STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115710	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hill Haven Nursing Home	880 Ridgeway Road Commerce, GA 30529

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the facility policy titled Abuse, Neglect and Exploitation and Misappropriation Prevention Program, the facility failed to protect one of 36 sampled residents (R) (R26) right to be free from physical and verbal abuse by another resident (R30). Findings include: Review of the facility's policy titled Abuse, Neglect and Exploitation and Misappropriation Prevention Program, revised April 2021, revealed the Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The includes but not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. 1. Review of the electronic medical record (EMR) for R26 revealed admission to the facility on [DATE] with diagnoses including Parkinson's disease, anxiety disorder, depression, and suicidal ideations. Review of the quarterly Minimum Data Set (MDS) assessment for R26, dated 01/09/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of the care plan for R26 revealed that she was dependent on staff for meeting emotional, intellectual, and social needs r/t (related to) physical limitations. Further review revealed that she had limited physical mobility r/t neurological deficits, poor balance/coordination, and weakness due to Parkinson's disease. Review of the progress notes for R26 revealed an entry dated 03/16/2026 at 2:15 PM by Social Services documenting that the Social Worker received a report regarding an incident involving R26. The note documented that the Social Worker met with R26, who stated that R30 threw a tray at her, the tray did not hit her, but the food got all over her, and R30 got in her face and stated that she would kill her. R26 stated she did not feel safe and requested that R30 be moved to another room. The note further documented that the Social Worker offered counseling services to R26, notified leadership of the conversation, and it was decided to move R30 to a different room. In an interview on 3/24/2026 at 9:30 AM, R26 stated that R30 had been her roommate since 07/08/2025. R26 reported that R30 engaged in disruptive behaviors, including dumping food and liquids on the floor. R26 stated she had repeatedly requested that the nurses in charge provide R30 with meals in the dining room under supervision; however, the staff continued to deliver meal trays to the room. R26 expressed ongoing concern that R30 will continue entering her room. R26 stated she is at high risk of falls due to an unsteady gait and fears that R30 may push her, which could result in a (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: 115710	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Hill Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 880 Ridgeway Road Commerce, GA 30529	

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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	fall and potential injury. 2. Review of the EMR for R30 revealed admission to the facility on [DATE] with diagnoses that included, but were not limited to, dementia with other behavioral, generalized anxiety disorder, dementia severe with psychotic disturbance, depression, psychosis, and mood [affective] disorder. Review of the quarterly MDS assessment for R30, dated 02/27/2026, revealed that a BIMS was coded as 99, indicating that the interview was not completed or was unsuccessful. The MDS documented that the resident exhibited physical and verbal behaviors toward others for one to three days. Review of the care plan for R30 revealed a focus area, dated 8/15/2024, that the resident has the potential for physical aggression due to anger, dementia, and poor impulse control. A goal was for the resident not to harm herself or others. Interventions included intervening before the agitation escalated. Further review revealed a focus area, dated 8/15/2025, that the resident had the potential to be verbally aggressive due to dementia, ineffective coping skills, and poor impulse control. Interventions included intervening before the aggression escalated. Review of the progress notes for R30 revealed an entry dated 03/16/2026 by Social Services documenting that R30's aggressive behavior toward her roommate (R26) had been reported. The note documented that, according to her roommate, R30 threw her tray and food at her and threatened to kill her. The Social Worker discussed with the Administrator, and it was decided to move R30. The Social Worker spoke with the family about the situation, and the family approved of the relocation while being aware of R30's actions. In an interview on 03/24/2026 at 1:12 PM, Certified Nurse Aide (CNA) BB stated that she was assigned to R26 and R30 on the day of the incident. She stated that she recalled picking up food from the floor in the room. CNA BB stated that food was located between R26's legs in her wheelchair, the food tray was on R26's bed, and R26 was upset. CNA BB stated that R30 said bad words often, and they could be seen as verbal abuse, and she could display physical aggression. In an interview on 03/24/2026, at 12:58 PM, CNA AA stated that R30 was upset, picked up her tray, threw food, and R26 felt frightened due to her Parkinson's disease and her inability to protect herself due to her tendency to lose her balance. CNA AA stated that a month earlier, R30 threw dessert at R26 and had previously hit R26. In an interview on 03/24/2026 at 4:56 PM, CNA EE stated that R30 had made threatening statements to other residents, and most residents identified and voiced these statements as threats. In an interview on 03/24/2026, at 5:27 PM, the Social Service Director (SSD) stated that she was aware of R30 behaviors. The SSD explained that R30 expressed more verbal aggression than physical aggression. The SSD further stated that on 03/16/2026, R30 threatened to kill her roommate and exhibited aggressive behavior in her pursuit. The SSD indicated that she took the threat seriously. In an interview on 03/25/2026 at 1:23 PM, the Medical Director (MD) stated R30's behaviors affect other residents considerably. The MD stated the facility had tried interventions and that R30 was impulsive. The MD stated R30 exhibited mostly verbal aggression and had made threatening statements to residents. The MD confirmed that R30 can exhibit physical aggression and that R26 feared she would be attacked.

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NAME OF PROVIDER OR SUPPLIER Hill Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 880 Ridgeway Road Commerce, GA 30529	

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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. 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 report an allegation of resident-to-resident verbal and physical abuse to the State Survey Agency (SSA) within the required time frame for one of 36 sampled residents. This deficient practice had the potential to place other residents at risk of physical and verbal abuse.Findings include: Review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigating, revised September 2022, revealed the 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. The Reporting Allegations to the Administrator and Authorities section included, .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.3. Immediately is defined as: a Within two hours of an allegation involving abuse or results in bodily injury. 1. Review of the quarterly Minimum Data Set (MDS) assessment for R26, dated 01/09/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of the progress notes for R26 revealed an entry dated 03/16/2026 at 2:15 PM by Social Services documenting that the Social Worker received a report regarding an incident involving R26. The note documented that the Social Worker met with R26, who stated that R30 threw a tray at her, the tray did not hit her, but the food got all over her, and R30 got in her face and stated that she would kill her. R26 stated she did not feel safe and requested that R30 be moved to another room. 2. Review of the quarterly MDS assessment for R30, dated 02/27/2026, revealed that a BIMS was coded as 99, indicating that the interview was not completed or was unsuccessful. The MDS documented that the resident exhibited physical and verbal behaviors toward others for one to three days. Review of the progress notes for R30 revealed an entry dated 03/16/2026 by Social Services documenting that R30's aggressive behavior toward her roommate (R26) had been reported. The note documented that, according to her roommate, R30 threw her tray and food at her and threatened to kill her. The Social Worker discussed with the Administrator, and it was decided to move R30. The Social Worker spoke with the family about the situation, and the family approved of the relocation while being aware of R30's actions. A review of the facility-provided document titled Investigation Summary, dated 03/16/2026, revealed: This incident was not reportable to state as it does not meet the definition of abuse. There was no willful intent to inflict harm, and there was no physical or mental harm. In an interview on 03/24/2026 at 11:05 AM, the Administrator stated that the incident was not reported to the State, as it was determined not to meet the criteria for abuse. The Administrator further stated that only a verbal investigation was conducted, consisting of conversations with several staff members; however, no documentation of the investigation was available for review. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross-Reference F600