STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115480	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archbold Living Thomasville	10629 U.S. Highway 19 South Thomasville, GA 31792

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 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 record review, staff interviews, and review of the facility's Abuse Prohibition Policy and Procedures, it was determined that the facility failed to report an allegation of abuse within two hours for one resident (R) (R1) of three sampled residents, after R1 reported another resident exposed his genitals to her. Findings include:Review of the facility's undated policy titled Abuse Prohibition Policy and Procedures, revealed under Reporting: A. Once a complaint or situation is identified involving alleged mistreatment, neglect, or abuse, the incident will be reported immediately, but no later than 2 hours after the allegation is made. Review of the annual Minimum Data Set (MDS), dated [DATE], revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.Record review revealed a progress note dated 6/19/2025 at 10:33 am written by the Therapy Manager that revealed On Tuesday, 06/16/25, resident self-propelled w/c to therapy gym and asked to speak with this writer regarding an issue she had. Resident reports that she was [NAME] herself down the hallway and when she got to the resident's room, that resident was standing in his hallway and exposed his genitals to her. Interview on 7/17/2025 at 9:46 am with Therapy Assistant AA, confirmed R1 approached her on 6/16/2025 with the allegation that another resident exposed himself to R1. She stated she immediately contacted the Social Worker to notify her of the allegation. She stated she documented the incident in the health record. Record review revealed a document titled [Named Organization] Long Term Care Facilities Complaint Form written on 6/19/2025 by the facility's Social Worker. It listed the date of the complaint as 6/16/2025, with R1 making the complaint. The document revealed that the coordinator (Social Worker) received the complaint on 6/16/2025, and the date of the complaint was referred to the appropriate department on 6/16/2025 (Social Services). The document was signed by the Social Worker.Review of the Facility Incident Report Form verified the facility reported the allegation on 6/19/2025 and not on 6/16/2025 when the allegation was first reported. There were no other incidents between the initial incident and the time the facility reported to the State Agency.Interview on 7/17/2025 at 9:52 am with the Director of Nursing (DON) and the Administrator revealed that the DON was made aware of the allegation of abuse on 6/19/2025 by Social Services. She stated she reported it to the state, notified family, law enforcement, and did an investigation. She revealed she is the abuse coordinator and when she's not at the facility the Assistant Director of Nursing (ADON) is her back up, however staff know if there is an allegation of abuse that they can call her 24/7. She confirmed that the allegation should have been reported on 6/16/2025 within 2 hours of the resident making the allegation and not days later on 6/19/2025. The Administrator thought that she was made aware of the allegation on 6/19/2025 and confirmed that DON is the abuse coordinator and that the DON should have been notified on 6/16/2025 so that the allegation could have been reported to the state. R1 refused to be interviewed on 7/17/2025. The Social Worker was on leave at the time of the survey and was unavailable for interview.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - 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 policy titled Falls risk assessment the facility failed to provide care by two staff members, for one resident (R)(R2) of three residents reviewed for falls. Actual harm was identified 4/29/2025 when R2 fell from the bed when rolled away from the Certified Nursing Assistant who was providing care to her. The fall resulted in R2 receiving Fracture of distal end of left femur and Fracture of distal end of right femur. Findings include:Review of the facility policy dated 8/2019, titled, Falls risk assessment, revealed Policy Interpretation and Implementation 6. The staff, with the input of the Attending physician will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities', activity tolerance, continence, and cognition. Review of the medical record for R2 revealed the resident was initially admitted to the facility on [DATE] with the following diagnosis's not limited to end stage renal disease, pain in right shoulder, chronic systolic heart failure, type 2 diabetes mellitus with diabetic chronic kidney disease. Review of Quarterly Minimum Data Set (MDS) dated [DATE] (MDS at time of fall) revealed that the resident had a Brief Interview for Mental Health Status (BIMS) of 15, indicating no cognitive impairment. Review of a progress note dated 4/29/2025 at 6:18 am revealed that R2 rolled too far to the side and rolled off bed during a bed bath. The fall was observed by Certified Nurse Assistant (CNA) BB, the CNA that was assisting the resident with the bed bath. The resident complained of pain, moves all extremities. The resident's daughter and physician was notified, and the resident was transferred to the emergency room by rescue. CNA BB was unavailable for interview due to being on leave. Record review revealed CNA BB's statement sent via text to the Director of Nursing (DON), (not dated) read, it was resident's bath night. I asked the resident around 2:15-2:30 am were they ready for their bath; they agreed and we proceed to take the bath. It was time of the bath to dry, enter, and secure the last part of the diaper. I asked the resident to turn to their side, the resident grabs for the grab bar, lifts their leg and ends up overturning the opposite direction of me. Their legs slips off the bed and then loses grasp of the grab bar and slides onto the ground. I check to see if resident is ok and immediately look for my nurse to notify what happened.Record review of the hospital emergency room report on 4/29/2025 revealed an x-ray report that listed a Fracture of distal end of left femur and Fracture of distal end of right femur. Due to the fractures, the resident was transferred to a Trauma Center in Florida. Interview on 7/15/2025 at 1:15 pm with the resident revealed that on 4/29/2025 she rolled off her bed while CNA BB was bathing and changing her. The resident said she thought prior to this incident, there were usually two staff giving her a bed bath but was unsure. She stated that the CNA asked her to turn the opposite way and when resident went to turn, she had more strength than she thought and rolled off the bed. An interview on 7/15/2025 at 1:45 pm with the DON revealed that once a fall takes place, the staff discuss the fall in the morning meeting with the Interdisciplinary Team. The DON revealed that interventions should be initiated after falls, and if additional interventions are needed. The DON revealed prior to the fall the resident required one staff member to assist her during bathing. After the fall, the care plan was updated for a two person assist with bathing. The DON revealed that the resident always turned on her own but this time overcompensated, which led the resident to roll onto the floor. When asked if rolling a resident away from you is best practice, she stated she knew what this surveyor wanted her to say but she can only say that the CNA asked the resident to turn away from her during care, and the resident fell on the floor because she had too much power by swinging her leg giving her too much momentum causing her to roll off bed. The DON stated that after the fall, the Assistant Director of Nursing (ADON) provided an inservice to all CNA's on bed mobility on 5/7/2025. The DON provided training to CNA BB on turning and repositioning and rolling in bed on May 2, 2025. The ADON conducted monitoring rounds 5/5/2025-7/92025. Interview on 7/15/2025 at 4:35 pm with Registered Nurse (RN) CC revealed that she did not remember getting any training on bed mobility but if she were by herself providing care to a resident, she would stand on the side of the bed and make sure the railing on the other side was pulled up. She would then roll the resident toward the rail. She stated that there are usually two staff assisting with bed baths and changing. Interview on 7/15/2025 at 4:41 pm revealed CNA DD revealed the facility gives bed baths with two staff. If she were to do a bed bath or change a resident by herself the best practice would be to have the resident roll towards her and not in the other direction. Interview on 7/15/2025 at 4:39 pm with CNA EE revealed the facility usually has two people assisting with bed baths. If she were by herself providing a bath, the best