STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115575	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tattnall Healthcare Center	142 Memorial Drive Reidsville, GA 30453

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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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 interview, record review, and review of the facility's policy titled Freedom of Abuse- Abuse Prevention: Fast Alerts, the facility failed to ensure two of four Residents (R) (R14 and R80) reviewed for abuse were free from resident-to-resident physical abuse. This failure had the potential to negatively impact all residents due to the facility's failure to prevent resident abuse.Findings included:A review of the facility's policy titled, Freedom of Abuse- Abuse Prevention: Fast Alerts, dated January 2025, indicated, Policy The purpose of this written Freedom of Abuse, Neglect, Exploitation: Abuse Prevention Standard is to outline the preventative and action steps taken to reduce the potential for abuse, mistreatment and neglect of residents and the misappropriation of resident property and to review practice and omissions which if allowed to go unchecked, could lead to abuse. This policy demonstrates a Zero Tolerance of Abuse of any type or manner and will address accordingly.A review of R14's admission Record, located in the Profile section of the electronic medical record (EMR), revealed R14 was admitted to the facility with diagnoses which included Alzheimer's disease, and anxiety disorder. A review of R14's care plan, dated 7/8/2024, located under the Care Plan tab of the EMR, contained the following Focus area, [R14's name] has a behavior problem R/T [related to] dementia. She can wander at times and intrude on others personal space. Can decide to sit in random chairs with no concern for who they belong to. The care plan's goal specified, She will be easily redirected without major complications through review date. A review of R14's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/14/2024, located in the MDS tab of the EMR, revealed R14 scored zero of 15 on the Brief Interview Mental Status (BIMS) which indicated severe cognitive impairment. The MDS indicated R14 exhibited wandering behavior daily.A review of R14's Capacity for Sexual Consent Assessment, dated 7/15/2024 and completed by the Social Services Director (SSD), and provided by the facility, indicated, R14 was assessed as not having the capacity to consent to sexual intimacy. A review of R14's notes, located in the Progress Notes section of the EMR, revealed the following entries:8/23/2024 at 8:44 pm, . Nursing observations, evaluation, and recommendations are: During PM (evening) med pass and rounds resident got OOB [out of bed] and wandered into a male resident's room. Another resident seen her and went to get staff. When staff entered the room this Resident had a bowel movement and had taken her brief off and laid across his bed. The male resident had his hand touching her buttocks. This resident was immediately covered and removed from room and taken to her own room on another hall to be cleaned and examined.8/23/2024 at 8:45 pm, . Skin note Genital area examined with no redness, swelling or tearing or abnormalities noted. Resident showed no signs or symptoms of anxiety, pain or distress.8/23/2024 at 9:19 pm, Social Services Progress Note Late Entry Note Text: SSD [Social Service Director] was notified of the incident involving [R14's name] wandering into a male room and lying across the bed. It was reported [R14's name} had a bowel movement, took her brief off, and lay across the male's resident bed. The male resident had his hand touching her buttocks. [R14's name] was immediately covered, removed, and taken to her room in another hall to be cleaned and examined. SSD visited [R14's name] in her room. The resident showed no signs of distress or anxiety. She was lying in her bed, randomly talking calmly. SSD will visit as needed.An observation on 8/18/2025 at 12:23 pm, revealed R14 was in the facility's main dining room eating her lunch meal. No concerns were noted.A review of R80's admission Record, located in the Profile section of the EMR, revealed R180 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). R80 was discharged from the facility on 10/11/2024.A review of R80's quarterly MDS assessment with an ARD of 7/1/2024, located in the MDS tab of the EMR, revealed R80 scored 13 of 15 on the BIMS which indicated he was cognitively intact and had not exhibited any physical, verbal, or other behavioral symptoms towards others.A review of R80's Capacity for Sexual Consent Assessment, dated 7/1/2024 and completed by the SSD, and provided by the facility, indicated, R80 was assessed as having the capacity to consent to sexual intimacy. A review of R80's notes, located in the Progress Notes section of the EMR, revealed the following entry: 8/23/2024 at 8:00 pm (noted as a late entry created on 8/26/2024 at 12:42 pm), . Nursing observations, evaluation, and recommendations are: A female resident wandered into his room, removed her soiled brief and laid across his bed and he proceeded to rub her buttocks with his hand .A review of the facility's investigation of the 8/23/2024 incident between R14 and R80, provided by the facility, revealed the facility substantiated resident to resident abuse. Included in the facility's investigation were witness statements from staff who witnessed the incident. A witness statement written by Certified

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F 0689 Level of Harm - Minimal harm or potential for 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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F 0689 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 observation, interview, record review, and review of the facility's policy titled Elopement Management, the facility failed to provide adequate supervision for one of four Residents (R) (R81) reviewed for accidents. Specifically, R81 eloped from the facility and the facility grounds without staff knowing the resident was missing, which placed him at risk for the resident to be in harm's way or a possible injury.Findings included:A review of the facility's policy titled, Elopement Management, dated January 2025, indicated, Clinical process that addresses a resident's risk of elopement from the premises or a safe area without authorization and/or necessary supervision to do so. A review of R81's admission Record, located in the Profile section of the electronic medical record (EMR), revealed R81 was admitted to the facility with diagnoses that included mild dementia with agitation and major depressive disorder.A review of R81's Elopement Evaluation, dated 3/17/2024 and provided by the facility, indicated he was at risk for elopement.A review of R81's Care Plan located under the Care Plan tab of the EMR, contained the following Focus area which was created on 6/9/2017, At risk for elopement R/T [related to] history of attempts of elopement. Care plan Interventions/Tasks, also initiated on 6/9/2017 included Attempt to make resident feel safe/secure within facility, Distract from wandering by offering pleasant diversions such as food, conversations, television, books, music, and Redirect if [R81's name] attempts to elope.A review of R81's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/26/2025, located in the MDS tab of the EMR, revealed R81 scored four of 15 on the Brief Interview Mental Status (BIMS) which indicated severe cognitive impairment. A review of R81's notes, located in the Progress Notes section of the EMR, revealed the following entries: 7/20/2025 at 10:00 am Progress Note: CNA [Certified Nursing Assistant/first name] returns the resident to the facility. She stated that We found him by the elementary school up the road. The resident is in NAD [no acute distress] and has no complaints. This nurse notified [name] LPN [Licensed Practical Nurse] immediately to notify her of the situation. This nurse last saw the resident at 8:50 am when I called his brother for him. The resident was sitting in the living room area. This is the last time this nurse saw the resident. 7/20/2025 at 10:30 am Elopement Evaluation: . resident has been hyperfocused on calling his brother since yesterday morning and this nurse observed hi [him] on 7/19/2025 tell his brother on the phone I want to go home come and get me. A review of the facility's investigation of R81's elopement from the facility provided by the facility, revealed, on 7/20/2025 [R81's name] was sitting outside on the porch while the smoking residents were on smoke break. When the other residents were escorted inside, he did not enter the building. Staff last saw him around 9:30 am. Once other residents were inside and staff members, he walked around building, through gate and down road. He was less than one eighth of a mile from the facility which is a five-minute walk when he was seen by someone. He was assisted to sit in the shade and the gentleman called a staff member from the facility to come get [R81's name] around 10 am. Staff member arrived and brought resident back to the facility. [R81's name] arrived back at the facility at 10:15 am. Upon return staff asked resident where he was going, he stated he was going home to get him some fried chicken on the bone. Staff performed a head-to-toe assessment with no injuries noted. Vital signs were taken and within normal limits. Resident denied pain or discomfort at that time. He was able to answer questions appropriately. Hydration was provided. After thorough investigation, the facility was able to substantiate the allegation of elopement as resident was outside of facility and facility grounds. During an observation on 8/20/2025 at 2:50 pm of the facility's doors which lead to the smoking patio area and the outside grounds, with the Director of Nursing (DON) present, revealed the doors to the outside smoking porch sounded an alarm when the doors were opened. Observations of the outside grounds around the smoking patio revealed the grounds were fenced and there were three outside gates. Observations of the three outside gates revealed they were unsecured and could be opened by moving the gate's latch to an upward position. The DON was showed which gate it was and thought that R81 exited the facility grounds from the gate on 7/20/2025. She confirmed that all three outside gates were currently not secured. During an interview on 8/20/2025 at 3:00 pm the DON confirmed R81 was an elopement risk and eloped from the facility on 7/20/2025. The DON stated R81 was found unsupervised approximately one eighth of a mile from the facility by a person who was not an employee of the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record review, the facility failed to serve food that was palatable and hot for three of five residents (R) (R25, R26, and R47) reviewed for food palatability out of a total sample of 33 residents. This failure had the potential for the residents to skip meals and potential for weight loss. Findings included:1. A review of R25's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/6/2025 and located in the electronic medical record (EMR) under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact.During an interview on 8/18/2025 at 11:21 am, R25 stated the food served at the facility did not always taste good. R25 stated the food lacked flavor and could be hotter when served at meals.2. A review of R26's Annual MDS, with an ARD of 7/17/2025 and located in the EMR under the MDS tab, revealed a BIMS score of 13 out of 15, which indicated the resident was cognitively intact.During an interview on 8/18/2025 at 1:40 pm, R26 stated the food was cold when served at meals. R26 specified the breakfast meal was the worst because her eggs, sausage, coffee, pancakes, and toast are cold when served. R26 stated that she had to soak her toast in milk or coffee because it is too hard for her to eat. R26 stated she wanted to be served hot food and hot coffee.3. A review of R47's quarterly MDS, with an ARD of 7/14/2025 and located in the EMR under the MDS tab, revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.During an interview on 8/18/2025 at 11:00 am, R47 stated she did not care for the food served at the facility. R47 specified she ate her meals in her room and her food was not always hot when served and did not always taste good to her.In response to resident complaints about food, a test tray was requested to be sent to the facility's C hallway during the breakfast meal on 8/20/2025. Observation revealed before the meal tray cart, which contained the test tray, left the kitchen at 8:34 am, resident meals were observed being served on heated plates. Food temperatures on the kitchen tray line were monitored by staff and were at acceptable levels of 140 degrees Fahrenheit (F) and above for the hot foods and below 40 degrees F on cold beverages being served. Toast was being served from a pan on the trayline. The test tray and other resident meal trays were placed on an enclosed tray cart that had no heating element and were delivered to the C hallway at 8:35 am. The last resident's breakfast tray was observed to be served on the C hallway on 8/20/2025 at 8:47 am. At this time, the food and beverages on the test tray were sampled in the presence of the Dietary Manager (DM). The DM utilized a calibrated facility thermometer to obtain temperatures of the food and beverages served on the test tray. The DM also tasted the food served on the requested test tray. Temperature checks and tasting of the food served on the test tray revealed the following: a. The scrambled eggs on the test tray registered 118 degrees F and were barely warm when tasted. The DM also tasted the scrambled eggs and confirmed the eggs tasted barely warm and needed to be hotter. b. The toast on the test tray registered 80 degrees F and was not warm and was very hard when tasted. The DM also tasted the toast and confirmed it was not warm and was very hard. c. The DM was unable to obtain an internal temperature on the slices of bacon served on the test tray. When the bacon was tasted it was barely warm. The DM also tasted the bacon and confirmed it was barely warm and needed to be hotter. During an interview on 8/20/2025 at 8:54 am, the DM stated the scrambled eggs, toast and bacon should be hot when served to residents.During an interview on 8/21/2025 at 7:15 pm, the Administrator stated the facility did not have a policy in relation to food palatability.