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 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. Based on observations, record reviews, and interviews, the facility failed to keep track of when to discard refrigerated food items through labeling and dating the items. This failure had the potential to negatively impact (through foodborne illness) 139 residents residing at the facility by exposing them to food items that may have spoiled.Findings include:An observation on 11/18/25 at 8:50 AM, during the Flash Tour. completed with the Director of Food and Nutrition Service (DFNS), of the kitchen revealed numerous food items located in the reach in refrigerators were not labeled or dated. The food items were as followed: cooked chicken breasts in a steam table pan, sliced ham covered by plastic wrap, opened packets of hot dogs, roast beef, fresh and cooked yellow squash located in a partially filled steam table pan, fresh broccoli, sliced cheese wrapped in plastic wrap, pork chops located in a partially filled steam table pan, raw fish located in a steam table pan, raw chicken breast located in a steam table pan, raw hamburger wrapped in plastic wrap, a container of ranch dressing, a container of coleslaw, and a bowl of marinara sauce. During an interview on 11/18/25 at 9:10 AM, the DFNS confirmed that all the food items listed above were in the reach in refrigerators and they were not labeled or dated. The DFNS stated this practice was unacceptable and all the items should have been labeled and dated. The DFNS said it was the responsibility of the cooks to maintain the reach in refrigerators and ensure items were labeled and dated. DFNS said all staff had received training regarding the labeling and dating of refrigerated food items. The DFNS stated the kitchen was short staffed yesterday. The DFNS instructed her staff to remove the undated items from the refrigerator.During an interview on 11/20/25 at 11:05 AM, the DFNS explained the kitchen staff had daily huddles and provided documentation that labeling and dating of refrigerated items was reviewed during February, April, May, June and July of 2025.Huddles completed closer to the survey date did not address labeling and dating items placed in the refrigerator. During an interview on 11/20/25 at 11:25 AM, Cook2 stated she did not know what happened on 11/18/25, or why she did not check the reach in refrigerator at the beginning of her 5:00 AM morning shift. Cook2 stated it was a rare occurrence that unlabeled and undated food items were in the reach in refrigerator. Cook2 confirmed she was aware all items needed to be dated and labeled once placed in the refrigerator.During an interview on 11/20/25 at 11:35 AM, Cook1confirmed it was the cook's responsibility to ensure items were labeled and dated in the reach in refrigerator. Cook1 explained that upon arriving for a shift she checked the reach in refrigerator for properly labeled and dated items. Cook1 confirmed she was aware all items needed to be dated and labeled once placed in the refrigerator. Review of the facility's undated policy titled, Food Service Requirements indicated, Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored.in accordance with professional standards for food service safety. Definitions.Food service safety refers to handling, preparing, and storing food in ways that prevent foodborne illness. Foodborne illness refers to an illness caused by the ingestion of contaminated food or beverages. Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handling process.3. Facility staff shall inspect all food, food products.for safe transport and quality upon delivery/receipt and ensure timely and proper (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	storage.c. Refrigerated storage.Practices to maintain safe refrigerated storage include.iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen/discarded.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to ensure physician orders for code status matched the residents' Physician Orders for Life Sustaining Treatment (POLST) and wishes for two of four residents (Resident (R) 57 and R49) reviewed for advance directives out of 29 sampled residents. This failure increased the likelihood of causing severe harm or death if CPR (Cardiopulmonary Resuscitation) was performed or withheld against a resident's wishes.Findings include:1. Review of the admission Record, located in the electronic medical record (EMR) under the Profile tab revealed R57 was admitted to the facility on [DATE] and returned from a hospital stay on [DATE]. R57 had diagnoses which included cerebral infarction (stroke) and sepsis (a life-threatening condition where the body's response to an infection damages its own tissues and organs).Review of the Care Plan, tab of the EMR revealed an intervention, revised on [DATE], under the focus area cognitive loss/decision making poor which instructed, Talk with resident and family [regarding] health care decisions: Code status, medications, treatments if needed, notify [provider] and document.Review of a POLST, form, dated [DATE], and located in the EMR under the Documents tab revealed that R57 checked the box Allow natural death [and] - do not attempt resuscitation [DNR] and signed the form.Review of a hospital Post Acute Transfer Summary, dated [DATE] and located in the EMR under the Documents tab revealed discharge orders for full code status (perform CPR) upon R57's discharge from the hospital.Review of R57's Order Summary Report, located in the EMR under the Orders tab revealed an order for full code dated [DATE].Review of the EMR revealed no documentation of a discussion with R57 regarding code status upon his return from the hospital. A new POLST was not completed.Review of R57's significant change Minimum Data Set (MDS) with an assessment reference date (ARD) of [DATE] and located under the MDS tab of the EMR revealed he scored 12 out of 15 on his Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment. Review of a Care Plan Conference Summary, dated [DATE] and located in the EMR under the Documents tab of the EMR revealed, Neither resident nor family participated in the care plan meeting. [R57] remains a full code. The document was signed by the former Social Services Director (SSD).During an interview on [DATE] at 12:42 PM, R57 responded that if his heart stopped beating and he stopped breathing, he did not want CPR done. I feel if my heart stops, it's my time to go. They [facility staff] asked me about that a long time ago, and I signed a paper.During an interview on [DATE] at 3:29 PM, Licensed Practical Nurse (LPN) 1 stated she looked at the Profile tab of the EMR to identify code status. In addition, POLST forms were located under the Documents tab. LPN1 verified that R57's code status order was for full code while his POLST reflected DNR and stated she was unsure what to do if they did not match.During an interview on [DATE] at 3:35 PM, Unit Manager (UM) 1 stated that she looked at the Profile tab of the EMR to verify what the residents' orders were for code status. Nurses entered orders into the EMR based on the Post Acute Transfer Summary orders from the hospital. If there were no orders, the nurses called the hospital to obtain orders. Nurses did not talk to the residents about their wishes regarding code status; social services had that discussion.During an interview on [DATE] at 3:51 PM, Registered Nurse (RN) 1 stated she located a resident's code status orders by looking at the Profile tab of the EMR. Nurses entered code status orders based on the hospital's discharge orders. If there were no written orders from the hospital, nurses called the hospital for clarification.During an interview on [DATE] at 4:12 PM, the former SSD stated if she noticed that a code status order changed during a resident's hospitalization, social services or the nurse practitioner followed up with the resident regarding their wishes. The former SSD reviewed code status orders, but not POLSTs, at residents' quarterly care plan meetings. If a resident was not present at the meeting, the former SSD did not follow up with them about their code status wishes. The former SSD verified there was no documentation in the EMR that anyone (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed up with R57 or R49 on their wishes regarding code status. The SSD stated they could run a report on code status orders. During an interview on [DATE] at 4:45 PM, the Director of Nursing (DON) stated that nurses looked at the residents' orders for code status which were reflected on the home page, or profile, of the EMR to determine whether to perform CPR. The DON expected someone, likely social services, or the physician, to reach out to the resident or family if they noticed a discrepancy with code status orders and POLSTs upon a resident's return from the hospital.During an interview on [DATE] at 7:36 PM, the Administrator stated she expected a POLST to be updated, given to the nurse practitioner to sign, and new orders entered into the EMR when a resident returned from the hospital.2. Review of R49's undated admission Record, located in the 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 Physician's Orders, dated [DATE], located in the EMR under the Orders tab, revealed an order for full code. Review of R49's POLST, dated [DATE] and located in the electronic medical record (EMR) under the Documents tab, revealed to attempt CPR. No other POLST was found in the medical record.Review of R49's Physician's Orders, dated [DATE], located in the EMR under the Orders tab, revealed an order for full code. Review of R49's Psychosocial Note, dated [DATE], located in the EMR under the Prog Notes tab revealed CODE STATUS: Care plan meeting held this morning. Neither resident nor family participated. Resident remains a FULL CODE per current MD [physician] order.Review of R49's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], 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 Hospital Discharge Orders, dated [DATE], located in the EMR under the Documents tab, revealed orders for DNR/DNI. There was no documented evidence of why R49's code status was changed to DNR/DNI. There was no documented evidence that R49 had been involved in changing the code status. Review of R49's Hospital Discharge Orders, dated [DATE], located in the EMR under Documents tab, revealed orders for DNR/DNI. There was no documented evidence of why R49's code status was changed to DNR/DNI. There was no documented evidence that R49 had been involved in changing the code status. Review of R49's comprehensive Care Plan, dated [DATE], located in the EMR under the Care Plan tab revealed a DNR/DNI code status. Review of R49's Psychosocial Note, dated [DATE], located in the EMR under the Prog Notes tab revealed CODE STATUS: Care plan meeting held [DATE]. Neither resident nor family participated. Resident remains a DNR/DNI per current MD order.Review of R49's Physician's Orders, dated [DATE], located in the EMR under the Orders tab, revealed an order for DNR/DNI. During an interview on [DATE] at 12:34 PM, R49 stated she wanted CPR and had completed a form in the past.During an interview on [DATE] at 3:36 PM, Unit Manager (UM) 2 confirmed she deleted R49's old orders and entered the new orders from hospital discharge orders dated [DATE] which included an order for DNR/DNI. UM2 stated she did not know who was responsible for completing the POLST to reflect the change in the resident's code status.During an interview on [DATE] at 4:13 PM, the Admissions Director, former SSD, stated the POLST was reviewed in the quarterly care plan meetings, and R49 did not attend the last care plan meeting held on [DATE] so her code status remained a DNR/DNI per the physician order. The former SSD verified there was no documentation in the EMR that anyone followed up with R49 after she returned from the hospital and there was not a process in place to identify these issues. Review of the facility's Advanced [sic] Directives policy, dated [DATE], revealed: Upon admission/readmission, the facility Social Services Director will inform and educate the resident, or POA [power of attorney] in writing about the right to refuse medical and surgical treatment and their right to an advance directive. The Social Services Director will assist the resident/POA in updating preferences for care and treatment at all quarterly care plan meetings, and anytime there is a re-admission to the facility. The social worker will maintain the Advance Directive DNRO [do not resuscitate order] log on a weekly basis and will update at each care plan review or with each new admission/readmission. A POLST is a form developed as a more (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	specific and detailed DNR [Do Not Resuscitate]. Like a DNR, the form is completed with the resident's doctor and based on end-of-life decisions. Once signed, doctors and other medical professionals must honor the instructions on the POLST.

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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 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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 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.) .