STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115556	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightmoor Nursing Center, LLC	3235 Newnan Road Griffin, GA 30223

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 - Minimal harm or potential for 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. (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 - 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 policy titled Abuse, Neglect, and Exploitation, the facility failed to protect one of 49 sampled residents (R) (R75) rights to be free from verbal abuse by another resident (R49). This deficient practice had the potential to place R75 at risk of a diminished quality of life. Findings include:Review of the facility's policy titled Abuse, Neglect, and Exploitation, revised 6/14/2024, included It is the intent of this facility to actively preserve each resident's right to be free from mistreatment, neglect, abuse, or misappropriation of resident property. We believe that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusions. The Definitions section included, . 2. Verbal Abuse is defined as any use of oral, written, or gestured language that willfully includes sparing and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include (but are not limited to), threats of harm, saying things to frighten a resident, such as telling resident that she will never be able to see her family again. 1. Review of the clinical record for R75 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, anxiety disorder, hypertension, and major depressive disorder.Review of the MDS for R75, dated 10/21/2025, revealed Section C (Cognitive Patterns) documented a BIMS score of 15 (indicating little to no cognitive impairment). Review of the Progress Notes for R75 revealed an entry dated 9/8/2025 documenting, (R75's name) expressed the desire to move to another room after his roommate had an unpleasant conversation between the two of them. He stated that his roommate kept repeating foul language to him over several times and that made him feel very uncomfortable. SSD made aware that resident is requesting a room change.2. Review of the clinical record for R49 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction, major depressive disorder, Alzheimer's disease, restlessness and agitation, unspecified psychosis not due to a substance or known diagnosis, rank insignificant physiological condition, and hypertension.Review of the Quarterly Minimum Data Set (MDS) for R49, dated 11/19/2025, revealed that Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of nine (indicating moderate cognitive impairment). Section E (Behaviors) documented that no behaviors were exhibited. Review of the care plan for R49 revealed a Focus, dated 7/3/2024 and revised 4/29/2025, that the resident was at risk for behaviors and had a history of yelling at staff and making inappropriate sexual comments. Interventions included, but were not limited to, intervening as needed to protect the rights and safety of others. Review of the Progress Notes for R49 revealed an entry dated 9/9/2025 documenting, Social Services (SS) spoke with R49 regarding his threatening statements toward another resident. R49 was observed rummaging through his roommates' belongings. The staff continued to redirect R49, and the redirection was unsuccessful. R49 and his roommate were separated, and R49 continued to yell out with aggression that he would kill his roommate. R49 admitted to making the statement of wanting to kill his roommate. SS initiated a 1013 (an involuntary mental health evaluation) for transport to (name of a mental health facility). SS called the representative, and she was appreciative of the information provided. She was also encouraged to call the facility for an update.In a telephone interview on 12/20/2025 at 10:30 am, the Social Service Director (SSD) disclosed that she had been made aware of the allegation of abuse by Certified Nurse Assistant (CNA) TT. The SSD stated that CNA TT visited her office to report that R49 had threatened to kill R75 and exhibited aggressive behavior in his pursuit. The SSD indicated that she took the threat seriously because R49 had the means but attempted to de-escalate the situation with R49; however, she was unable to redirect his aggression.In an interview on 12/20/2025 at 11:07 am, Licensed Practice Nurse (LPN) II indicated that she observed R49 rummaging through the items of R75 while using inappropriate language. She stated that she attempted to intervene but was unsuccessful, prompting her to leave in order to seek assistance from the SSD. In an interview on 12/21/2025 at 10:43 am, CNA TT confirmed that he was assigned to R49 and R75 on the day of the alleged abuse. He stated that he recalled a verbal threat made by R49, which was derogatory words towards R75. CNA TT noted that R49 typically uses vulgar language and has previously exhibited aggressive behavior with different roommates. CNA TT explained that, after multiple attempts to redirect R49, he informed LPN II, who also attempted to redirect R49 but without success. CNA TT stated he reported the situation to the SSD.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 policy titled Abuse, Neglect, and Exploitation, the facility failed to ensure a thorough investigation was conducted in a timely manner following an allegation of resident-to-resident verbal abuse involving two residents (R) (R75 and R49) from a sample of 49. Findings include:A review of the facility's policy Abuse, Neglect, and Exploitation, revised 6/14/2024, revealed the Investigation section included, . 4. Interviews will be conducted all pertinent parties. Written signed statements from any involved parties will be obtained and notarized, if possible. Statements will be gathered from the suspect person making accusations resident involved, reliable resident who may have witness the incident and any other persons who may have some information identify any possible conflicts between witnesses. 5. Past performances and/or previous incident of involved parties will be evaluated. Review of schedules and assignments showing when and where suspect was working at the time of the alleged incident. 6. Describe actions taken by facility to protect the resident and to prevent a possible reoccurrence during the investigation. 7. All investigative information will be kept on file in a secured location. All information gathered is confidential in nature.1. Review of the clinical record for R75 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, anxiety disorder, hypertension, and major depressive disorder.Review of the MDS for R75, dated 10/21/2025, revealed Section C (Cognitive Patterns) documented a BIMS score of 15 (indicating little to no cognitive impairment). Review of the Progress Notes for R75 revealed an entry dated 9/8/2025 documenting, (R75's name) expressed the desire to move to another room after his roommate had an unpleasant conversation between the two of them. He stated that his roommate kept repeating foul language to him over several times and that made him feel very uncomfortable. SSD made aware that resident is requesting a room change.2. 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R49 and his roommate were separated, and R49 continued to yell out with aggression that he would kill his roommate. R49 admitted to making the statement of wanting to kill his roommate. SS initiated a 1013 (an involuntary mental health evaluation) for transport to (name of a mental health facility). SS called the representative, and she was appreciative of the information provided. She was also encouraged to call the facility for an update. In a telephone interview on 12/20/2025 at 10:30 am, the Social Service Director (SSD) disclosed that she had been made aware of the allegation of abuse by Certified Nurse Assistant (CNA) TT. The SSD stated that CNA TT visited her office to report that R49 had threatened to kill R75 and exhibited aggressive behavior in his pursuit. The SSD indicated that she took the threat seriously and attempted to de-escalate the situation with R49; however, she was unable to redirect his aggression. The SSD confirmed that she did not contact law enforcement or the Ombudsman. She stated that she remembered conducting an interview with R75 but did not document it. The SSD further stated that she did not perform any other investigative tasks and was unable to provide additional information. In a concurrent interview on 12/20/2025 at 11:07 am, Licensed Practice Nurse (LPN) II indicated that she observed R49 rummaging through the items of R75 while using inappropriate language. She stated that she attempted to intervene but was unsuccessful, prompting her to leave in order to seek assistance from the SSD. LPN II stated she had no further documentation of the incident. The Director of Nursing (DON) stated that allegations of abuse, neglect, or exploitation should be reported within two hours. The residents should be separated, interviews should be conducted, interventions implemented, and any necessary actions should be taken.In an interview on 12/20/2025, at 11:09 am, the Administrator stated that he expected staff to promptly inform him of any instances of abuse. He stated that he typically would call the police in such situations. The Administrator also acknowledged that he was aware of an incident that took place on 9/9/2025, although he was not the Administrator at that time. Further