STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115363	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Rome	1345 Redmond Circle Rome, GA 30165

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 - 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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility policy titled, Abuse, Neglect and Exploitation, the facility failed to protect one of 11 Residents (R) (R1) right to be free from physical abuse perpetrated by Certified Nursing Assistant (CNA)1). Specifically, CNA1 held R1 down with her knee on his chest and flicked R1 on the face. This failure caused R1 to experience psychosocial harm and created the potential for this and other residents to experience further abuse. Findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation dated 3/1/2023 indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of property.Protection of the Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the (abuse) investigation.E. Protection from retaliation; F. Providing emotional support and counseling to the resident during and after the investigation, as needed. Review of R1's admission Record in the Electronic Medical Record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. The residents' diagnoses included dementia and heart disease. Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/2025 in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated the resident was moderately cognitively impaired.Review of R1's Progress Note, dated 7/11/2025 at 10:48 am in the EMR under the Notes tab revealed, Approx. [approximately] 7:30 am. Nurse entered room. Resident attempted to get out of bed without assistance. Bed was set in lowest position. Nurse encouraged resident to stay in bed and not to get up without assistance. 7:40 am, nurse was asked by staff to come to room. Resident had placed himself in floor. No injuries noted. Staff then assisted resident back into bed to assist with dressing and resident was then placed into w/c [wheelchair]. Resident became increasingly agitated and combative. Preceded to call staff derogatory names and racial slurs. Resident then yelled I'll get my time with yall. Resident was put in w/c and placed near nursing station. Resident refused morning medications.Review of the facility's Grievance Form dated 7/11/2025 (no time was indicated) revealed a grievance had been filed on that date by the resident's family member (F)1. The document indicated that F1 reported that R1 told her a girl had flicked his nose several times and sat on top of him. The form indicated F1 reported that R1 indicated he wanted out of the facility now due to the incident and reported he was being abused. The report further indicated that upon interview by staff after the report was received from the F1, R1 reported a girl stood over him and flicked his nose several times and had her knees in his chest. The report indicated R1 stated to the staff member conducting the interview he had been abused, and he was very upset and agitated and was saying he wanted out of this place. The report indicated F1 was at his side during the interview, and she was trying to calm/console him.Review of the facility's investigation into the above allegation of abuse revealed a thorough investigation. Staff interviews conducted during the investigation revealed three staff members (Licensed Practical Nurse (LPN1), CNA2 and CNA3 were in R1's room and directly observed the incident during which CNA1 flicked R1 in the face and held R1 down by placing her knee on his chest. The investigation revealed the incident occurred on 7/11/2025 at approximately 7:15 am and that CNA1 remained in the facility and worked providing direct care to residents until the end of her shift on 7/11/2025 at 2:00 pm. The documentation revealed CNA1 was placed on administrative leave on 7/11/2025 after she worked for her remaining shift and left the facility for the day. The Final Investigation Report related to the incident, dated 7/16/2025 revealed the facility substantiated physical abuse by CNA1 toward R1 and indicated CNA1's employment with the facility had been terminated related to the event. The documentation indicated the incident had been reported to the local police department. Documentation in the investigation file revealed a warrant had been placed for the arrest of CNA1 related to the incident on 8/20/2025 and that CNA1 had been arrested related to the incident on that date.R1 was no longer residing in the facility at the time of the survey conducted 8/26/2025 through 8/28/2025 and could not be interviewed.CNA1 could not be reached for interview.During an interview with CNA2 on 8/26/2025 at 10:05 am, she confirmed she was present on 7/11/2025 when the allegation of abuse of R1 by CNA1 occurred and confirmed she witnessed CNA1 flick R1 in the face and hold R1 down on the floor by putting her knee in his chest.During an interview with CNA3 on 8/26/2025 at 5:02 pm, she confirmed she was present on 7/11/2025 when the allegation of abuse of R1 by CNA1 occurred and confirmed she

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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 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. (continued on next page)

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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 0609 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 interviews, record review, and review of the facility's policy titled, Abuse, Neglect and Exploitation, the facility failed to ensure timely reporting of an allegation of physical abuse for one of 11 Residents (R) (R1) reviewed for abuse. This failure caused R1 to experience psychosocial harm and created the potential for this resident and other residents to experience further abuse. Findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation dated 3/1/2023 indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of property; and Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. , law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Review of R1's admission Record in the Electronic Medical Record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The residents' diagnoses included dementia and heart disease. Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/2025 in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated the resident was moderately cognitively impaired.Review of R1's Progress Notes dated 7/11/2025 at 10:48 am in the EMR under the Notes tab, revealed Approx. (approximately) 7:30 am. Nurse entered room. Resident attempted to get out of bed without assistance. Bed was set in lowest position. Nurse encouraged resident to stay in bed and not to get up without assistance. At 7:40 am, nurse was asked by staff to come to room. Resident had placed himself in floor. No injuries noted. Staff then assisted resident back into bed to assist with dressing and resident was then placed into w/c (wheelchair). Resident became increasingly agitated and combative. Preceded to call staff derogatory names and racial slurs. Resident then yelled, I'll get my time with yall. Resident was put in w/c and placed near nursing station. Resident has also refused morning medications.Review of the facility's investigation revealed the alleged allegation of abuse occurred at approximately on 7/11/2025 at 7:30 am and was directly observed by three staff members (Certified Nurse Aide (CNA)2, CNA3 and Licensed Practical Nurse (LPN)1) who were in the R1's room with CNA1. However, the incident was not reported by any of the three staff members who observed the incident to administration. The investigation revealed the Administration became aware of the allegation of abuse of R1 by CNA1 when the incident was reported to management by R1's family member (F)1 via the facility's grievance process on the afternoon of 7/11/2025. The incident was then reported to the Administrator, who was the facility's Abuse Coordinator on 7/11/2025 at approximately 4:30 PM. The incident was reported to the State Agency (SA), the local police department, the resident's physician, and the local Ombudsman. The incident was reported to the SA on 7/11/2025 at 6:50 pm (more than 11 hours after the incident occurred). During an interview on 08/26/25 at 10:05 AM, CNA2 confirmed she was present on 7/11/2025 when the allegation of abuse of R1 by CNA1 occurred and confirmed she did not report the abuse to anyone in facility Administration. CNA2 stated she thought LPN1 would report the incident since she was present when the incident occurred. During an interview on 8/26/2025 at 5:02 pm, CNA3 confirmed she was present on 7/11/2025 when the allegation of abuse of R1 by CNA1 occurred and confirmed she did not report the abuse to anyone in facility Administration. CNA3 stated she got busy with her duties after the incident and did not report the event.During an interview on 8/26/2025 at 1:55 pm, LPN1 confirmed she was summoned to R1's room on 7/11/2025 at 7:30 am by CNA3. When she arrived in the resident's room, she observed CNA1 preparing to flick R1 in the face. LPN1 confirmed she did not report the abuse to facility's Administration and stated she should have reported the abuse immediately to the Administrator or the nurse in charge on the day of the incident.During an interview on 8/26/2025 at 1:30 pm, Registered Nurse (RN1) confirmed she was the charge nurse in the building on the day of the alleged abuse of R1 by CNA1. RN1 confirmed the abuse had not been reported to her until R1's family member reported the incident on the afternoon of 7/11/2025. RN1 confirmed CNA2, CNA3, and LPN1 had not reported the incident of abuse to her after the event occurred and stated the incident should have been reported to her, or someone in Administration, immediately after the event occurred. During an interview on 8/26/2025 at 3:00 pm, the Administrator confirmed the abuse of R1 by CNA1 on 7/11/2025 had not been reported to her timely. She