STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115277	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peachtree Nursing and Rehabilitation LLC	200 Medical Drive Lagrange, GA 30240

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 - Minimal harm or potential for 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 interviews, record review, and policy review, the facility failed to ensure residents were free from abuse and neglect for one of four residents (Resident (R) 49) reviewed for abuse and neglect out of 29 sampled residents. The facility neglected the resident when Certified Nurse Aide (CNA) 1 removed the call light out of the resident's reach. CNA 1 intimidated R49 when she stood over her and told the resident not to use the call light again. These failures had the potential to cause unmet care needs. Findings include:Review of R49's undated admission Record, located in the Electronic Medical Record (EMR) under the Profile tab, revealed she was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, Reiter's disease, and cervicalgia. Review of R49's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/29/25 and located in the EMR under the MDS tab, revealed R49 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R49's Nursing Progress Note, dated 10/30/25 and located in the EMR under the Prog Notes tab, revealed, Spoke with resident's daughter concerning agency staff removing call light out of residents reach. Daughter was notified that agency staff will not be returning to the building. Daughter said thank you and expressed no other concerns.Review of a Facility Incident Report Form, dated 10/30/25 and provided by the facility, revealed at 5:30 AM on 10/30/25, Licensed Practical Nurse (LPN) 3 entered R49's room after hearing R49 yelling for help and saw her call light laying on the back of her bed out of reach. R49 told LPN3 that CNA1 removed the call light and told her not to use it again. LPN3 reported it to Charge Nurse (CN) 2. CN2 went to R49's room and found the call light hanging behind the head of the bed on the floor. R49 reported to CN2 that CNA1 came into the room after she pressed the call light for incontinent care and moved the call light behind her head, stood over her, and told her not to use it again because she continued to call for help. CN2 attached the call light around the bed rail and provided incontinent care to R49. CNA1 admitted to CN2 that she removed the call light from R49 because she kept calling for assistance and told her to stop using it. CN2 also told CNA1 not to go back to R49's room, all call lights must be answered, and to ask for help if she needed help in caring for the residents. The Director of Nursing (DON) reported the incident to the agency and told them not to send CNA1 back to the facility.During an interview on 11/21/25 at 11:27 AM, R49 stated she woke up from sleep and pressed her call light because she was wet and needed to be changed. R49 stated CNA1 came into her room, put the call light behind her head, and stood over her and told her not to use the call light again because she had been calling for assistance all morning. R49 indicated she felt intimidated by CNA1 when she was standing over her. R49 also indicated that when CNA1 left her room, she yelled for help until LPN3 came into her room and she reported the incident to her. R49 confirmed CN2 provided incontinent care and placed her call light on her bed rail within her reach.During an interview on 11/20/25 at 9:56 AM, the Administrator confirmed R49 was neglected and abused on 10/30/25 when CNA1 removed R49's call light from her reach, did not provide incontinent care, and told R49 not to call for assistance anymore. During an interview on 11/20/25 at 1:13 PM, CNA1 confirmed R49 rang for assistance on 10/30/25 around 5:15 AM, she went into her (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 - Minimal harm or potential for actual harm Residents Affected - Few	room, threw her call light out of her reach, and told her to stop pressing the call light. CNA1 also confirmed CN2 told her not to move the resident's call lights and not to return to R49's room. CNA1 stated she was busy with her other assigned residents on the floor, got stressed out, and needed assistance with the residents. CNA1 stated R49 called for assistance many times that shift.During an interview on 11/20/25 at 2:36 PM, CN2 confirmed that LPN3 reported she heard R49 yelling for help, she entered her room, and saw her call light hanging from the wall on the floor out of R49's reach. CN2 confirmed R49 told her CNA1 came into her room after she pressed the call light, moved it where she could not see it, and told her not to press it again. CN2 stated she provided incontinent care to R49 and placed her call light on the bed rail. CN2 stated she removed R49 from CNA1's assignment, reported R49 had been neglected to the DON, and completed a grievance/complaint form regarding the incident. During an interview on 11/20/25 at 11:50 AM, LPN3 stated she heard R49 yelling for help from her room. When she entered the room, the call light was behind R49's head on the back of the bed. LPN3 stated R49 was upset due to CNA1 removing the call light and telling her not to use it again after R49 pressed the call light when she needed incontinent care. LPN3 indicated she reported the neglect to CN2. CN2 went to R49's room, attached her call light to the bed rail, and provided incontinent care to R49.During an interview on 11/21/25 at 9:26 AM, the DON confirmed CNA1 neglected and abused R49 when she placed her call light out of her reach, did not provide incontinent care for her as requested, and stood over R49 and told her not to use the call light again.Review of the facility's policy titled, Prohibition of Resident Abuse & Neglect, revised 01/20/25, revealed, It is the policy of [the nursing home] that each resident will be free from abuse, neglect, corporal punishment, misappropriation of resident property, and exploitation. Our facility practices ZERO tolerance of resident abuse, neglect, mistreatment, exploitation, or misappropriation of property by anyone including staff members, other residents .

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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. Based on interviews, record review, and policy review, the facility failed to ensure abuse and neglect by staff was reported timely to the Director of Nursing (DON) and to the State Survey Agency (SSA) when a resident's call light was placed out of reach, and told not to use the call light anymore by Certified Nursing Assistant (CNA)1 for one of four residents (Resident (R) 49) reviewed for neglect out of 29 sampled residents. Findings include:Review of R49's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/29/25, located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.Review of R49's Nursing Progress Note, dated 10/30/25, located in the EMR under the Prog Notes tab, revealed Spoke with resident's daughter concerning agency staff removing call light out of residents reach. Daughter was notified that agency staff will not be returning to building. Daughter said thank you and expressed no other concerns.Review of a Facility Incident Report Form, dated 10/30/25 and provided by the facility, revealed the facility performed an investigation and confirmed neglect and abuse occurred on 10/30/25 at 5:30 AM. It was reported to the State Survey agency on 10/30/25 at 10:30 AM. The investigation revealed Licensed Practical Nurse (LPN) 3 entered R49's room after hearing R49 yelling for help and saw her call light laying on the back of her bed out of reach. R49 told LPN3 that CNA1 removed the call and told her to not to use it again. LPN3 reported it to Charge Nurse (CN) 2. CN2 went to R49's room and found the call light hanging behind the head of the bed on the floor. R49 told CN2 that CNA1 came into the room after she pressed the call light for incontinent care and moved the call light behind her head, stood over her, and told her not to use it again because she continued to call for help. CN2 attached the call light around the bed rail and provided incontinent care to R49. CNA1 admitted to CN2 that she removed the call light from R49 because she kept calling for assistance and told her to stop using it during an interview. CN2 reported the allegation of neglect to Unit Manager (UM) 1 at the end of her shift and then UM1 reported it to the Director of Nursing (DON) around 8:00 AM. The DON reported the allegation of abuse and neglect to the Administrator at 8:30 AM.During an interview on 11/20/25 at 9:56 AM, the Administrator confirmed she was not notified of the allegation of mental abuse and neglect of R49 when LPN3 and CN2 observed the call light was not in reach, the resident stated she was told not to use it again, and incontinent care was not provided by the CNA on 10/30/25 at 5:30 AM. The Administrator stated she was notified by the DON after she arrived at work around 8:30 AM on 10/30/25. The Administrator stated allegations of abuse should be reported within two hours to the SSA, so she did not meet the required timeframes.During an interview on 11/20/25 at 2:36 PM, CN2 confirmed LPN3 reported she heard R49 yelling for help, she entered her room, saw her call light hanging from the wall on the floor , and R49 told her CNA1 came into her room after she pressed the call light, moved it where she couldn't see it, and told her not to press it again. CN2 stated she completed a grievance/complaint form and gave it to UM1 to give to the DON but did not report it to the DON. CN2 stated abuse should be reported within two hours, but she was not sure if it was abuse or neglect, so she did not report it timely.During an interview on 11/20/25 at 11:50 AM, LPN3 stated she heard R49 yelling for help from her room. When she entered the room the call light was behind her head on the back of the bed. LPN3 also stated R49 was upset due to CNA1 removing the call light and telling her not to use it again after R49 had pressed the call light when she needed incontinent care. LPN3 indicated she reported neglect to CN2 immediately on 10/30/25 around 5:30 AM. CN2 went to R49's room, attached her call light to the bed rail, and provided incontinent care to R49.During an interview on 11/21/25 at 9:26 AM, the DON confirmed UM1 reported the allegation of abuse and neglect to her at 8:00 AM and she reported it to the Administrator at 8:30 AM on 10/30/25.Review of the facility's policy titled Prohibition of Resident Abuse & Neglect, revised 01/20/25, provided by the facility, revealed . Reporting 1. Any witnessed, alleged, or suspected violations involving mistreatment, neglect, or abuse, . MUST BE (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REPORTED IMMEDIATELY TO THE EMPLOYEE'S SUPERVISOR. 2. The supervisor must immediately notify the Administrator and/or the Director of Nursing. 3. Abuse allegations (abuse, neglect, exploitation or mistreatment, . will be REPORTED IMMEDIATELY to the appropriate authorities by the Administrator and/or Director of Nursing including but not limited to, local law enforcement agencies, NJDOH [New Jersey Department of Health], and Ombudsman in compliance with regulatory requirements .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to ensure another method to call for assistance was provided when a resident's call light malfunctioned and was removed from the resident's wall for one of four residents (Resident (R) 157) reviewed for call lights out of 29 sampled residents. This failure had the potential to result in residents' care needs not being met by nursing staff. Findings include:Review of R157's undated admission Record, located in the electronic medical record (EMR) under the Profile tab revealed she was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia following CVA, and mild protein calorie malnutrition. R157 expired in the facility on [DATE]. Review of R157's change in condition Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident was cognitively intact.Review of a Facility Incident Report Form, dated [DATE] and provided by the facility, revealed at 8:59 AM on [DATE], Family Member (FM) 157 notified the Administrator R157's daytime caregiver found the call light cord rolled up on the bedside table, and it was not in the wall while there the last two mornings. The investigation revealed that Certified Nursing Assistant (CNA) 2 removed the call light cord from the wall due to it malfunctioning as it was turning on without anyone pressing it every 15 to 20 minutes. The call light malfunction was recorded in the maintenance workbook on [DATE] by CNA2. The call light cord was found to be in working order on [DATE] by the Maintenance Technician. The Director of Nursing (DON) verified the call light was in place and properly functioning on [DATE]. The Maintenance Technician T verified the call light was properly functioning and in place again on [DATE]. CNA2's undated written statement revealed R157 pulled the call light out of the wall because she was aggravated that it kept turning on without pressing it on [DATE]. The call light was not placed back in the wall, and another means to communicate with nursing staff was provided to the resident. CNA2 informed the agency CNA assigned to R157 on the evening shift on [DATE] of the malfunctioning call light and told her to round on the resident every one to two hours. An interview conducted by the Administrator on [DATE] with R157 revealed someone removed the call light out of the wall on [DATE], she was not provided with another means to communicate with staff, but care was provided for her. CNA2 was suspended during the investigation and terminated on [DATE]. An interview was attempted with FM157 on [DATE] at 7:00 PM, 7:05 PM, and 7:15 PM, but the phone call was not returned. An interview was attempted with CNA2 on [DATE] at 4:10 PM, 5:15 PM, and 5:20 PM, but the phone call was not returned. During an interview on [DATE] at 4:14 PM, Licensed Practical Nurse (LPN) 6 confirmed that CNA2 and her observed the call light turning off and on without R157 pressing the call light and she saw the call light laying across her abdomen during medication administration on [DATE]. LPN6 stated CNA2 did not inform her that she removed R157's call light from the wall and she did not see CNA2 remove it from the wall. During an interview on [DATE] at 8:27 AM, the Administrator stated her investigation revealed the call light was not accessible to R157 when CNA2 removed the call light and did not provide her with another means to communicate with nursing staff on [DATE] and there was no evidence of neglect or abuse. The Administrator stated during an interview with R157, she said someone removed the call light from the wall, but she did not know who did it a few days ago and all her care needs were met. Review of the facility's policy titled Call Lights: Accessibility and Timely Response, dated [DATE], provided by the facility, revealed Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines: . 5. Staff will ensure the call light is within reach of resident and secured, as needed . 8. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediate or alternative solutions until the problem can be remedied. (Examples include: replace call light, provide a bell or whistle, increase frequency of rounding, etc.) .