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: 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 (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 0600 Level of Harm - Actual harm Residents Affected - Few	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 both men had physical and mental disabilities. There was evidence that the facility reported the initial allegation of physical abuse to the State Survey Agency (SSA) timely along with the five-day follow-up investigation. The facility was able to substantiate the allegation of resident-to-resident physical abuse. During an interview on 8/5/2025 at 8:49 am, R125 stated he remembered the incident with R117 and stated he was attacked by R117 while he was visiting with R63. R125 stated the attack scared him, and he was hurt. R125 stated he was no longer afraid of him since he no longer sees R117. During an interview on 8/5/2025 at 3:55 pm, the Director of Nursing (DON) stated that both R125 and R117 were prior roommates and were separated immediately after the resident-to-resident altercation. The DON stated R117 was very protective of R63 and stated there have been no further issues between R125 and R117. 2. A review of a document provided by the facility for R25 titled Face Sheet indicated that the resident was admitted to the facility on [DATE]. A review of a care plan for R25 titled Care Plan dated 8/9/2019 indicated the resident had a diagnosis of dementia. A review of the R25's annual MDS with an ARD of 9/11/2024 indicated the resident had a BIMS score of 11 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was dependent on staff for all activities of daily living (ADLs). A review of a document provided by the facility for R78 indicated the resident was admitted to the facility on [DATE]. A review of the quarterly MDS with an ARD of 12/21/2024 revealed R78 had a BIMS score of 15 out of 15, which revealed the resident was cognitively intact. A review of an untitled document provided by the facility (referred to as a follow-up to the initial State Survey Agency incident), 9/20/2024, indicated that on 9/13/2024, R78, who was a former roommate of R25, observed Housekeeper 1 enter their room and leaned over and kissed R25 on the mouth. There was no resistance made by R25. R78 stated the privacy curtain was pulled between R78 and R25, and she was able to see the incident from the mirror that faced the two residents. According to R78, no other touching happened. An interview was conducted with R25, and she denied the allegation. The report continued and indicated that Housekeeper 1 initially denied the allegation and stated he reached over R25's bed to pick up her bedding. Housekeeper 1 was then interviewed by the police and admitted that he kissed R25 on the forehead and touched her hand. Housekeeper 1 was immediately suspended pending the investigation. The police did not pursue charges. The family member (F)1 took (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R25 to the emergency room to be tested for sexually transmitted diseases, and the results were negative. The resident did not have a pelvic exam conducted. A review of a document provided by the facility titled ED (Emergency Department), dated 9/14/2024, indicated R25, who had a history of dementia and resided in a nursing home, was brought in by F1. According to this document, the resident denied being kissed or touched but did state she had a boyfriend at the facility who would clean her room and did not live at the facility. A review of a document provided by the facility titled Official Statement, dated 9/20/2024, indicated Housekeeper 1 was terminated due to his admission to the police of kissing R25's forehead and touching her hand. During an interview on 8/4/2025 at 8:54 am, F1 stated that the facility investigated the allegation of sexual assault and confirmed she took R25 to the emergency room to be tested for sexually transmitted diseases. F1 stated the police were called and did not press charges against Housekeeper 1 due to R25's memory problems. F1 confirmed R25 shared her incident while in the emergency room. During an interview on 8/6/2025 at 12:30 pm, R78 confirmed she remembered R25 being kissed by Housekeeper 1. R78 stated she was in bed with the privacy curtain drawn and could see R25 in bed when Housekeeper 1 entered their room and bent over to kiss R25 on the mouth. R78 revealed that Housekeeper 1 eventually left the room. During an interview on 8/6/2025 at 8:59 am, the DON stated Housekeeper 1 was immediately terminated. The DON confirmed Housekeeper 1 was terminated based on his admission to the police department. During an interview on 8/6/2025 at 9:39 am, R25 stated she did not remember being kissed by Housekeeper 1 and stated she felt safe and was treated well. (Cross Reference F745)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure proper infection control for three of 60 sampled residents (Residents (R) 9, R 139, and R 193). Specifically, infection control measures/enhanced barrier precautions were not carried out during gastrostomy tube care. This failure increased the risk for infections and cross-contamination.Findings included:A review of the facility's policy titled, Transmission-Based Precautions (Contact, Enhanced Barrier Precautions, Droplet, Airborne and reviewed on 12/27/2024 stated .Enhanced Barrier Precautions (EBP) are indicated for Patients with any of the following: .indwelling medical devices even if the patient is not known to be infected or colonized with a MDRO [multidrug-resistant organism].EBP expands the use of PPE [personal protective equipment] and refers to the use of a gown and gloves during high-contact activities that provide opportunities for transfer of MDROs to staff hands and clothing.Examples of high contact patient care activities requiring gown and glove use for Enhanced Barrier Precautions include:.device care or use:.feeding tube.wound care: any skin opening requiring a dressing.A review of the undated Center for Disease Control (CDC) signage titled, Enhanced Barrier Precautions stated .Everyone must: .wear gloves and a gown for the following High-Contact Resident Care Activities.Device care or use:.feeding tube.wound care: any skin opening requiring a dressing.1. A review of R9's admission Record located under the Profile tab in the Electronic Medical Record (EMR) revealed R9 was admitted with diagnoses that included but were not limited to dementia.A review of R9's quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 7/6/2025 included pressure ulcers.A review of R9's Care Plan located in the EMR under the Care Plan tab, revised 5/2/2025, revealed R9 had pressure ulcers on the sacrum and left foot with interventions including EBP secondary to pressure ulcer.A review of R9's Physician Order located in the EMR under the Orders tab included EBP starting 5/6/2025.During an observation and interview on 8/7/2025 at 8:30 AM, Licensed Practical Nurse (LPN)6/ Wound Care Nurse provided wound care for R9, who had pressure ulcers to the left foot and sacrum. LPN6 performed hand hygiene prior to donning (putting on) gloves and a gown. LPN6 removed the soiled dressing to R9's left foot, discarded dressing, cleansed wound with normal saline (NS), applied skin prep to surrounding tissue, applied alginate (salt or [NAME] of alginic acid derived from seaweed) and covered with bordered dressing, donned non-skid socks, doffed (removed) soiled gloves and applied clean gloves after she completed wound care to the left foot. LPN6 did not change gloves between clean/dirty dressings and did not perform hand hygiene. LPN6 then proceeded to do wound care to the sacral wound, donned clean gloves, but did not perform hand hygiene before donning clean gloves. R9 had a large bowel movement (BM), LPN6 cleaned BM, doffed soiled gloves, washed hands, donned clean gloves, applied a clean brief under the resident, cleansed the wound, doffed soiled gloves, and did not perform hand hygiene prior to donning clean gloves and applying clean dressings. When asked why she did not perform hand hygiene between glove changes, she said they could not take the hand sanitizer bottle with them to avoid contamination, and she didn't realize she didn't change her gloves from dirty to clean dressing application on the left foot. LPN6 stated she didn't realize she needed to perform hand hygiene between glove changes, and that's just the way she's always done it. LPN6 confirmed that there was signage outside of R193's room for enhanced barrier precautions.2. A review of R139's admission Record located under the Profile tab in the EMR revealed R139 was admitted with diagnoses that included, but were not limited t,o gastrostomy status.A review of R139's quarterly MDS located in the EMR under the MDS tab with an ARD of06/19/2024 included gastrostomy (g-tube) status.A review of R139's Care Plan located in the EMR under the Care Plan tab, revised 7/3/2025, included g-tube status and maintaining EBP.A review of R139's Physician Order located in the EMR under the Orders tab included EBP starting 5/6/2025 related to g-tube status.During an observation and interview on 8/6/2025 at 4:30 PM, R139 was in bed and receiving (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g-tube care by the Assistant Director of Nursing (ADON) 1. The ADON1 performed hand hygiene, donned gloves, and did not don a gown. There was no EBP signage on the resident's room door. When the ADON1 was asked if R139 was on EBP, she said, There's no sign on the door, but most residents who have a g-tube are on EBP. She revealed that this resident only got a water flush, so she wasn't sure if R139 was on EBP. The ADON1 stated she didn't wear a gown due to there not being an EBP sign on the door, and wasn't sure if she was supposed to wear one or not.3. A review of R193's admission Record located under the Profile tab in the EMR revealed R193 was admitted with diagnoses that included, but were not limited to, gastrostomy status.A review of R193's quarterly MDS located under the MDS tab with an ARD of 7/15/2025 revealed a BIMS score of zero out of 15, which indicated R193 was severely cognitively impaired and had a feeding tube.A review of R193's Care Plan located in the EMR under the Care Plan tab, revised 2/2/2024, revealed R193 had a g-tube with interventions to maintain EBP.A review of R193's Physician Orders located in the EMR under the Orders tab included EBP starting 5/6/2025 related to gastrostomy status.During an observation and interview on 8/6/2025 at 11:02 AM, R193 was lying in bed and receiving gastrostomy tube (g-tube) care by Registered Nurse (RN)1. RN1 donned gloves but did not don a gown during g-tube care. When RN1 was asked why she did not wear a gown, she stated that she was nervous and forgot. RN1 confirmed that she should have worn both gown and gloves during g-tube care. RN1 confirmed that there was signage outside of R193's room for enhanced barrier precautions.During an interview on 8/7/2025 at 10:40 AM, the Director of Nurses (DON) confirmed that it was her expectation that staff wears a gown and gloves during high-contact resident care activities, including g-tube and wound care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interviews, the facility failed to ensure that Activities of Daily Living (ADL) care was provided for one of 60 sampled residents (R) (R11) related to bathing.Findings included:A review of a document provided by the facility for R11 titled Face Sheet indicated the resident was admitted to the facility on [DATE].A review of the quarterly Minimum Data Set for R11 with an Assessment Reference Date (ARD) of 6/17/2025 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which revealed the resident was cognitively intact. The assessment indicated that the resident required partial/moderate assistance with activities of daily living.A review of a document provided by the facility for R11 titled Physical Functioning Instructions for the month of 5/2025 indicated the resident only received a bath on 5/6/2025. There was no evidence that the resident refused to be bathed.A review of a document provided by the facility for R11 titled Care Plan for R11 dated 6/9/2025 indicated the resident required assistance with functional mobility with activities of daily living.A review of a document provided by the facility for R11 titled Physical Functioning Instructions for the month of 6/2025 indicated the resident received a bath on 6/10/2025. There was no evidence that the resident refused to be bathed.Review of a document provided by the facility for R11 titled Physical Functioning Instructions for the month of 7/2025 was requested and not provided.During an interview on 8/5/2025 at 8:32 AM, R11 stated she had not received a bath consistently twice a week and was to receive a bath on Tuesdays and Fridays. During an interview on 8/6/2025 at 4:15 PM, the Director of Nursing (DON) confirmed all residents were to receive showers twice a week or per the preference of the resident. The DON stated there was a time when the electronic medical records were not working properly, and was unable to provide a date when this occurred. The DON revealed the residents were to receive showers, we try to do them twice a week, or more or less. The DON stated there were no facility policies for bathing.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review, resident and staff interviews, and facility policy review, the facility failed to ensure coordination of care was provided for one resident (R)(R118) out of one for a survey sample of 60, by failing to follow through with a consultant pulmonologist medication recommendation. This failure placed the resident at risk for delayed treatment related to her coughing. Findings included:A review of a facility policy titled Medication Orders dated 12/31/2024 indicated .Each medication order is documented in the patient's medical record with the date, time, signature, and title of the person receiving the order. Clarify the order with the prescriber.Notes the order and enters it on the Physician Order Sheet if not written there by the prescriber.Transfer orders (admission or readmission orders sent with a patient by a hospital or other health care center).The nurse will implement a transfer order without further validation if it is signed and dated by the patient's current attending physician.A review of a document provided by the facility for R118 titled Face Sheet indicated the resident was re-admitted to the facility with a diagnosis of acute and chronic respiratory failure with hypoxia (low oxygen in the bloodstream).A review of the annual Minimum Data Set (MDS) assessment for R118 with an Assessment Reference Date (ARD) of 6/18/2025 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which revealed the resident was cognitively intact. A review of a document provided by the facility for R118 titled Care Plan dated 10/10/2024 indicated the resident had a history of acute and chronic respiratory failure.A review of a document provided by the facility for R118 titled After Visit Summary, dated 7/17/2025, indicated a pulmonologist ordered to administer Tessalon capsules (to relieve coughs). There was no documentation that would indicate how many capsules were to be taken or how often the medication was to be administered to the resident. A review of a document provided by the facility for R118 titled Nurse Note dated 7/17/2025 indicated the pulmonologist ordered the resident Tessalon capsules to treat her cough.During an interview on 8/6/2025 at 2:16 PM, R118 stated she had a recent appointment in the community with a pulmonologist who had ordered her Tessalon capsules for her chronic cough. The resident stated she brought in the prescription and gave it to the facility after her appointment.During an interview on 8/6/2025 at 2:18 PM, Licensed Practical Nurse (LPN) 3 stated that when a resident brought in a prescription from a physician in the community, the prescription was then given to LPN 7, who was the Nurse Manager.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure one of 60 sampled residents (Resident (R) 193) received appropriate gastrostomy tube management. Specifically, R193's gastrostomy tube had black discoloration in the tube which may indicate colonization of the tube with fungi, which could lead to infection, blockages, and/or material deterioration.Findings included:A request was made for the gastrostomy tube management policy, but it was not made available.A review of the facility policy titled Clinical Care Decision provided by the facility indicated the guidelines were to make .clinical decisions are made based upon the health care needs of the patient. Availability and access to quality health services require collaborative planning by healthcare professionals to meet the health needs of the patient. All Health Care Professionals have a responsibility to help promote that each patient's right to health care is met.A review of R193's admission Record located under the Profile tab in the Electronic Medical Record (EMR) revealed R193 was admitted with diagnoses that included, but were not limited t,o gastrostomy status.A review of the quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 7/15/2025 revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15, which indicated R193 was severely cognitively impaired and had a feeding tube.A review of the Care Plan located in the EMR under the Care Plan tab, revised 2/2/2024, revealed R193 had a gastrostomy tube. Interventions included assessing feeding tube placement, patency, and residual every shift and before /after administration of any fluids or medications; flushing the tube with water as ordered by the physician; and maintaining enhanced barrier precautions.A review of R193's nursing Progress Notes located in the EMR under the Progress Notes tab from August 2024 to the present did not mention discoloration to the gastrostomy tube.A review of R193's NP (Nurse Practitioner) Progress Notes located in the EMR under the Scan Docs tab and dated 7/16/2025 indicated g-tube (gastrostomy tube) was in place with no documentation as to the condition of the tube.During an observation and interview on 8/6/2025 at 11:02 AM, R193 was lying in bed at a 45-degree angle. Registered Nurse (RN)1 assessed the gastrostomy tube and confirmed that the tube had black discoloration in the interior of the tube for a long time. RN1 stated that the discoloration had been there for several months, and she was not sure if anyone had reported it to the NP or Medical Director (MD), but she should have.

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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 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)