and interview on 1/6/2026 at 11:38 am revealed R11 lying on bed watching television. R11 stated that she had been here about 6 months; she came for therapy. R11 stated that first name of staff, the head person, cussed her and her sister out because he wanted me to leave. The resident gave her sister's telephone number as well as consent for the surveyor to contact the sister. Interview on 1/7/2026 at 1:56 pm revealed R11 lying in bed snacking and watching television. R11 stated that the person that cussed her out was a tall, slender black guy and she stated he had a high position at the facility. R11 was able to describe where the staff member's office was located. She confirmed that the alleged perpetrator was the DON.Interview on 1/8/2026 at 9:25 am revealed R11 sitting up in bed watching television. She stated that she was a little irritated yesterday because people kept entering her room and she sort of just wanted it to be over. Interview on 1/8/2026 at 9:44 am with a family member of R11 revealed that R11 told her she had fallen the previous night and that the nurse had cursed at her.An interview on 1/8/2026 at 11:16 pm with Unit Manager (UM) FF revealed that she was notified by LPN GG that R11 reported that she had fallen and had been cursed at by the nurse on night shift. UM FF said that she went and spoke with R11, and R11 said she fell and was told to get up harshly. UM FF then notified the DON. UM FF defined verbal abuse as being spoken to harshly. She also confirmed that she reported any abuse allegations to the DON. UM FF confirmed her knowledge of having two hours to report abuse to the state. UM FF also confirmed she had in-service training on abuse when she started working at the facility.An interview on 1/8/2026 at 4:05 pm with LPN GG revealed that at shift change while making rounds, R11 told her that she had fallen off the bed and hit her head the previous night and that LPN JJ told her to get the ‘curse-word' up. LPN GG stated she then reported the allegation to the UM.An interview on 1/8/2026 at 6:23 pm with DON revealed, If abuse is reported to myself, I should report to the abuse coordinator. I'm here early so a lot of time I will initiate the investigation. I submit and investigate reports of abuse to the state. When asked who was the staff member that cussed at the resident, the DON stated that he did not have a known person of interest. The DON stated that she (R11) initially told him that the staff stated, get the ‘curse word' off the floor, but when the DON told her that he had to report the incident, R11 then said that the staff did not curse her and just told her to get out the bed. The DON confirmed that that the incident was not reported because the resident changed her story.An interview on 1/8/2026 at 6:23 pm with Administrator in Training (AIT)/ Abuse Coordinator revealed that after the DON talked to R11, she changed her story. The AIT stated that it was reported to him that R11 told the DON that the staff did not cuss him. AIT confirmed the allegation was not reported. The AIT also confirmed that verbal abuse was a reportable incident. The AIT confirmed that the administrator was aware of the 12/16/2025 incident on night shift and that although he was the abuse coordinator, the Administrator determined what would be reported to the state.