STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115273	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglasville Center for Nursing and Healing LLC	4028 Hwy 5 Douglasville, GA 30135

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff and resident interviews, and review of the facility policy Discharge and Transfer Policy, the facility failed to ensure that treatment was provided in a timely manner following a right hip fracture for one of three residents (R1). Actual harm was identified on 8/24/2025 when R1 fell and suffered a right hip fracture that was not recognized until 8/25/2025 when the resident was sent to the hospital and had to undergo surgery for an intertrochanteric fracture of the right hip.Findings include:A review of the facility policy titled Discharge and Transfer Policy, revised 7/18/2025, did not reveal details regarding emergency transfers.Review of the electronic medical record (EMR) for R1 revealed diagnoses including, but not limited to, cerebral infarction affecting the dominant right side; muscle weakness; Difficulty in walking; not elsewhere classified; altered mental status, and history of falling.Review of the most recent Annual Minimum Data Set (MDS) dated [DATE] documented that R1 had a Brief Interview for Mental Status (BIMS) score of 12, indicating some cognitive impairment.Review of the care plan dated 10/19/2024 revealed that R1 was at risk of injury due to falls.Review of the Nurses Notes dated 8/24/2025 at 4:14 pm that the R1 was heard yelling out for help, and on arrival was observed on the floor, lying on her right side next to the bed. As soon as possible, an X-ray of the right femur/hip and skull series was ordered.A review of an X-ray report completed at the facility on 8/24/2025 and signed by a physician at 1:08 pm revealed impression: questionable nondisplaced fracture of the right femoral neck. Correlate clinically and follow up with a dedicated hip exam.Review of the Nurses Notes dated 8/25/2025 at 3:45 pm revealed that R1 was sent out to the hospital by Emergency Medical Services (EMS) at 9:47 am due to signs and symptoms of pain.Review of the Hospital Discharge summary dated [DATE] revealed that R1 was admitted to the hospital on [DATE] with a fractured right hip, and surgery was performed.Interview on 10/27/2025 at 11:59 am with a Licensed Practical Nurse (LPN) AA and Registered Nurse (RN) CC on the Central Unit, where the resident resides, revealed that when a resident falls, the usual procedure is to send them out to the hospital. Both LPN AA and RN CC reported that when a resident who is immobile falls, they would use a mechanical lift to remove the resident from the floor, notify the doctor, and obtain an X-ray if ordered.Interview on 10/28/2025 at 11:30 am with R1 revealed that she remembered the night she fell and broke her femur. She stated that she did not know why they did not send her that night. R1 stated that she did get pain medication.Interview on 10/28/2025 at 12:00 pm with the Director of Nursing (DON) stated that she has always told her staff that if they have any doubt, then send the resident out. The DON revealed that the information on the X-ray was dated Sunday afternoon, and the physicians were not in the office at that time. The electronic signature and time and date from the computer on the X-ray form are dated 8/24/2025 at 2:37 p.m. She revealed that the Nurse Practitioner (NP) assessed R1 the next morning.Interview on 10/28/2025 at 12:05 pm with Unit Manager Registered Nurse (RN) BB revealed that on the morning of 8/25/2025, she called the night shift nurse, LPN AA, to ask why R1 had not been sent to the hospital. RN BB stated that the LPN AA reported to her that she had made numerous calls to the physician and nurse practitioner with no reply. RN BB stated there were two x-rays in the chart: one showing no fractures but not imaging the femur, and the second showing the femur with a displaced fracture, received on 8/24/2025 at 2:37 pm by fax machine, with NP signature stating to send R1 out.Interview on 10/29/2025 at 9:52 am with NP DD revealed that she was not in the facility on 8/24/2025, but she was notified of R1's fall when it occurred. NP DD stated that she ordered X-rays and instructed the nurse to notify the on-call physician, as she was not on call. She revealed that on 8/25/2025, she reviewed the X-ray report and dated it 8/24/2025. NP DD revealed she assessed R1 on the morning of 8/25/2025, and R1 was in excruciating pain, and she was sent out to the hospital on Monday morning, 8/25/2025.Phone interview on 10/29/2025 at 1:30 pm with the Medical Director (MD) EE of R1 who revealed that his policy on any fall or injury in the facility would be to order an X-ray if required and await the results prior to immediately sending out, unless the resident was assessed and had pain, tenderness then he expected the resident to be sent out immediately if injured.