STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115412	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Tifton	1451 Newton Drive Tifton, GA 31794

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 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 review of the facility's policy titled Abuse, Neglect and Exploitation, the facility failed to obtain a consent to become the representative payee (someone who manages the resident's Social Security benefits to make sure the resident's basic needs were met) for one out of 15 sampled residents (R) (R9).Findings include:Review of the facility's policy titled Abuse, Neglect and Exploitation with a revision date of 7/1/2024 revealed the policy of this facility is 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 resident property. Definitions: Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.Review of medical records revealed R9 was admitted to the facility with the following but not limited to diagnoses of paraplegic, chronic pain syndrome, opioid dependence, osteoarthritis, insomnia, and urine retention.Review of R9's Annual Minimum Data Set (MDS) dated [DATE], Quarterly MDS dated [DATE], and Quarterly MDS dated [DATE], revealed for Section C (Cognitive Patterns) a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.Review of the Medical Source Opinion of Patient's Capability to Manage Benefits form (Form SSA-787 Social Security Administration (SSA)), indicated the facility was applying for representative payee to manage the resident's SSA benefits. The form was completed and signed by a physician on 2/19/2025 who indicated the resident did not have a general understanding of his or her finances, did not have sufficient ability to handle a checking/savings account, and did not have sufficient ability to pay bills in a timely manner. It also indicated the resident could not successfully manage or direct the management of funds to meet basic needs (e.g. food, clothing, shelter). Further documentation on the form noted that the resident was a long-term care resident at [Name of Facility] due to being a paraplegic.During an interview with the Administrator on 7/28/2025 at 2:45 pm, she stated the resident did not pay his bill while he was a resident. The facility set up a payment plan for the resident on 11/1/2024 to make payments each month but he never made a payment. She also stated the facility did not issue a 30-day discharge notice due to nonpayment. She stated she was not the Administrator during that time, but they probably applied to be the Representative payee because the resident was not paying his bill. The Administrator did state the resident was alert and oriented and there was nothing to indicate otherwise.The Administrator provided a copy of a form titled [Name of facility] Payment Agreement Form signed by the resident on 11/1/2024 agreeing to pay an outstanding balance of $5,512.00 in monthly payments of $200.00 per month beginning on 12/3/2024. Review of the Resident Statement Landscape form revealed the facility received the resident's SSA deposit on 6/3/2025. The amount deposited was $718.00. The resident's care cost payment was $648.00 with $70. 00 applied to his account.The resident discharged home on 7/1/2025 and on 7/3/2025, the $718.00 deposit to the facility was rejected. Therefore, the facility only received one payment on 6/3/2025.During an interview with the Business Office Manager (BOM) on 8/4/2025 at 3:10 pm, she stated that she started as the BOM on 3/17/2025 and was not involved in the application for representative payee for this resident. She stated apparently a regional person came in the facility to address the overage of one million dollars owed to the facility from several residents, most of which were Medicaid pending approval. Residents who owed money were placed on a payment plan. The regional person applied for representative payee for two other residents. However, consent was given for those two residents. The BOM did confirm that R9 was alert and oriented.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 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, staff and resident interviews, and review of the facility policy titled, Abuse, Neglect and Exploitation, the facility failed to implement the protection of resident and reporting/response components of their abuse policy when one resident (R) (R1) alleged R2 struck him five times on his left side. The total sample was 15. Findings include:Review of the facility's policy titled Abuse, Neglect and Exploitation, with a revision date of 7/1/2024 revealed component VI. Protection of Resident noted 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 investigation. Examples include but are not limited to : Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. Providing emotional support and counseling to the resident during and after the investigation, as needed. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. Component VII Reporting/Response noted the facility will have written procedures that include: 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. Review of medical records revealed that R1 was admitted to the facility with the following diagnoses but not limited to: morbid obesity, nontraumatic intracerebral hemorrhage, absence of right leg above knee, congestive heart failure and gout.Review of R1's Quarterly Minimum Data Set (MDS) dated [DATE], revealed Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.During an interview with R1 on 7/22/2025 at 11:45 am, he revealed that on 5/5/2025 around 2:00 am, the resident (R2) across the hall came into his room and woke him up by sitting on the foot of his bed. He asked R2 What are you doing? and told him You got to go. He stated R2 got up and punched him in the chest a couple of times. He started hollering for help and five to ten minutes later a Certified Nursing Assistant (CNA) came in and took R2 back to his room. He stated he was emotionally upset, had flashbacks and did not feel safe in the facility. He stated nobody ever came to talk with him afterwards to ask him what happened or how he felt.Review of the nurses note dated 5/2/2025 at 4:20 am revealed, R1 reported being hit five times by an unwelcomed resident on left side while lying in bed. Both nurses reported to resident room and asked what side the incident happened. The resident stated, I was hit five times on left side. Both nurses assessed resident, no injuries, marks, bruises, cuts or scratched were visible at time of assessment.Review of the Nurse Practitioner (NP) Progress Note dated 5/5/2025 revealed the resident (R1) reported to her that another resident came into his room and was hitting him with his fists in the chest. He reported that he was scared to go to sleep last night because he was not sure if the other resident would come back. The NP further noted that she explained to him that what happened to him was not ok and would be handled by Administrator.Review of the NP progress note dated 5/7/2025 revealed that the resident (R1) reported that he does not feel safe here since being assaulted by another resident. It was reported that the resident had scissors under his pillow and would not give them to the staff last night. When NP saw the resident there was nothing on his bed except a sheet. The resident said he would protect himself at all cost.Further review of medical records revealed, although R1 had reported to the NP he did not feel safe in the facility, there was no documentation the NP had reported these findings to the staff or requested for the resident to be evaluated by the Social Worker for a psychological evaluation.During an interview with the Social Worker on 7/22/2025 at 2:57 pm, she stated that they usually discuss any allegations of abuse in the morning meetings and she would usually follow up with the residents after the allegation for several weeks just to observe for any behaviors and refer them to CHE Behavioral Health if needed. She confirmed she did not follow up with R1 after his allegation of abuse on 5/4/2025. She also stated that no one reported to her of the resident having scissors under his pillow because he was scared.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review and review of the facility's policy titled, Abuse, Neglect and Exploitation, the facility failed to ensure that an allegation of abuse was reported to law enforcement for one out of 15 sampled residents (R) (R1).Findings include:Review of the facility's policy titled Abuse, Neglect and Exploitation, with a revision date of 7/1/2024 under Component VII - Reporting/Response revealed, the facility will have written procedures that include: 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. Review of medical records revealed, R1 was admitted to the facility with the following diagnoses that included but not limited to: morbid obesity, nontraumatic intracerebral hemorrhage, absence of right leg above knee, congestive heart failure and gout.Review of R1's Quarterly Minimum Data Set (MDS) dated [DATE], revealed Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.During an interview with R1 on 7/22/2025 at 11:45 am, he revealed that on 5/5/2025 around 2:00 am, the resident (R2) across the hall came into his room and woke him up by sitting on the foot of his bed. He asked R2 What are you doing? and told him You got to go. He stated R2 got up and punched him in the chest a couple of times. He started hollering for help and five to ten minutes later a Certified Nursing Assistant (CNA) came in and took R2 back to his room. He stated he was emotionally upset, had flashbacks and did not feel safe in the facility. He stated nobody ever came to talk with him afterwards to ask him what happened or how he felt.Review of the nurses note dated 5/2/2025 at 4:20 am revealed, R1 reported being hit five times by an unwelcomed resident on left side while lying in bed. Both nurses reported to resident room and asked what side the incident happened. The resident stated, I was hit five times on left side. Both nurses assessed resident, no injuries, marks, bruises, cuts or scratched were visible at time of assessment.Review of the Facility Incident Report Form dated 5/4/2025 revealed the facility reported an allegation of resident-to-resident abuse that had occurred on May 4, 2025, at approximately 2:50 am. The report revealed that R2 was disoriented and wandered into R1's room. R1 stated that R2 struck him on his left side before exiting the room. R2 stated he did not hit or strike R1 and thought he was in his own room. The report indicated that the Administrator and the Responsible Party were notified but it did not indicate that the police was notified.During an interview with the Administrator on 7/23/2025 at 12:40 pm, she stated she was not the Administrator at that time but stated in this case she would have definitely called the Sheriff department.Refer to F607

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to revise the care plan for one out of 15 sampled residents (R) (R1). Specifically, the facility failed to address R1's psychological needs related to an allegation of physical abuse.Findings include:Review of the facility's policy titled Comprehensive Care Plans with a revision date of 3/1/2025 revealed, it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Under the section titled Policy Explanation and Compliance Guidelines noted the comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Review of medical records revealed that R1 was admitted to the facility with the following diagnoses but not limited to: morbid obesity, nontraumatic intracerebral hemorrhage, absence of right leg above knee, congestive heart failure and gout.Review of R1's Quarterly Minimum Data Set (MDS) dated [DATE], revealed Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.During an interview with R1 on 7/22/2025 at 11:45 am, he revealed that on 5/5/2025 around 2:00 am, the resident (R2) across the hall came into his room and woke him up by sitting on the foot of his bed. He asked R2 What are you doing? and told him You got to go. He stated R2 got up and punched him in the chest a couple of times. He started hollering for help and five to ten minutes later a Certified Nursing Assistant (CNA) came in and took R2 back to his room. He stated he was emotionally upset, had flashbacks and did not feel safe in the facility. He stated nobody ever came to talk with him afterwards to ask him what happened or how he felt.Review of the Nurse Practitioner (NP) Progress Note dated 5/5/2025 revealed the resident (R1) reported to her that another resident came into his room and was hitting him with his fists in the chest. He reported that he was scared to go to sleep last night because he was not sure if the other resident would come back. The NP further noted that she explained to him that what happened to him was not ok and would be handled by Administrator.Review of the NP progress note dated 5/7/2025 revealed that the resident (R1) reported that he does not feel safe here since being assaulted by another resident. It was reported that the resident had scissors under his pillow and would not give them to the staff last night. When NP saw the resident there was nothing on his bed except a sheet. The resident said he would protect himself at all cost.Review of R1's care plan revealed a focus area of the resident having a behavior problem by choosing to keep medications at bedside and will refuse his medications at times. Further review of R1's care plan revealed, there was no evidence that the facility had assessed the resident's psychosocial needs after the allegation of physical abuse on 5/4/2025. Therefore, the care plan was not revised to reflect the resident's fear of being in the facility and having flashbacks of the alleged incident.Refer to F607 and F745.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the Social Worker job description, the facility failed to assess the psychosocial status and provide medically related social services to one out of 15 sampled residents (R) (R1) after an allegation of physical abuse.Findings include:Review of the Social Worker job description revealed the Administrative Functions was to ensure that each resident receives necessary behavioral health care and services to obtain and maintain the highest practical physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.Review of medical records revealed that R1 was admitted to the facility with the following diagnoses but not limited to: morbid obesity, nontraumatic intracerebral hemorrhage, absence of right leg above knee, congestive heart failure and gout.Review of R1's Quarterly Minimum Data Set (MDS) dated [DATE], revealed Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.During an interview with R1 on 7/22/2025 at 11:45 am, he revealed that on 5/5/2025 around 2:00 am, the resident (R2) across the hall came into his room and woke him up by sitting on the foot of his bed. He asked R2 What are you doing? and told him You got to go. He stated R2 got up and punched him in the chest a couple of times. He started hollering for help and five to ten minutes later a Certified Nursing Assistant (CNA) came in and took R2 back to his room. He stated he was emotionally upset, had flashbacks and did not feel safe in the facility. He stated nobody ever came to talk with him afterwards to ask him what happened or how he felt.Review of the Nurse Practitioner (NP) Progress Note dated 5/5/2025 revealed the resident (R1) reported to her that another resident came into his room and was hitting him with his fists in the chest. He reported that he was scared to go to sleep last night because he was not sure if the other resident would come back. The NP further noted that she explained to him that what happened to him was not ok and would be handled by Administrator.Review of the NP progress note dated 5/7/2025 revealed that the resident (R1) reported that he does not feel safe here since being assaulted by another resident. It was reported that the resident had scissors under his pillow and would not give them to the staff last night. When NP saw the resident there was nothing on his bed except a sheet. The resident said he would protect himself at all cost.Further review of medical records revealed, although R1 had reported to the NP he did not feel safe in the facility, there was no documentation the NP had reported these findings to the staff or requested for the resident to be evaluated by the Social Worker for a psychological evaluation.During an interview with the Social Worker on 7/22/2025 at 2:57 pm, she stated that they usually discuss any allegations of abuse in the morning meetings and she would usually follow up with the residents after the allegation for several weeks just to observe for any behaviors and refer them to CHE Behavioral Health if needed. She confirmed she did not follow up with R1 after his allegation of abuse on 5/4/2025. She also stated that no one reported to her of the resident having scissors under his pillow because he was scared. During an interview with the Administrator on 7/22/25 at 4:20 pm, she confirmed that the Social Worker should have followed up with the resident after the allegation of abuse. She revealed that she would expect the Social Worker to follow up with residents to monitor for behaviors and to refer them to CHE Behavioral Health if needed.