STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115707	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sgmc Health Villa	138 West Thigpen Ave Lakeland, GA 31635

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on resident and staff interviews, record reviews, and review of the facility's policy titled, Villa Abuse, Neglect, Exploitation, Mistreatment of Individuals, the facility failed to ensure that an allegation and suspicion of abuse was reported to the State Survey Agency (SSA) within the required time frame for one of 14 sampled residents (R) (R A). Findings include: Review of the facility's policy titled Villa Abuse, Neglect, Exploitation, Mistreatment of Individuals dated 8/1/2022, under the Policy section revealed, 8. In response to allegations of abuse, neglect, exploitation, or mistreatment of an individual, [facility name] ensures that the allegations are immediately reported to the [facility name] Administrator. If the event(s) that caused suspicion result in serious bodily injury, it must be reported to The Georgia Department of Community Health no later than (2) hours after forming the suspicion. If the event(s) causing suspicion did not result in serious bodily injury, it must be reported to The Georgia Department of Community Health no later than (24) hours after the suspicion is formed. Review of the clinical record revealed that RA was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, cerebral infarction, left non-dominant side hemiplegia and hemiparesis, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that RA was assessed as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. She was also assessed on the MDS assessment as needing staff assistance for Activities of Daily Living (ADL) care. Review of personnel information for Certified Nursing Assistant (CNA) BB revealed she was hired on 5/6/2024. Review of a Corrective Action Form dated 8/22/2024, and signed by the Assistant Director of Nursing (ADON), revealed that several complaints were made about CNA BB's work performance. The form also documented that education was given to CNA BB, and a verbal warning was explained. Review of written statements by facility staff, collected by the ADON in response to the allegation against CNA BB, revealed a statement dated 8/19/2024 from an unnamed Licensed Practical Nurse (LPN), that documented the LPN had heard CNA BB make a comment to RA about taking her bra off and lying in bed with RA. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility documentation revealed there was no evidence that the initial allegation of an inappropriate and/or sexual relationship or behavior, that involved CNA BB and RA was reported to the State Survey Agency. Interview on 10/7/2024 at 1:33 pm, the ADON revealed that a CNA reported to her that CNA BB was spending a lot of time in RA's room, that CNA BB had shaved RA's private area (pubic area), and that CNA BB had been seen hanging out in RA's room, lying across the bottom of the bed watching television with RA. The ADON revealed she spoke with CNA BB about boundaries. The ADON also revealed that CNA BB was educated that staff do not shave resident's private areas. When asked if the concerns raised about CNA BB and RA were of an inappropriate sexual relationship or behavior, the ADON's response was no, not sexual, just that CNA BB was hanging out with RA and spending all of her free time in RA's room. Interview on 10/7/2024 at 3:30 pm with the Administrator, when asked about the facility's abuse coordinator, the Administrator revealed it would be the Social Services Director (SSD) or himself. The Administrator confirmed that the allegation involving CNA BB and RA was not reported to the State Survey Agency. Interview on 10/8/2024 at 4:14 pm, the SSD revealed that she, the ADON, and the Director of Nursing (DON) spoke with CNA BB on 8/22/2024 and explained that shaving of the private area was not a task staff performed. The SSD revealed that she and the ADON also spoke with RA on 8/22/2024, and the resident had no concerns about CNA BB. RA, stated that she and CNA BB had a friendly relationship, that they always talked, and watched television. Interview on 10/22/2024 at 12:58 pm with CNA BB, when asked about the nature of her relationship with RA, CNA BB responded that she was friendly with RA and described herself as a people-person. CNA BB denied any type of inappropriate or sexual relationship with RA. CNA BB confirmed that she did shave RA's private area and that it was at RA's request, and she was not aware that she could not. CNA BB confirmed that she had received education from the ADON on 8/22/2024. Telephone interview on 10/30/2024 at 1:30 pm with the Administrator revealed he also had concerns with the wording of the abuse policy related to the time frame for reporting abuse with or without injury, and within two-hours or 24-hours. He revealed the policy was written by the previous Administrator, and he thought the policy and regulation were awkward to read, and he felt it could be clearer. He expected staff to use the two-hour guideline for reporting abuse. Any incident of abuse, actual, suspected, or alleged, injury or no injury, neglect, exploitation, mistreatment, misappropriation should be reported immediately to the Administrator and no later than two hours to the state agency.

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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	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on resident and staff interviews, record review, and review of the facility's policy titled, Villa Abuse, Neglect, Exploitation, Mistreatment of Individuals, the facility failed to implement thorough protective measures following an allegation of staff to resident abuse. Specifically, the facility failed to remove a staff member from the schedule and allowed the staff member to work in the area where the resident/victim resided during the investigation of abuse, for one of 14 sampled residents (R) (R A). Findings include: Review of the facility's policy Villa Abuse, Neglect, Exploitation, Mistreatment of Individuals dated 8/1/2022, revealed the Procedure portion of the policy included a section on Protection and documented that the facility would take all necessary steps to protect individuals from harm during an investigation and steps may include, but are not limited to the following: suspension of the suspected abuser, reassignment of staff member to another section, reassignment of the individual to another section, transfer of the individual to another facility, and heightened aware of staff. Review of the clinical record revealed that RA admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, cerebral infarction, left non-dominant side hemiplegia and hemiparesis, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that RA was assessed as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. RA was also assessed on the MDS as needing staff assistance for Activities of Daily Living (ADL) care. Review of personnel information for Certified Nursing Assistant (CNA) BB revealed she was hired on 5/6/2024. Review of a Corrective Action Form dated 8/22/2024, which was signed by the Assistant Director of Nursing (ADON), revealed that several complaints were made about CNA BB's work performance. The form documented that education was given to CNA BB and a verbal warning was explained. Review of written statements by facility staff with a date range of 8/19/2024 through 8/21/2024, and collected by the ADON in response to the allegation of inappropriate conduct against CNA BB and RA, revealed a statement dated 8/19/2024 from an unnamed Licensed Practical Nurse (LPN). The statement documented that the LPN overheard CNA BB make a comment to RA about taking her bra off and lying in bed with RA. Review of the Daily Assignment Sheets forms from 8/15/2024 through 8/22/2024, revealed that CNA BB worked the 3:00 pm to 11:00 pm shift on 8/15/2024, 8/16/2024, 8/19/2024, 8/202024, 8/212024, and 8/22/2024, although the facility staff were aware of an allegation of an inappropriate relationship between CNA BB and R A, and they had collected statements starting on 8/19/2024. CNA BB was assigned to RA's hall on 8/16/2024 8/19/2024, 8/20/2024 and 8/22/2024. Review of facility documentation revealed there was no documented evidence CNA BB was reassigned, suspended, or limited access to RA during the facility's investigation. (continued on next page)

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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	Interview on 10/7/2024 at 1:33 pm, the ADON revealed that a CNA reported to her that CNA BB was spending a lot of time in RA's room, that CNA BB had shaved RA's private area (pubic area), that CNA BB had been seen hanging out in RA's room, and lying across the bottom of the bed watching television with RA. The ADON revealed she spoke with CNA BB about boundaries and that CNA BB was educated on 8/22/2024 that staff do not provide shaving of resident's private areas. When asked if the concerns raised about CNA BB and RA were of an inappropriate sexual relationship or behavior, the ADON's response was no, not sexual, just that CNA BB was hanging out with RA and spending all her free time in RA's room. Interview on 10/8/2024 at 4:14 pm, the Social Services Director (SSD) revealed that she, the ADON, and the Director of Nursing (DON) spoke with CNA BB on 8/22/2024 and explained that shaving of the private area was not a task staff performed. The SSD also revealed that she and the ADON spoke with R A on 8/22/2024, and RA had no concerns about CNA BB. RA said they had a friendly relationship and that they always talked and watched television. Interview on 10/22/24 at 12:35 pm, and review of the staff's written statements with a date range of 8/19/2024 to 8/21/2024, the ADON was asked what date she was first notified of a concern with CNA BB and R A. The ADON responded that she did not recall the exact date she was notified initially but confirmed it would have been within a few days prior to the staff's written statements dated 8/19/2024. The ADON revealed that when this incident was first reported to her, she went to the DON that same day to ask if she was aware of anything. The next day she (the ADON) was told by Human Resources to get statements in writing, so she began telling staff to write down and submit their statements. During the interview the ADON confirmed that CNA BB still worked but was not assigned to RA for those first few days. The ADON stated she told staff to switch out RA's room if CNA BB had that hall. Interview on 10/22/2024 at 12:58 pm, when asked about the nature of her relationship with RA, CNA BB responded that she was friendly with RA and described herself as a people-person. CNA BB denied any type of inappropriate relationship or sexual relationship with RA. CNA BB confirmed that she did shave RA's private area and that it was at RA's request, and that she was not aware she could not. CNA BB confirmed that she received education from the ADON on 8/22/2024. When CNA BB was asked if she was taken off the schedule or had a schedule change during the time frame prior to receiving the education from the ADON on 8/22/2024, she responded no.