STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER Countryside Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 233 Carrollton Street Buchanan, GA 30113	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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, Exploitation or Misappropriation-Reporting and Investigating, the facility failed to conduct a thorough investigation for an allegation report of sexual abuse for one resident (R) (R3) from a sample of 5 residents. The deficient practice increased the risk that allegations went without a thorough investigation resulting in potential harm to residents. Findings include:A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 09/2022 documented under section titled Policy Interpretation and Implementation and section titled Investigating Allegations and 1. All allegations are thoroughly investigated. 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence. e. interviews any witnesses to the incident. h. interviews staff members (on all shifts who have had contact with the resident.l. documents the investigation completely and thoroughly. Documented for number 8. The following guidelines are used when conducting interviews: .d. Witness statements are obtained in writing, signed and dated.Record review revealed R3 was admitted to the facility on [DATE] with pertinent diagnoses included but not limited to Alzheimer's disease, anxiety disorder, dementia.Review of Minimum Data Set (MDS) assessment with an assessment reference date of 02/19/2026 revealed R3 had a Basic Interview for Mental Status (BIMS) score of 08, which indicated moderate cognitive impairment.Record review revealed R 1 was admitted to the facility on [DATE] with pertinent diagnoses included but not limited to Type 2 diabetes, other esophagitis with bleeding, age-related nuclear cataract bilaterally, other schizophrenia, generalized anxiety disorder, moderate intellectual disabilities, and major depressive disorder.Review of Minimum Data Set (MDS) assessment with an assessment reference date of 02/20/2026 revealed R1 had a Basic Interview for Mental Status (BIMS) score of 99, which indicated severe cognitive impairment.Record review revealed R2 was admitted to the facility on [DATE] with pertinent diagnoses included but not limited to sepsis, liver cirrhosis, chronic pain syndrome, major depression and insomnia.Review of Minimum Data Set (MDS) assessment with an assessment reference date of 03/11/2026 revealed R2 had a Basic Interview for Mental Status (BIMS) score of 15, which indicated little to no cognitive impairment.Review of facility reported incident dated 03/02/2026 documented under Type of Incident, and Other, and Please Specify: Male Resident wandering into Female room touching one inappropriately, staring at one and then watching the third while in the bathroom brushing her teeth. This was initially reported by R2.Review of facility's final investigation report dated 03/07/2026 documented On February 28, 2026, R1 was wandering into a female, three bedroom and according to R2, in the bathroom with the door closed, stated he (R1) inappropriacy touched one resident (R3) and stared at one for a length of time. He then proceeded to go to the bathroom door, opened the door and stared at the female in the bathroom, and After the investigation, it has been determined this was unsubstantiated.An interview was conducted with the Administrator on 03/31/2026 at 5:42 PM regarding the facility's process for investigating allegations of sexual abuse. The Administrator stated that the investigation of the reported incident was conducted by the former Director of Nursing (DON) along with herself. She stated that R2 initially reported the allegation to the Registered Nurse, who then notified the Administrator. She stated this (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not the first occurrence of R1 wandering into other residents' room. The Administrator defined sexual abuse as unwanted or inappropriate touching. She stated that the allegation involved R1 entering a resident's room, sitting on the resident's bed, and allegedly touching the resident's leg. The Administrator stated that staff interviews included the Registered Nurse and Certified Nursing Assistant; however, she acknowledged that no written statements were obtained. The Administrator reported that a stop sign (banner) had been placed on the resident's door prior to the incident and stated it is effective most of the time, though not completely she confirmed that no additional residents were interviewed to assess their sense of safety following the incident. The Administrator stated that it is very important to conduct thorough investigations of abuse allegations to ensure resident safety.