STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115728	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archway Transitional Care Center	4373 Houston Avenue Macon, GA 31206

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 - Immediate jeopardy to resident health or safety 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 staff and resident interviews, record reviews and a review of the facility's policies titled Abuse Prohibition - Reporting and Investigating and Abuse Prohibition, the facility failed to protect one Resident's (R) (R1) right to be free from sexual abuse by a resident (R2). Additionally, the facility failed to provide adequate protection for R1 while investigating the allegation of sexual abuse by R2. The facility sample size was 18.On January 12, 2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator, Director of Nursing (DON), and the Divisional Nurse Consultant were informed of the Immediate Jeopardy (IJ) on January 12, 2026, at 10:47 am. The noncompliance related to the IJ was identified to have existed on December 20, 2025.An Acceptable IJ removal Plan was received on January 14, 2026. Based on observation, record reviews, and review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on December 31, 2025.Findings include:Review of the facility policy Abuse Prohibition with a revision date of 4/7/2025, included the definition of sexual abuse as sexual harassment, sexual coercion or sexual assault.Review of the facility policy Abuse Prohibition - Reporting and Investigating with a revision date of 12/27/2024 documented the following procedures will be followed to protect the patient from harm during the investigation: Center will respond immediately to protect the alleged victim and integrity of the investigation; Increased supervision of the alleged victim and residents; At the discretion of the Administrative staff, room or staffing changes may be implemented, if necessary, to protect the resident(s) from the alleged perpetrator.R1 was admitted to the facility on [DATE] with the following, but not limited to diagnoses: major depressive disorder, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cognitive communication deficit, muscle weakness, and contracture of right hand.Review of the admission Minimum Data Set (MDS) assessment for R1 dated 12/23/2025 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment.R2 was admitted to the facility on [DATE] with the following, but not limited to diagnoses: insomnia, major depressive disorder recurrent severe without psychotic features, history of non-suicidal self-harm, and unspecified dementia with psychotic disturbance.Review of the five-day MDS assessment for R2 dated 12/1/2025 indicated the resident had a BIMS score of 2, indicating severe cognitive impairment.Review of the Nurses' Notes for R2 dated 12/20/2025 at 8:05 pm revealed, that Licensed Practical Nurse (LPN) AA was notified by Certified Nursing Assistants (CNA) BB and CC that the resident was standing at the bedside of his roommate with his penis out of his pants and moving his hands in an upward and downward motion while standing near the roommate. The CNAs attempted to redirect the resident, but he refused to move from R1's bedside. Staff asked R2 if he needed to use the restroom. The CNAs pointed (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	out the restroom and attempted to show him where it was, but he refused to enter the restroom. The CNAs guided R2 back to his side of the room while pulling the privacy curtain to divide the room, but the resident snatched the curtain back and sat in a chair at his roommate's (R1) bedside. When LPN AA entered the room, R2 was sitting at the roommate's bedside. LPN AA spoke to R2 about the incident and encouraged him to go to his side of the room, and he did. She asked the resident why he had taken out his private part, and he stated, I didn't do that. The LPN asked R1 whether R2 touched him, whether he pulled his covers back, and he touched the covers, or whether he had done this before. The roommate stated, No!Review of the 12/20/2025 Nurses' Notes further noted that at 8:13 pm, the Administrator and the DON were notified concerning R2 exposing himself. At 8:22 pm, the Sheriff's Department was called. At 8:57 pm, the Sheriff's deputy arrived at the facility, and a report number was given. At 8:57 pm, the Nurse Practitioner (NP) was notified and informed of the incident, who noted initiating behavior protocol and making a psychiatrist referral. At 10:27 pm, the daughter was notified of the incident.Review of the Line of Sight Observation forms from 12/20/2025 to 12/31/2025 revealed, documentation of staff monitoring R2 once every hour.Further review of R2's clinical record revealed, a 12/22/2025 progress note from a Licensed Professional Counselor (LPC) who noted the resident denied remembering any recent inappropriate behavior. The LPC noted they reviewed with the resident the need to comply with facility rules and expectations of respecting others. The resident (R2) expressed understanding. (R2 BIMS of 2)Further review of R2's clinical record revealed, a 12/23/2025 progress note from the Psychiatric NP who noted that staff reported that the resident had exhibited inappropriate sexual behavior and was redirected appropriately and had no recent history of hypersexual behaviors. She further noted that an urinalysis was ordered to rule out a urinary tract infection, and there were no other episodes since the incident. The NP recommended no change to medications and to maintain the current medication regimen. An interview on 12/29/2025 at 12:25 pm with R1 revealed, that his roommate had sat on his bed near the foot of his bed naked from the waist down with his penis in his hand. He did not know what the resident was doing with his penis. R1 stated he told him to go and motioned for him to leave. He stated he did not report the incident to anyone and did not know whether anyone saw what happened. He stated that it was the first time it had happened and that it did not bother him. He confirmed that R2 was still residing in the room with him.An interview on 12/31/2025 at 10:10 am with LPN AA revealed that a CNA came and got her to report that R2 was standing at the chest area next to R1 with his penis out, doing an up and down motion with his hands. She stated the CNAs tried to redirect R2 back to his side of the room and pull the privacy curtain between the two beds, but R2 snatched the curtain back open. When she entered the room, R2 was sitting in a chair on R1's side of the room. With much encouragement, R2 finally went back to his side of the room. She assessed R1and asked him whether R2 had touched him or pulled his covers back, to which R1 replied, no. R1 also denied R2 touching him with his private parts. She stated she called the DON and the Administrator, who instructed her to call 911, which she did. She also called the NP who ordered a psychiatrist referral. She stated that she implemented the one-hour checks and that the DON and the Administrator agreed. LPN AA stated she did not move the resident that night because no male beds were available.An interview on 12/31/2025 at 10:25 am with CNA BB revealed she was making rounds when she saw R2 walking around R1's bed with something in his hand, and he was moving his hand. She wasn't sure what she was seeing, so she called another CNA into the room, who confirmed her observation. CNA BB stated R2 was standing near R1's head with his penis in his hand, masturbating. She was not sure if R1 was awake. She and the other CNA tried to assist R2 to the restroom, but he got angry and then sat down in the chair. She asked R1 if he was ok, then went to get the nurse. She (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated that both residents denied the incident. She checked on the residents every hour, and sometimes more often. They kept the door open and the privacy curtain pulled between the two beds. R2 slept in his bed all night. CNA BB stated that the next morning, she got him (R2) up and dressed, then took him out of the room.An interview on 12/30/2025 at 11:30 am with the Administrator revealed that the hourly monitoring ended on 12/29/2025. She stated she decided to monitor hourly. They did not send the resident (R2) to the emergency room (ER) because the NP did not order it; only a psychiatry referral was ordered. The Administrator stated they moved R1 to a different room on 12/29/2025.An interview on 1/6/2026 at 11:32 am with the DON revealed that the evening staff called her to report the incident. She stated the nurse explained to her everything she put in place and that she was fine with the interventions. She stated that at the time, she thought the hourly monitoring was appropriate because R2 had never had that behavior and was usually a well-mannered man. The DON further revealed that, looking back on it now and moving forward, they would be providing one-to-one supervision in a situation like that, especially since no male beds were available.

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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 reviews, and a review of the facility's policy titled Abuse Prohibition-Reporting and Investigating, the facility failed to report an allegation of physical abuse to the State Survey Agency (SSA) in a timely manner involving two Residents (R) (R6 and R7) from a sample of 18 residents.Findings include: Review of a facility policy titled Abuse Prohibition - Reporting and Investigation with a revision date of 12/27/2024. Under the Reporting section of the Guidelines included all allegations of abuse or allegations involving serious bodily injury must be reported immediately but no later than 2 hours.Review of the clinical record for R6 revealed a Nurse's Note dated 12/12/2025 at 7:36 pm that documented the writer was summoned to the dining room regarding an altercation between a resident and another male resident (R7). Witnesses stated that R6 walked up to R7 and started hitting him in the head. Resident was escorted back to his room for assessment. Writer assessed R6 and noted bleeding from the index finger on the right hand from previous injury. Will continue with plan of care.However, review of the Facility Incident Report Form (FRI) dated 12/13/2025 revealed, the facility documented the date and time of the incident as 12/13/2025 instead of 12/12/2025.Further review revealed the 12/19/2025 follow up report to the SSA noted the incident occurred on 12/13/2025.During an interview with the Administrator on 1/7/2026 at 11:35 am, she stated she was not sure why the FRI was reported late.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interviews, record reviews, and review of the job descriptions for the Administrator and the Director of Nursing (DON), the facility Administration failed to ensure that one Resident (R) (R1) was protected from sexual abuse by a resident R2 and failed to provide adequate protection of R1 while conducting an investigation of an allegation of sexual abuse from R2. The sample size was 18.On January 12, 2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator, Director of Nursing (DON), and the Divisional Nurse Consultant were informed of the Immediate Jeopardy (IJ) on January 12, 2026, at 10:47 am. The noncompliance related to the IJ was identified to have existed on December 20, 2025.An Acceptable IJ removal Plan was received on January 14, 2026. Based on observation, record reviews, and review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on December 31, 2025.Findings include: Review of the undataed job description for the Administrator for Inpatient Services revealed, the summary of the job description noted the Administrator was responsible for directing the day-to-day functions of the Nursing Center in accordance with current federal, state, and local regulations that govern long-term care centers, and as may be directed by the Regional [NAME] President, to provide appropriate care for our patients. The category of Essential Duties and Responsibilities included to operate the Nursing Center in accordance with the established guidelines of the organization and in compliance with federal, state, and local regulations. Also, assumes responsibility for procedural guidelines relative to the prevention and reporting of patient abuse.Review of the undated job description for the DON for Inpatient Services revealed, the summary of the job description noted the DON was responsible for planning, organizing, developing, and directing the overall operation of our Nursing Services Department in accordance with federal, state, and local regulations governing our nursing center, and as be directed by the Administrator and/or the Medical Director, to provide appropriate care.Administration failed to maintain an environment free from sexual abuse and failed to provide adequate protection during the investigation of the alleged sexual abuse for R1.Cross-reference to F600. An interview on 12/30/2025 at 11:30 am with the Administrator revealed that hourly monitoring ended on 12/29/2025. She stated she made the decision to do hourly monitoring. They did not send the resident to the emergency room (ER) because the Nurse Practitioner (NP) did not issue an order to send the resident there. The NP only gave an order for a psychiatry referral. The Administrator stated they moved R1 to a different room on 12/29/2025.An interview on 1/6/2026 at 11:32 am with the DON revealed, that the evening staff called her to report the incident. She stated the nurse explained to her what all she had put in place and that she was fine with the interventions. The DON further stated that at the time, she believed hourly monitoring was appropriate because R2 had never exhibited that behavior and was usually a well-mannered man. She then stated that looking back on it now and moving forward, they would be doing one to one supervision in a situation like that, especially since there were no male beds available.During a subsequent interview with the Administrator and the DON on 1/6/2026 at 12:15 pm, the Administrator wanted to discuss the timeline of the incident. The Administrator summarized what happened and stated she felt as if the facility had done everything they needed to do to keep R1 safe since R2 had never had this behavior before.R1 and R2 continued to reside in the same room from the date of the incident on 12/20/2025 until the surveyor inquired to the Administrator about placement options for the aggressor (R2) on 12/29/2025. R1 was moved to a different room on 12/29/2025.