

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Harborview Thomasville		STREET ADDRESS, CITY, STATE, ZIP CODE 930 South Broad St. 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 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 observations, staff interviews, record review, and facility policy titled Elopement and Wandering Residents, the facility failed to follow the care plan for one resident (R) (R1) of three sample residents related to a non-functioning wander guard bracelet. This deficient practice places residents at risk for elopement and potential injury or harm. Findings include: A review of the facility policy, Elopement and Wandering Residents, dated 7/1/2025 documented that residents that exhibit wandering behaviors and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care. A review of the Face Sheet for R1 revealed she was admitted on [DATE], with the diagnoses that included but were not limited to unspecified dementia, anxiety disorder, major depressive disorder, delusional disorder and cognitive communication deficit. A review of the Quarterly Minimum Data Set, dated [DATE] for R1 revealed that Section C (Cognitive Pattern) had a Brief Interview Mental Score of 99 indicating severe cognitive impairment. Section GG (Functional Abilities) revealed that R1 required supervision for self-care. A review of the care plan dated 8/11/2025 for R1 documented that she was at risk for elopement related to dementia. Documented under interventions, Wander guard bracelet to be worn and ensure proper functioning. An observation and interview with Unit Manager (UM) on 9/29/2025 at 2:45 pm revealed that R1 had a wander guard bracelet on her right ankle. When the UM checked the bracelet for proper functioning, there was no response from the device. UM confirmed the bracelet was not functioning properly and needed to be replaced. An interview with the Administrator on 10/1/2025 at 7:30 am revealed that all the exit doors are locked with a keypad in addition to the wander guard system. An interview with the Chief Operating Officer (COO) on 10/1/2025 at 3:15pm revealed that staff should monitor the residents. An interview with Unit Manager on 10/2/2025 at 10:16am revealed that wander guards should be checked daily and wander guard bracelets are replaced when the batteries are low or the bracelet malfunctions. An interview with Interim Director of Nursing (DON) on 10/2/2025 at 10:45am revealed that wander guard bracelets should be checked daily for proper functioning.		

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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