STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115322	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Health Center by Harborview	3888 Lavista Road Tucker, GA 30084

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and review of the facility policy titled, Resident Rights, the facility failed to ensure that resident's verbal concerns were communicated in a grievance form for two of 11 sampled residents (R) (R4 and R5). The deficient practice had the potential for resident's concerns not to be addressed.Findings Include:A review of the policy titled Resident Rights with a revision date of February 2021 revealed under Resident Rights: .9. Grievances The resident has the right to: a. Voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished; and the behavior of staff fand of other residents; and other concerns regarding their Long-Term Care (LTC) facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have.1. Review of the admission record for R4 showed that resident was admitted to the facility with diagnoses of but not limited to myopathy, hyperlipidemia, post laminectomy syndrome, essential (primary) hypertension, secondary malignant neoplasm of bone, malignant neoplasm of prostate, wedge compression fracture of third thoracic vertebra, subsequent encounter for fracture with routine healing, thrombocytopenia, anemia, hyperglycemia, disorder of bone, unspecified, low back pain, unspecified, chest pain, spondylosis with myelopathy, thoracic region, acute embolism and thrombosis of right femoral vein, non-pressure chronic ulcer of back with unspecified severity, paraplegia, incomplete, weakness, fusion of spine, thoracic region.A review of the care plan for R4 showed resident had been care planned for needing assistance with grooming, bathing, and personal hygiene related to hospitalization, surgery, and self-care impairment.A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for R4 showed a Brief Interview for Menal Status (BIMS) score of 13, indicating little or no cognitive impairment.During an interview on 9/22/2025 at 11:19 am with R4 revealed that he did recall Certified Nursing Assistant (CNA) AA and stated that he had pushed his call button to be changed. R4 stated that he had filled his urinal and had begun using his brief. Resident stated that when CNA AA changed him, she spilled part of the urine on him. He stated that CNA AA removed his gown, wiped up the urine, and placed the same brief back on him, and she never returned to this room. R5 stated that he never saw the CNA again. Resident stated that he shared his concerns with Registered Nurse (RN) BB and the incident occurred around 7/28/2025.During an interview on 9/22/2025 at 4:00 pm, RN BB stated that she was told by R4 about the incident that occurred between CNA AA, but she did not complete a grievance form, and a grievance form should have been completed.A review of the Grievance Log from January 2025 to September 2025 showed no grievances listed for R4.2. A review of the admission record for R5 showed that resident was admitted to the facility with diagnoses of but not limited to essential hypertension, type 2 diabetes mellitus without complications, sprain of ligaments of cervical spine, initial encounter, sleep apnea, gastro-esophageal reflux disease without esophagitis, disease of gallbladder, spondylolisthesis, cervical region, depression, unspecified, benign prostatic hyperplasia without lower urinary tract symptoms, nicotine dependence, other tobacco product, uncomplicated, trigeminal neuralgia, encounter for surgical aftercare following surgery on the nervous system, muscle weakness, dysphagia, oral phase, difficulty in walking, not elsewhere classified, weakness, other retention of urine, acute kidney failure, unspecified, unspecified open wound, left ankle, initial encounter, urinary tract infection, obstructive and reflux uropathy.A review of the quarterly MDS assessment dated [DATE] showed a BIMS score of 15, indicating no cognitive impairment.A review of the care plan for R5 showed that resident is care planned for use of an indwelling catheter due to a diagnosis of obstructive neuropathy.During an interview on 9/22/2025 at 4:15 pm, R5 stated that he received care from CNA AA and described her care as more than gruff. Resident stated that he asked that CNA AA not provide care for him anymore. R5 stated that other residents did not want CNA AA to care for them as well. R5 stated that he believed that CNA AA had an issue with cleaning males' private parts. He stated that he believed that because of that, CNA AA would not clean him and would leave feces on him. R5 stated that it wasn't so much how CNA AA made him feel, but he didn't want her to provide care for him. R5 stated that he informed Licensed Practical Nurse (LPN) CC about the incident.A review of the Grievance Log from January 2025 to September 2025 showed no grievances listed for R5.An interview on 9/22/2025 at 4:28 pm with the Administrator revealed if a resident made verbal concerns about care and services, that information should be placed on a grievance form and it should be followed up with by the Grievance Officer.