STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115460	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland Health and Rehabilitation	151 Wisdom Road Peachtree City, GA 30269

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: (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	Based on resident and staff interviews, record review, facility policy review, the facility failed to protect the resident's right to be free from physical abuse and/or sexual abuse/deprivation by staff and /or resident for four of 60 sampled residents (R) (R125, R117, R63, and R25) related to (1) failure to ensure R125 was protected from R117 and as a result, R125 was physically assaulted by R117 and (2) the facility failed to ensure R25 was protected from sexual assault by Housekeeper 1. Harm was identified to have occurred on 1/26/2025, when R125 was assaulted by R117, resulting in R125 receiving multiple skin tears to the left arm, neck, and face. Findings included: A review of a facility policy titled Abuse Prohibition dated 4/7/2025 indicated .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. This policy applies to anyone subjecting a patient to abuse, including, but not limited to, center staff, other patients, consultants, or volunteers. 1. A review of a document provided by the facility for R125 titled Face Sheet indicated the resident was admitted to the facility on [DATE]. A review of R125's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/10/2024, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which revealed the resident was cognitively intact. The assessment indicated that the resident had no behaviors directed towards others. The assessment indicated the resident used a wheelchair for mobility. A review of Nurses Notes dated 1/26/2025, indicated R125 reported to the nurse he was in R63's room when R117 arrived in R63's room and asked R125 to leave. When R125 attempted to leave R117 assaulted him, resulting in the resident being physically assaulted, resulting in R125 receiving multiple skin tears to the left arm, neck, and face. A review of a progress note provided by the facility for R125 titled .Behavioral Health. dated 1/27/2025 indicated the therapist met with R125 due to staff reporting that he was involved in an altercation with another male resident (R117) in which R125 was physically attacked from behind by R117 after words were exchanged. R125 suffered physical bruising and abrasions to his face. A discussion was had regarding boundaries with his encounter with R117, and there were no further recommendations identified. A review of a care plan for R125 titled Care Plan dated 2/10/2025, indicated the resident had a physical altercation with another resident (R117) when he was visiting his female friend (R63).A review of a document provided by the facility for R117 titled Face Sheet indicated the resident was admitted to the facility on [DATE]. A review of R117's quarterly MDS with an ARD of 1/2/2025 indicated the resident had a BIMS score of nine out of 15, which revealed the resident was moderately cognitively impaired. The assessment indicated that the resident had no behaviors directed at others. The assessment indicated the resident used a wheelchair for mobility. A review of a care plan for R117 titled Care Plan dated 1/31/2025 revealed that the resident got into an altercation with his roommate (R125) due to a female resident's friendship (R63). A review of a document provided by the facility for R63 titled Face Sheet indicated the resident was admitted to the facility on [DATE]. A review of the annual MDS with an ARD of 1/17/2025 indicated R63 had a BIMS score of 00 out of 15, which revealed the resident was severely cognitively impaired. A review of a document provided by the facility titled (Police Department), dated 1/26/2025, indicated police arrived at the facility in response to a physical altercation between two residents over their visitation with R63. According to the police report, R117 rolled down the hallway to his female friend's room (R63), in which he observed R125 visiting. Upon R117 entering the room of R63, R117 admitted that he asked R125 to leave, and R125 told R117 no, and then both R117 and R125 began to argue. This was when R117 slapped the face of R125. Both residents were provided with a room change after this incident. A review of an untitled document provided by the facility (referred to as a follow-up to the initial State Survey Agency incident), dated 1/31/2025, indicated that on 1/26/2025, R125 was self-propelling towards the nursing station when Certified Nurse Aide (CNA) 4 observed multiple red linear areas on his face, neck, and hand. CNA4 stopped R125 and immediately called the Assistant Director of Nursing (ADON) 1 over, and the resident was assessed. R125 reported he was in the room of his female friend when R117 entered and told R125 to leave. According to R125, when he turned around, R117 began to scratch his neck and face. R125 reported he had attempted to turn around to R117, when R117 attempted to hit R125, and when R125 blocked the hit, R125 sustained additional skin tears on his left hand from R117. An interview was then completed with R117 by the facility, in which R117 admitted he slapped R125 and did not know how the scratches occurred on R125's hands, neck, and face. R117 stated he did not know since the entire incident happened so quickly. The police were notified and arrived on the scene and did not pursue charges since

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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 clinical record review, facility document review, and staff interviews, the facility failed to ensure one resident (Resident (R) 25) was provided mental health services after sexual abuse which involved Housekeeper 1. This failure had the potential for R25 to suffer potential psychological stress after the event.Findings included: A review of a document provided by the facility titled Job Description, dated 2/3/2024, indicated the Social Worker was responsible for planning, organizing, and directing the overall operation of the Social Services Program to provide for the psychosocial needs of the patients and families served by the center.A review of a document provided by the facility for R25 titled Face Sheet indicated the resident was admitted to the facility on [DATE].A review of the annual Minimum Data Set (MDS) assessment for R25 with an Assessment Reference Date (ARD) of 9/11/2024 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident was moderately cognitively impaired.A review of an untitled document provided by the facility (referred to as a follow-up to the initial State Survey Agency incident), dated 9/20/2024, indicated that on 9/13/2024, R25 was kissed by Housekeeper 1. The police were notified, and Housekeeper 1 admitted that he kissed R25 and touched her hand.A review of a document provided by the facility for R25 titled Care Plan failed to address the sexual assault by Housekeeper 1, and that the resident, at the time of the incident, was unable to consent to the act.A review of R25's electronic medical records (EMR) failed to address psychological services after an incident of being kissed by Housekeeper 1.During an interview on 8/6/2025 at 10:43 AM, the Administrator stated a psychological visit would be made by the Social Worker (SW) if there was an allegation of abuse/neglect. The Administrator stated based on the SW's assessment, the resident would then be seen by psychological services, and then care would be planned after the event. The Administrator stated the care plan would need to be developed so the staff could monitor the resident for any associated behaviors. The Administrator stated this would be completed by the SW.During an interview on 8/6/2025 at 11:49 AM, SW1 stated she was not employed by the facility at the time R25 was kissed by Housekeeper 1. SW1 stated the resident would need to be assessed by the SW and a referral made for mental health evaluation. SW1 stated it was important to then update the resident's care plan so staff could monitor any associated psychological stress related to the incident. (Refer to F600)