STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115358	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treutlen County Health and Rehabilitation	2249 College Street, North Soperton, GA 30457

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and a review of the facility's policy titled Abuse Prohibition, the facility failed to protect the resident's right to be free from physical abuse by facility staff for one of three residents (R) (R1) reviewed for abuse. The abuse had the potential to affect all residents residing in the facility at that time. Findings included:Review of the facility's policy titled, Abuse Prohibition with review date 4/7/2025 revealed, It is the intent of this center to actively preserve each patient's right to be free from mistreatment, neglect, abuse or misappropriation of patient property. We believe that each patient has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. The purpose of these identified procedures is to assure that we are doing all that is within our control to create a standard of intolerance and to prevent any occurrences of any form of mistreatment, neglect, abuse or misappropriation of any patient and/or their property. The procedures herein establish standards of practice for protection of patients and for identification and prevention of abuse. This policy applies to anyone subjecting a patient to abuse including, but not limited to, center staff, other patients, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals.A record review revealed R1 had a primary diagnosis of Alzheimer's disease with early onset. Other diagnoses included, but not limited to, dementia in other diseases classified, pain, and generalized anxiety disorder. R1 resided on the C Hall.Review of the facility-reported incident revealed a Facility Incident #202505379, dated 5/25/2025, that documented an allegation of staff-to-resident abuse. The form included that the allegation involved R1 and a Certified Nursing Assistant (CNA CC). Further review of the form revealed that the police were called, interviewed CNA CC, and escorted CNA CC to her car. The facility suspended CNA CC's CC upon her exit, pending an investigation, until further notice. CNA CC had no further contact with residents following the incident. Interview with two witnessing CNAs reported that R1 became combative during care and struck out at staff. CNA CC responded to the aggression by hitting R1 in the face. The charge nurse performed a head-to-toe assessment and reported redness to the left side of R1's face. The physician and responsible party were notified of the incident and redness to R1's face. The physician ordered an X-ray, which showed no adverse findings. A pain and behavior assessment was also performed, with no pain noted and no psychosocial trauma. Review of the (named law enforcement) assault report dated 5/30/2025 revealed the Offenses was Statute 16-5-100-Curelty to a person [AGE] years of age or older. A review of the accompanying investigation included a 5-day follow up report to the State Agency, Police assault report, incident report, resident interview and skin assessments, staff education, letter to families, termination of CNA CC, audit clinical assessments, weekly audits, witness statements, staffing for the time of the incident, and QAPI Ad Hoc notes. The conclusion summary of the investigation revealed that, based on witness statements and physical symptoms noted during assessment, there was enough evidence, and the facility substantiated that CNA CC physically abused R1.Review of the 5-day follow-up report dated 5/27/2025 revealed CNA CC had been terminated. CNA CC had also been arrested and charged with Elder Abuse. Follow-up Social Service note dated 6/25/2025 documented R1 was wandering throughout the facility as desired. R1 reported she felt safe in the environment, appetite was good, sleeping well, no delusions, no anxiety, no change in sleep patterns or physical aggression was noted.Review of the Quarterly Minimum Date Set (MDS) assessment dated [DATE] revealed Section C-Cognitive Patterns, there was no BIMS (Brief Interview for Mental Status) score reported because R1 was rarely/never understood, had short and long-term memory problem, and severely impaired cognitive skills for daily decision-making, indicating R1 never/rarely made decisions. Section D -Mood was not completed, R1 declined to respond to questions. Section G Functional Status revealed R1 was independent to limited assist. R1 did not have any impairment to her upper extremities or her lower extremities on either side. Review of the care plan, revised date 5/27/2025 revealed that R1 had potential for trauma due to (d/t) experience with healthcare worker dated 5/27/2025 related to history of trauma experience by healthcare worker, history of abuse/neglect. An observation and interview were attempted on 12/22/2025 at 8:39 am with R1, who was very confused and did not respond appropriately, if at all, to questions. Additional observations during the survey revealed R1 ambulating aimlessly throughout the facility. R1 never spoke or answered any simple, short questions.An interview on 12/22/2025 at 8:10 am during a brief entrance conference with the Assistant Director of Nursing (ADON) confirmed that the allegation that R1 was struck was substantiated. The ADON stated the facility