GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Dean Burke, MD, Commissioner

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

6/30/2026

IMPORTANT NOTICE-PLEASE READ CAREFULLY
SENT VIA INTERNET EMAIL TO:
dana@lighthousepch.com

Dana Robinson, Administrator
279 Haig Mill Road
Dalton, GA 30721

Re: SOUTHERN HAVEN
Notice of Survey Results (NOSR)

Dear Ms. Robinson

On 6/2/2026, **staff** from the ***Department of Community Health (DCH), Healthcare Facility Regulation Division (HFRD), State Licensure PCH Team***, completed a survey of the above referenced facility to assess compliance with Rules and Regulations **Chapter 111-8- 62.**

1. REPORT OF MOST RECENT SURVEY

Based on the survey findings:

_XX_ No violations of the Rules and Regulations of the above referenced Program were cited. Attached is a copy of the Survey Report for your records.

___Violations of the Rules and Regulations for *the above referenced chapter*, were cited. Any cited violations are subject to supervisory review and may be deleted, corrected, or have additional violations added. Any revisions of the survey report will be sent under separate cover along with an amended survey report. If the cited violations have resulting and/or additional enforcement action, this notification will be sent after the allowed period for disagreement.

2. STATEMENT OF DISAGREEMENT

A. If the administrator/provider does not want to dispute the deficiencies cited in the inspection report, pursuant to **Rules and Regulations for *the above-mentioned chapter,*** a Plan of Correction (POC) must be developed and submitted to the Department within 10 days of receipt of this letter.

B. If the administrator or provider disagrees with any of the deficiencies noted in the Survey Report and wishes to contest the findings, they may request an Informal Dispute

Resolution Review (IDRR) by submitting a written Statement of Disagreement (SOD) to the program for review. The SOD must include documentation, witness statements or other evidence showing the deficiency that was cited in error. Failure to submit appropriate evidence will not alter the survey results. The program leadership will review your IDRR and Statement of Disagreement to make a determination. **Note - Additional violations may be cited after reviewing of the Statement of Disagreement.**

(i) If the Department partially or fully agrees with the Statement of Disagreement, the violations noted in the inspection report may be deleted or corrected, potentially leading to a reduction or elimination of pending enforcement actions. A revised survey report will be sent under separate cover reflecting the amended information.

(ii) If the Department disagrees with your Statement of Disagreement, the Adverse Action letter, associated with the cited violations will be sent to you under separate cover. A revised 2567 Survey Report will be sent under separate cover.

3. PLAN OF CORRECTION (POC)*

Pursuant to the General Licensing and Enforcement Rules and Regulations Chapter 111-8-25-.06(6), within ten (10) days of receipt of the inspection report you **MUST** submit a written plan for correcting any rule violations identified. This rule also provides that you may also submit a Statement of Disagreement along with the POC.

The POC shall:

- Identify the methods and procedures to be used in the correction of the deficiencies.
- Identify the dates corrections have or will be completed; and
- Specify how the facility will monitor the corrections to achieve and maintain compliance.

The date by which corrections must be completed shall be **no later than thirty (30) days** from 7/1/2026 . Your POC will be kept on file. It is the facility's responsibility to monitor the effectiveness of the POC. The POC will be reviewed in addition the program may conduct a follow-up inspection, as necessary.

Please submit the Plan of Correction to the program through the portal link provided in a separate email. The portal may also be accessed at https://gahles.dch.georgia.gov

4. ENFORCEMENT ACTION

Pursuant to the Rules and Regulations for Enforcement of General Licensing and Enforcement Requirements, R&R Chapter 111-8-25, the Department may impose a sanction for the violation of any rule. Notice to the governing body regarding the imposition of a sanction will be sent under separate cover after the period to submit a Statement of Disagreement has expired or after the written notification of the program's decision of the Statement of Disagreement has been communicated to the administrator/provider. Failure to correct violations or failure to maintain

compliance once corrections are made may result in further sanctions, including revocation of your permit.

5. POSTING OF THE INSPECTION REPORT

DCH-HFRD Rules and Regulations require that the most recent inspection report and POC must be displayed in the home in a location that is routinely used to communicate information to the residents. If the community maintains a website, it will post a web link on the main page, to provide access to copies of the inspection reports and POC for the previous 18 months. The attached survey report will be on file and will be available online at https://forms.dch.georgia.gov/HFRD/ .

If we may be of assistance, please do not hesitate to call or email.

Sincerely,

Elizabeth Thomas

Elizabeth Thomas, Compliance Specialist III, QA State Programs
State of Georgia, Department of Community Health
Healthcare Facility Regulation Division
Personal Care Home Program
17th Floor, 2 Martin Luther King Jr Dr SE, East Tower
Atlanta, GA 30334

Enclosures

cc: Facility File

[1] The Plan of Correction (POC) may also be mailed to the undersigned at 2 Martin Luther King Jr. Drive SE, East Tower, Atlanta, GA 30334.

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED:
	PCH002478	A. BUILDING B. WING:	6/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN HAVEN	279 HAIG MILL ROAD DALTON GA 30721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
JSZ6 0000	0000 - Opening Comments. The purpose of this visit was to investigate allegation intake GA50011450. An on-site visit was made on 6/2/2026, and the investigation was completed on 6/11/2026. No rule violations were cited as a result of this investigation.

HFR
Healthcare Facility Regulation

Resident/Participant Identifiers

Facility Name:	Southern Haven	**Provider Number:**	PCH002478
Surveyor(s):	Nazila Aghazadeh	**Survey Exit Date:**	6/2/2026

	Resident/Participant Name	Phone Number	Notes
R1.			
R2.			
R3.			
R4.			
R5.			
R6.			
R7.			
R8.			
R9.			
R10.			
R11.			
R12.			
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R14.			
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R17.			
R18.			
R19.			
R20.			
R21.			
R22.			
R23.			
R24.			
R25.			
R26.			

Additional Notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED:
	PCH002478	A. BUILDING B. WING:	**9/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN HAVEN	**279 HAIG MILL ROAD** **DALTON GA 30721**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	0000 - Opening Comments.
JSZ6 0000	>>>>The purpose of this visit was to conduct a re-licensure. This inspection started on 9/26/25 and was completed on 9/26/25. No rule violations were cited as a result of this inspection.

Dear Department of Community Health,

Please accept this letter as Southern Haven's formal statement of disagreement and request that Citation # JSZ6 1507SS=D issued on January 8, 2025 from an inspection dated December 3, 2025 for alleged noncompliance with Rule 111-8-62.15(2) 1507 be rescinded.

The resident was admitted under emergency circumstances due to the family's immediate concern that the resident's prior living arrangement could no longer meet his care needs. Because this resident was admitted under a previous administrator, all documentation present in the resident record at the time of inspection was provided in full transparency, including preliminary notes generated prior to the in-person functional assessment. Provider evaluations occasionally use terminology that requires clarification when applying regulatory definitions related to personal care home scope of services. At the time of the resident's admission, the administrator LaRay Ramey determined that the resident's prior setting was no longer appropriate to meet his functional and care needs and the family expressed concern that the resident's prior care setting may not have supported optimal functional independence. The resident demonstrated to the administrator that he was able to stand and pivot with assistance, follow commands, understand emergency evacuation instructions and participate appropriately. Because the administrator completed an in person assessment and deemed his abilities appropriate based on Rule 111-8-62-.03 as a resident able to self propel a wheelchair and pivot for transfers, preliminary telephone notes were superseded by the administrator's in-person functional assessment, which governed the admission determination.

The resident was admitted under the emergency admission provisions of Rule 111-8-62-.15, with the required provider evaluation scheduled and completed within the allowable timeframe. Please see the attached letter by Amy Walka, CRNP explaining her reasoning for ordering assistive devices. At the time this equipment was ordered, the resident was able to participate in his care, including transfers and emergency response consistent with personal care home requirements. Over the course of his stay at Southern Haven, his Parkinson's disease has advanced. He is still able to appropriately voice care needs and pain and participate in his care; however, the use of assistive devices has shifted to weight dependence due to increased pain and signs of developing contractures with the progression of his disease process noted September 2024 (4 months after his admission, not prior to admission).

He was reclassified to "aging in place status" June 2025 with confirmation from the previous manager, Brittany Walker that notification of his aging in place status was hand delivered to the fire department on July 7, 2025 (a screenshot of this statement has been previously provided.) Under the current rule, we did not see a requirement for signature receipt of the notification to the fire department simply that we needed to notify them of any residents deemed aging in place. While we understand the benefit of having such documentation as proof of delivery, notification to the local fire department was delivered consistent with facility practice. While a signed receipt was not initially retained, written confirmation was obtained upon request. We assure you, moving forward, obtaining a signed copy for our records is our updated protocol moving forward. The primary care provider has been recommending hospice to his daughter since late 2024/early 2025. He currently is able to respond correctly and hold meaningful conversations. He also is still to date able to assist with care needs including participation in dressing including but not limited to combing his hair, putting on his hats, using his upper body with fine motor assistance and choosing attire. He often will ask staff to please take him to his bed because his bottom gets sore sitting for long periods of time. The inspector notes that he was not able to answer her questions but I wanted to explain his personality & normal behavior patterns so that it can be noted that he is not only capable of answering questions appropriately and he verbalizes care needs but will choose to not reply. The resident is capable of appropriate communication and decision-making but may decline engagement at times, which is consistent with his baseline behavior pattern.

We understand that the department is concerned with a resident's ability to exit in case of an emergency situation. Not only have we been completing monthly fire drills but on February 2, 2025 we had a fire threat. An outside fire occurred on one of the air conditioning units outside (no damage or building involvement). Because the fire was external, fire detection devices were not triggered to automatically engage but staff identified a potential threat and acted accordingly. Staff immediately sounded the alarm and exited all residents per protocol. Staff successfully evacuated all residents promptly and safely during an actual emergency event, demonstrating functional evacuation capability. While this resident often declines participation in fire drills, he has participated at times, participating in the November 2025, December 2025 and January 2026 drills (copies attached). In addition, we have advised staff that because he is aging in place, he must participate to prove that we are able to safely exit him from the building. Southern Haven conducts and documents monthly fire drills. When a resident declines participation, staff document the refusal and adjust emergency planning accordingly to ensure resident safety. We educate any resident to the need for participation and adjust plans & protocols accordingly to anticipate challenges that may arise in the event of a real fire event. Additionally, when residents refuse participation for some staff and not other staff, additional education has also been given to the staff member with techniques to encourage participation.

Additionally, we have 24/7 awake staff. While we have one awake staff member at night in the care home portion of the building, we have an apartment space downstairs where a live-in caregiver is on call for emergency situations. We have housed a 2nd staff member allowed to sleep during the night since 2021 prior to Richard Harrison's or any other resident needing this second person assistance during the night. Southern Haven maintains continuous overnight coverage, including an awake staff member on duty and an additional on-call staff member residing onsite for emergency response. This staffing model has been in place since prior to the resident's admission. Staff may utilize non-emergent 911 assistance to assist with residents when needed which is part of our standard protocols. During a brief period of apartment repair in November 2025, staff were to contact the on call manager if additional assistance was needed.

Southern Haven uses additional tools and equipment to ensure residents safety is a top priority. We utilize both pressure pads that alert staff if a resident changes position or gets up from their bed (or chair if they are in a wheelchair). Additionally, we utilize CarePredict which also alerts in real time if a resident falls. Additionally, this system allows residents to call for staff assistance and for time capture of response time.

Regarding scheduled staff, our schedule system is set up to depict a 7am to 7pm and 7pm to 7am schedule. We schedule two awake staff during the dayshift 7am to 7pm and one awake staff during the night shift 7pm to 7am. Since we have an apartment space downstairs with an asleep staff member on call for emergencies during the night shift, we do not post that schedule. To clarify, all staff are scheduled 7am to 7pm or 7pm to 7am unless special arrangements are made (sometimes staff will split a shift when needed). However, staff B often has conflicts with working the entire shift due to personal childcare needs. We are flexible with her schedule and other team members often assist her with these special circumstances by coming in early or staying late for her when she has to leave or arrive later. She is scheduled 7am-7pm but often arranges with other staff members when she comes in later or if she has to leave early, sometimes this resembles 8a-5pm of her clocked in hours while other staff members make up the gapped time difference. Staff B is the only staff member who deviates from the 7am-7pm schedule on a predictable basis with childcare needs and she only deviates when necessary. The information that we schedule from 7am to 7pm for only one caregiver and the second staff member 8am-5pm each day is not accurate. Again, staff B has special circumstances that we accommodate by bringing in other staff members early and late as needed.

Please note that staff A, Dana Robinson, is an owner of Southern Haven. While she was the administrator on record in the last quarter of 2018 following change of ownership, several administrators have been employed between 2019-2025. LaRay Ramey was the administrator for Southern Haven from October 2022-June 30 2025. Following LaRay Ramey's departure, Dana Robinson filled in as an interim administrator until a suitable

replacement could be identified. The facility has been actively interviewing for a permanent administrator. As an owner, I consider myself a director of all operations but want to clarify, I have not been in an active director employee role on going while other administrators have been employed.

All staff are adequately trained as proxy caregivers and on any equipment including emptying foley catheters when appropriate, medication assistance, transfers, hoyer lifts when applicable, etc. Each of these skills are trained and checked off by return demonstration utilizing the medication and non medication HMA forms as appropriate. We provide training during the new hire training period, on an annual basis and any time additional training is identified. Both staff B & staff C were not only trained when they were hired but participated in the last annual hoyer training on 01/14/2025. In addition, staff are constantly reminded to report any equipment that requires repair or malfunctions or any potentially hazardous situation. This is not only discussed and recorded during the initial onboarding process but also listed in the employee handbook which employees are required to sign that they have read, understand and will follow the rules, policies & procedures, protocols, etc. While I understand that sometimes employees get nervous when inspectors are present and do not know what to say or say things out of fear of getting in trouble, we have adequate documentation proving that appropriate training was provided on the use of a hoyer lift both on non medication HMA forms and by employees signing the handbook. Staff are trained and competent in the use of assistive equipment, with documented training and return demonstrations. Staff A personally assisted two other staff members with the hoyer with resident 1 on November 21, 2025 and November 22, 2025. At that time, the equipment was in full working order and both staff members, Kelly Horton & Allie McCormack each correctly and safely operated the equipment with the legs in the full open position. In addition, Staff A educated these staff members on the sling positioning for going from bed to chair versus chair to bed. The opportunity for questions was given and additional information was provided to all staff by house manager, Kelly Horton.

Southern Haven takes the safety and care of our residents very seriously and strives to go above and beyond minimum standards. We utilize extensive training, equipment/technology to give our residents and staff improved care and outcomes. We understand the concern with documentation in the resident's file that reflected preliminary information prior to the in-person assessment. We assure you that resident 1 was admitted to Southern Haven under an emergency circumstance, contingent on the medical providers assessment within the 14 day window. His disease process progressed to an aging in place situation. The PCP, physical therapist, previous manager, and previous administrator discussed the need for hospice care multiple times over the year. The current administrator, staff A was under the impression resident 1 was already on hospice at the time he was deemed aging in place. When Staff A learned he was not aging in place, she also began discussing the requirements for aging in place at Southern Haven with the care team and the family. The daughter decided on a hospice December 2025. An updated signed notification to the fire department was signed and delivered December 3, 2025.

Based on the above, Southern Haven respectfully requests that Citation #JSZ6 1507SS=D for Rule 111-8-62-.15(2) be rescinded, as the evidence demonstrates that this event did not meet the regulatory definition of a resident who did not meet the qualifications to be admitted.We admitted the resident under emergency circumstances due to an urgent need for placement, not due to a determination of abuse or neglect. At all times, Southern Haven prioritized the resident's safety, timely medical evaluation, and family communication.
As always, thank you for everything you do to keep our residents and all seniors in Georgia safe and properly cared for.

Respectfully,

Dana Robinson

Plan of Correction

111-8-62-.15(2) 1507 - Admission

Corrective action for affected resident

Resident A family discussed interviewing hospice companies on December 3, 2025 and resident A's daughter decided on a hospice on December 10, 2025. Resident was admitted on December 12, 2025.

Identification of others at risk

No other residents had admission issues present.

Systemic Changes

Staff were trained on reporting broken equipment timely. New hoyer was provided and staff were trained on how to properly use new equipment. Visuals were laminated and posted in resident room and med room for hoyer use quick guide December 3, 2025.

Policy and Procedure

Policies were updated to include new hoyer lift and training for specific lift. In addition policies were updated to include obtaining a signature for aging in place and bringing a copy back from the fire department. All information will be reviewed and monitored for the next 3 months and evaluated if further training or education is needed.

Re: Request for Reconsideration of Citation – Rule 111-8-62-.30
Citation Date: December 3, 2025
Citation #: JSZ6 3004 SS=D

Dear Department of Community Health,

Please accept this letter as an official statement of disagreement and request to rescind the citation from December 3, 2025. Rule 111-8-62-.30 states that a serious incident must be reported within 24 hours; however, based on the clinical assessment of the care team involved with this resident's care this was not viewed as a serious incident but a natural occurrence of end stages of multiple disease processes including osteoporosis and dementia.

Because section 2a states that any accidental or unanticipated death of a resident not directly related to the natural course of the resident's underlying medical condition must be reported, the same logic disqualifying something related to the natural course of the resident's underlying medical condition was applied in this interpretation. Southern Haven interpreted subsection (2)(b) in light of subsection (2)(a), which distinguishes reportable events from those arising from the natural course of disease. This resident's need for medical treatment was not derived from an external injury but a natural advancement of her underlying medical condition.

Resident EJ was a resident of Southern Haven since 2013, prior to current ownership. Over the years, her multiple disease processes have naturally progressed including a stroke in 2021 which further progressed her dementia symptoms. In 2023 she suffered a fall that resulted in a broken bone and surgery. She had osteoporosis at this time so it is not certain if the fall caused the break or if the break caused the fall. She stood up from the dining table and fell to the floor. Regardless, staff witnessed the event, documented appropriately and reported timely. Once we learned there was a break involved with the fall, we followed protocol and reported the incident to the Department of Community Health within the 24 hour time frame. Because this resident is living with dementia, she was discharged 4 days post-op with the support of outpatient physical and occupational therapy through the Weston Group. Her daughter, Karen Phillips felt like she would be more inclined to participate in therapy with familiar care staff to encourage her and support the physical and occupational therapists rather than the unfamiliar setting and care staff at a rehab facility. She had a remarkable recovery and continued residing with Southern Haven.

Over the last decade, she has gone on and off hospice services as her care needs have required/suggested. At times she was more or less qualified for hospice support. Her disease processes continued to advance. In February 2025 she was re-admitted to hospice with clear advancement in her disease processes. Her disease process advanced to the point of it being extremely unlikely to see improvement to no longer qualify or benefit from hospice support.

October 6, 2025, redness was noted by her hospice aide. Upon learning of this redness, we did an internal investigation by interviewing night staff and day staff. No redness was reported or noted during the shift change report that morning. We reviewed documentation and supportive technology including pressure sensing pad technology that alerts when a person's weight shifts i.e. if someone comes off the pad or changes positions. Staff adamantly denied any alerts the night prior or any signs or symptoms of pain or distress at any point. Staff reported normal participation and reactions to care staff assistance. In addition, we utilize CarePredict technology which is a wearable device that reports falls in real time as well as how long staff are interacting with residents and responding to alerts. Upon reviewing these technology reports, no fall was indicated and the night staff responded and provided adequate care. Two hour rounds were confirmed both with video

surveillance and care interaction reports from the wearable technology we utilize. Upon learning of the redness, we immediately requested the hospice nurse to evaluate and communicated with the resident's daughter who also came to assess her mother. Within a few hours it was decided for the resident to be transferred to the hospital for additional evaluation and imaging considering her history. There was zero indication that any abuse, neglect or even an external event occurred outside of normal disease progression. At the time the redness was identified, the facility had no evidence of trauma, fall, or injury of unknown origin. Based on contemporaneous clinical information, staff reasonably believed this presentation was related to disease progression rather than an acute injury requiring immediate incident reporting under Rule 111-8-62-.30(2)(b). Imaging was obtained in the hospital and a break was detected. At this point, hospice services were terminated and the resident underwent a surgery. The surgeon confirmed based on reviewing the imaging that the resident's bone was "eaten up with osteoporosis". The daughter communicated with us that the surgeon said the bone was "splintered"and happened within less than 24 hours. We collaborated with the hospice and physical therapy group that worked with her in the past. The physical therapy group contact, Jill Spear, confirmed that with severe cases of osteoporosis they have seen where there is no fall or imposed/external injury other than a possible explanation of a foot hooked on the adjacent leg or in a sheet and the "right amount of torque" results in a bone splintering just in this manner. Even just the weight of their own body can cause such breaks in severe osteoporosis cases. Following surgery, the resident was returned to our care the next day following surgery. While we expected a four day post op observation in the hospital, we welcomed her back to a familiar place that recognized her non-verbal cues and needs for care whenever the hospital deemed it appropriate for discharge. Collaborating with Willowbrook hospice, the nurse practitioner who cared for her prior to hospice services (Amy Walka), and the Weston physical therapy group who cared for her previously, she was off hospice for a couple of weeks to evaluate the progress she would make with therapy. The therapist created transfer videos to educate staff with her increased care needs. On October 21st her daughter and care team decided to stop therapy and return to hospice care. With extensive collaboration and internal investigation at the onset of symptoms, immediate proactive action by staff and all care teams, and post surgery, it was deemed by all care teams involved that the break was not the result of an external injury or injury of unknown origin but a result of complications from osteoporosis.

Again, at the time the redness was identified, there was no evidence of an acute injury, fall, or trauma, and the facility reasonably believed this represented disease progression rather than a new, acute injury triggering immediate reporting under 111-8-62-.30(2)(b). Care team members viewed this similarly to other advanced disease complications that routinely require hospitalization but are not typically treated as reportable incidents absent evidence of trauma or neglect. This is also evidenced by the fact that we reported the injury following a fall in 2023. The facility's use of pressure sensing pads, wearable fall detection technology, and documented two-hour rounds demonstrates that Southern Haven maintained appropriate supervision and timely assessment of the resident, further supporting that this was not a preventable or reportable injury under the rule.

Based on the above, Southern Haven respectfully requests that Citation #JSZ6 3004 SS=D for Rule 111-8-62-.30 be rescinded, as the evidence demonstrates that this event did not meet the regulatory definition of a reportable serious incident under subsection (2)(b). We recognize that some facilities may elect to report all fractures regardless of cause; however, Southern Haven interpreted Rule 111-8-62-.30(2)(b) to apply to injuries arising from accidents, trauma, abuse, neglect, or unknown causes — not to complications clearly attributable to advanced disease, as in this case. We recognize that Rule 111-8-62-.30(2)(b) does not explicitly differentiate between traumatic and disease-related injuries, and that facilities may reasonably interpret its application differently. At all times, Southern Haven prioritized the resident's safety, timely medical evaluation, and family communication.

As always, thank you for everything you do to keep our residents and all seniors in Georgia safe and properly cared for.

Respectfully,

Dana Robinson, RN
Director of Operations
Southern Haven

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED:
	PCH002478	A. BUILDING B. WING:	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN HAVEN	279 HAIG MILL ROAD DALTON GA 30721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
JSZ6 0000	0000 - Opening Comments. The purpose of this visit was to investigate intake GA50007028. The investigation began on 12/3/25, an onsite visit was made on 12/3/25, and the investigation was completed on 12/5/25.
	111-8-62-.15(2) 1507 - Admission. No home is permitted to admit or retain a resident who needs care beyond which the home is permitted to provide. This RULE is not met as evidenced by: >>>>Based on observation, record review, and staff interviews, the facility failed to ensure that a was admitted or retained who needed care beyond which the home was permitted to provide for 1 sampled Resident (Resident #1) The findings included: On 12/3/25 at 9:30 a.m., during a general tour of the facility, Resident #1 was observed in a hospital bed, with full metal side rails in the down position. Equipment included a fall mat, a mechanical lift, and a full-body reclining chair with wheels and wheel locks. Resident #1 was unable to answer any questions. The record review showed Resident #1 was admitted to the facility on 5/6/24. Resident #1's preadmission screening assessment dated 5/3/24 stated the resident was "Total assist/non-weight bearing." Additionally, handwritten notes documented “2-3 person assisted”. Resident 1's preadmission screening documented Resident 1 needed 2-3 person assist and was unable to stand or pivot on own. Record review of the Physician Medical Evaluation (PME) form dated 5/3/24 documented Resident #1 required total help for ambulating, bathing, dressing, grooming, and transferring. The PME documented that Resident #1 was unable to ambulate, required staff assistance during the night, and required 24-hour nursing supervision. The form was completed and specified to return to the current facility director.

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111-8-62-.15(2) JSZ6 1507 SS=D	Record review of a second PME, provided by the director dated 5/20/24, documented that resident needs could safely be met "only with a Barton chair (a specialty medical transport and positioning chair designed for patients who cannot safely transfer for non-ambulatory patients), Hoyer lift, hospital bed with trapeze, and aggressive therapy". Record review of the individual service plan for Resident #1, dated 8/11/25, specified that Resident #1 was a "multi-person assist" for transfers. Record review of the facility staff schedule for October, November, and December showed one staff person worked in the facility from 7:00 p.m. to 7:00 a.m., 7 days per week. On 12/3/25 at 10:58 a.m., during an interview, Staff B stated two staff work day shift, one person from 7:00 a.m., and a second staff member from 8:00 a.m. to 5:00 p.m. Staff B stated there is only one staff person in the home overnight. Staff B stated Resident #1 was total care and required the Hoyer lift to get out of bed. Staff B stated Resident #1 doesn't like to be out of bed for long. On 12/3/25 at 12:00 p.m., Observation of Staff B and Staff C assisting Resident #1 out of bed by Hoyer lift. Both staff members stated they had not had training to use the Hoyer lift since being employed at the home. Neither staff member opened the base of the legs of the Hoyer (which could cause tipping of the lift) once the resident was raised in the lift and transferred to the reclining chair near the door. Both staff members stated that if there were not two staff members on duty at the facility, they would not be able to get the resident out of bed. Both staff stated the resident was not on hospice and did not know where the Hoyer came from but had been here for quite some time. The Hoyer bar that was used to open the base of the legs was broken. Staff said they can only open the base by kicking it. On 12/3/25 at 2:00 p.m., during a telephone interview, Staff A stated there was only one person on duty at night and that if Resident #1 needed assistance during the night, staff could call for non-emergency EMS to help assist. Staff A stated the facility was working towards having a live-in, in the basement, that will be a second person if needed. On 12/5/25 at 5:00 p.m. Staff A stated he/she was not the Administrator that did the assessment and was not involved with Resident #1's admission but confirmed he/she was the director of the facility. Staff A stated he/she thought the resident would be allowed to remain in the facility as an aging-in-place resident and notified the fire department on 12/3/25. Staff A stated he/she was unaware that evacuation was required during fire drills, as Resident #1 was documented to have refused to evacuate during prior fire drills.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN HAVEN	279 HAIG MILL ROAD DALTON GA 30721

111-8-62-.30(2)(b) JSZ6 3004 SS=D	111-8-62-.30(2)(b) 3004 - Reporting. The serious incidents that must be reported to the Department include the following: ... (b) Any serious injury to a resident that requires medical treatment. This RULE is not met as evidenced by: >>>>Based on record review and staff interview, the facility failed to ensure that any serious injury to a resident that required medical treatment was reported to the Department for 1 resident of 1 sampled resident (Resident #2). The findings included: Record review of the Physician Medical Evaluation form dated 8/2/13, diagnoses were Hypertension, Dementia, Diabetes, and Anxiety. Resident #2 required a walker as needed. Resident #2 was independent with Ambulating, bathing, dressing, eating, grooming, toileting, and transferring. Record review of the facility provided status report showed Resident #2 was transferred to the hospital for possible dislocation of the the hip on 10/6/25 at 5:29 p.m. The report documented Resident #2 returned from the hospital after hip surgery on October 08, 25, at 7:51 p.m. Record review of the facility incident report dated 10/6/25 showed the resident had an injury in his/her bedroom. The incident description noted Resident #2 had redness, pain, and swelling to his/her right hip. Resident #2 pain score was documented as 9-10. The incident report documented that the resident was unable to answer questioning about what happened. The incident report documented the resident's legs likely tangled, and the “torc” caused the bone to splinter. The report documented Resident #2 experienced a change in condition and was reclassified to aging in place because he/she were unable to bear weight on that leg to assist with pivot transfers. On 12/5/25 at 5:30 p.m., during an interview, Staff A stated Resident #2 was in bed, and her leg must have been tangled. Resident #2 went to the hospital, had surgery. We were told by the family that Resident #2 had Osteoporosis. Resident #2 was able to turn and move in bed and could transfer and walk short distances prior to the fracture. Resident #2 was admitted to hospice on 10/22/25. Resident #2's fracture was not reported to the Department because there was no fall. Staff A stated the PME was not updated following the change in condition and hospitalization.

Resolution Review (IDRR) by submitting a written Statement of Disagreement (SOD) to the program for review. The SOD must include documentation, witness statements or other evidence showing the deficiency that was cited in error. Failure to submit appropriate evidence will not alter the survey results. The program leadership will review your IDRR and Statement of Disagreement to make a determination. **Note - Additional violations may be cited after reviewing of the Statement of Disagreement.**

(i) If the Department partially or fully agrees with the Statement of Disagreement, the violations noted in the inspection report may be deleted or corrected, potentially leading to a reduction or elimination of pending enforcement actions. A revised survey report will be sent under separate cover reflecting the amended information.

(ii) If the Department disagrees with your Statement of Disagreement, the Adverse Action letter, associated with the cited violations will be sent to you under separate cover. A revised 2567 Survey Report will be sent under separate cover.

3. PLAN OF CORRECTION (POC)*

Pursuant to the General Licensing and Enforcement Rules and Regulations Chapter 111-8-25-.06(6), within ten (10) days of receipt of the inspection report you **MUST** submit a written plan for correcting any rule violations identified. This rule also provides that you may also submit a Statement of Disagreement along with the POC.

The POC shall:

- Identify the methods and procedures to be used in the correction of the deficiencies.
- Identify the dates corrections have or will be completed; and
- Specify how the facility will monitor the corrections to achieve and maintain compliance.

The date by which corrections must be completed shall be **no later than thirty (30) days** from 7/1/2026 . Your POC will be kept on file. It is the facility's responsibility to monitor the effectiveness of the POC. The POC will be reviewed in addition the program may conduct a follow-up inspection, as necessary.

Please submit the Plan of Correction to the program through the portal link provided in a separate email. The portal may also be accessed at https://gahles.dch.georgia.gov

4. ENFORCEMENT ACTION

Pursuant to the Rules and Regulations for Enforcement of General Licensing and Enforcement Requirements, R&R Chapter 111-8-25, the Department may impose a sanction for the violation of any rule. Notice to the governing body regarding the imposition of a sanction will be sent under separate cover after the period to submit a Statement of Disagreement has expired or after the written notification of the program's decision of the Statement of Disagreement has been communicated to the administrator/provider. Failure to correct violations or failure to maintain

compliance once corrections are made may result in further sanctions, including revocation of your permit.

5. POSTING OF THE INSPECTION REPORT

DCH-HFRD Rules and Regulations require that the most recent inspection report and POC must be displayed in the home in a location that is routinely used to communicate information to the residents. If the community maintains a website, it will post a web link on the main page, to provide access to copies of the inspection reports and POC for the previous 18 months. The attached survey report will be on file and will be available online at https://forms.dch.georgia.gov/HFRD/ .

If we may be of assistance, please do not hesitate to call or email.

Sincerely,

Elizabeth Thomas

Elizabeth Thomas, Compliance Specialist III, QA State Programs
State of Georgia, Department of Community Health
Healthcare Facility Regulation Division
Personal Care Home Program
17th Floor, 2 Martin Luther King Jr Dr SE, East Tower
Atlanta, GA 30334

Enclosures

cc: Facility File

[1] The Plan of Correction (POC) may also be mailed to the undersigned at 2 Martin Luther King Jr. Drive SE, East Tower, Atlanta, GA 30334.

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED:
	PCH002478	A. BUILDING B. WING:	6/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN HAVEN	279 HAIG MILL ROAD DALTON GA 30721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
JSZ6 0000	0000 - Opening Comments. The purpose of this visit was to investigate allegation intake GA50011450. An on-site visit was made on 6/2/2026, and the investigation was completed on 6/11/2026. No rule violations were cited as a result of this investigation.

HFR Healthcare Facility Regulation

Resident/Participant Identifiers

Facility Name:	Southern Haven	Provider Number:	PCH002478
Surveyor(s):	Nazila Aghazadeh	Survey Exit Date:	6/2/2026

	Resident/Participant Name	Phone Number	Notes
R1.			
R2.			
R3.			
R4.			
R5.			
R6.			
R7.			
R8.			
R9.			
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R23.			
R24.			
R25.			
R26.			

Additional Notes