

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER Carrollton Manor, Incorporated		STREET ADDRESS, CITY, STATE, ZIP CODE 2455 Oak Grove Church Road Carrollton, GA 30117	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49140</p> <p>Based on observations, resident family and staff interviews, record review, and review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, the facility failed to report an incident of sexual abuse for one of three sampled residents (R) (R1). This failure had the potential for abuse to other residents by staff.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating states under Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Under Policy Interpretation and Implementation, Reporting Allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. the facility medical director.</p> <p>Review of the electronic medical record (EMR) revealed R1 was admitted to the facility with diagnoses of, but not limited to fracture of lumbar vertebra, anxiety disorder, depression, Alzheimer's type dementia, and major depressive disorder.</p> <p>Review of most recent Quarterly Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of 5, indicating significant cognitive impairment.</p> <p>Review of the care plan indicated R1 has impaired cognitive function related to Alzheimer's related dementia; a mood problem related to a diagnosis of mood disorder due to known physiological condition with mixed features; limited physical mobility r/t (related to) vertebrae fracture.</p> <p>(continued on next page)</p>		

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 4/8/2025 at 12:49 pm of R1 with spouse present revealed R1 was not able to be interviewed, but the spouse stated that he did not have any concerns about the incident. He stated that his stepdaughter told him that she observed her mother get upset with CNA AA because R1 mistook CNA AA for the stepdaughter's husband. He stated he felt bad for CNA AA.</p> <p>During an interview on 4/7/2025 at 10:30 am with the Administrator, they presented exhibit 7, wherein the investigation for sexual abuse had been requested. There was no evidence of police involvement in the exhibit. The Administrator revealed, at the request of the family, the police not be notified nor the resident be sent to the hospital for a sexual assault evaluation. The Administrator indicated that Adult Protective Services had not been notified.</p> <p>Interview on 4/8/2025 at 10:47 am with CNA BB revealed that she reported any allegations of abuse to the Director of Nursing (DON).</p> <p>Interview on 4/7/2025 at 3:26 pm with the Ombudsman revealed that she was not notified of the allegation of sexual abuse. She was concerned not to have been involved in the process.</p> <p>Interview on 4/8/2025 at 11:15 am with the Social Service Director (SSD) revealed that the DON was the Grievance Officer, and that in any allegations of abuse or neglect you have two hours to report to the state agency, Ombudsman, local police, Adult Protective Services, family and the doctor. She revealed she was not involved directly in the grievance process but would have expected the police to have been notified if there were an allegation of sexual abuse. The Ombudsman and Adult Protective Services should have been notified in the case of an allegation of rape.</p> <p>Interview on 4/8/2025 at 11:22 am with Unit Manager LPN CC, she revealed any allegations of abuse were required to be reported to the DON who was the Abuse Coordinator. The DON did the investigation. She didn't know if notifying the police was a requirement. LPN CC said LPN DD asked R1 what she wanted to do, and R1 said to call the police.</p> <p>Interview on 4/8/2025 at 12:09 pm with the DON revealed that they thought that reporting to the State, speaking to the family, and doing their own investigation was all they had to do.</p> <p>Interview on 4/8/2025 at 1:39 pm with the Administrator revealed that the morning of the incident, R1's husband did not want his wife sent to the hospital to be assessed nor have the police involved. When asked why the Administrator did not call the police according to their own facility policy, he stated, If we think it really happened, we would have followed the policy completely. We didn't think it happened.</p>		