STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115275	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A.G. Rhodes Home, Inc, The	350 Boulvard, S.E. Atlanta, GA 30312

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of the facility's policy titled Production, Purchasing, and Storage, the facility failed to ensure that opened food items in the reach-in refrigerator area were labeled, dated, and discarded by the expiration date. The census was 127.Findings included:A review of the facility's policy titled Production, Purchasing, Storage procedures revealed that most, but not all, products contain an expiration date. The words sell-by preceded the date. The sell-by date is the last date that food can be sold or consumed; do not sell products in retail areas or place them on patient trays/resident plates past the date on the product. Foods past the use by, sell-by, best-by, or enjoy by date should be discarded. Cover, label, and date unused portions and open packages. Use the (specific) labeling system or complete all sections on an. orange label. Products are good through the close of business on the date noted on the label. Refer to the Food Storage Chart in this policy to determine discard dates for food items.During the initial brief tour on 12/2/2025 at 8:55 am, the Dietary Manager (DM) revealed a 48 fluid ounce (oz) bottle of lemon concentrate in the stand-alone double refrigerator, which had an expiration date of 11/28/2025. The DM stated that it is everyone's job to check expiration dates and labels. One 40-pound (lb) box of chicken leg quarters was revealed in the food storage walk-in refrigerator with an expiration date of 11/7/2025, and one box of raw eggs with an expiration date of 11/29/2025. The DM stated that the staff who labeled the items made a mistake.On 12/4/2025 at 10:09 am, [NAME] MM confirmed during the interview that she was in charge of labeling and dating the chicken that was sighted. She mentioned that on that particular day, she used different pieces of chicken and did not follow the proper labeling and dating procedures, which were overlooked.During an interview conducted on 12/4/2025 at 10:28 am, the Kitchen Supervisor indicated that he manages and supervises the kitchen operations. He acknowledged that it is the responsibility of all staff to ensure proper labeling and dating. However, when the state officials arrived at the facility, he was in the midst of correcting and completing other tasks.On 12/4/2025 at 11:07 am, a follow-up interview with the Dietary Manager (DM) revealed during the interview that it is a collective responsibility to verify labeling and dating; however, Kitchen Supervisor MM oversees this task. The DM acknowledged the mislabeling incident and verified the expiration date, noting that she discarded the item as it had exceeded the three-day limit.During an interview conducted on 12/4/2025 at 11:46 am, the District Manager indicated that she dislikes handwritten paper labeling. They are currently implementing a new labeling system, which is still a work in progress. However, all staff have received training in it, and there have been no reported issues so far.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115275	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A.G. Rhodes Home, Inc, The	350 Boulvard, S.E. Atlanta, GA 30312

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, staff interviews, and review of facility policy titled Compactor Procedures, the facility failed to ensure the outdoor garbage and refuse area was maintained in a sanitary manner, creating the potential for harboring pests and insects. The facility census was 127.Findings included:A review of the facility's undated policy titled Compactor Procedures revealed that the facility will ensure the area around the compactor is clear of clutter and trip hazards.During an observation and interview on 12/2/2025 at 9:30 am, the vicinity of the dumpster was observed to be spotted with trash, discarded food, Styrofoam cups, plastic lids, a broom-like handle, and various other debris. During the interview with the Dietary Manager, it was confirmed that the kitchen staff does not hold responsibility for the dumpster; that responsibility falls under maintenance. She also indicated that the kitchen staff maintains the walkway to the trash and the area by the entrance of the compactor, but not the space below and beside it.During an observation and interview conducted on 12/4/2025 at 11:27 am, the dumpster area was observed with the presence of discarded food and white-like ice cream under the ramp and beside the dumpster, along with a broom-like handle, plastic lids, and various debris. During the interview with the Dietary Manager, she confirmed the presence of these items and mentioned that the responsibility for cleaning the dumpster area is a joint effort between kitchen staff and maintenance staff.During an interview on 12/4/2025 at 3:00 pm, the Maintenance Director confirmed that his team is responsible for keeping the facility's grounds clean, including the space around the dumpster.During an interview conducted on 12/4/2025 at 3:23 pm, Dietary Aid (DA) LL confirmed that he is responsible for the disposal of waste in the dumpster. He stated that if he accidentally spills any trash, he makes it a priority to clean it up. However, he mentioned that it is generally dark at the end of his shift, and he relies on his phone for a flashlight. Furthermore, DA LL explained that the trash located beneath the ramp has been present for several months and believed it was from when the compactor was emptied.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115275	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A.G. Rhodes Home, Inc, The	350 Boulvard, S.E. Atlanta, GA 30312

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record reviews, and review of the facility's policy titled Activities of Daily Living, the facility failed to provide Activities of Daily Living (ADL) care for one of 40 sampled residents (R) (R22) related to incontinence care. Psychosocial harm was identified on 12/3/2025 when R22 soiled herself and requested assistance, but no one came to provide care for over two hours. She revealed that this made her feel really bad, she felt as if she did not matter, and she felt that the staff did not care about her.Findings included: A review of the facility's policy titled Activities of Daily Living (ADL), last revised 3/10/2023, documented that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.A review of the electronic medical record (EMR) revealed that R22 was admitted to the facility on [DATE] with diagnoses that included severe persistent asthma with (acute) exacerbation, chronic diastolic (congestive) heart failure, Parkinson's disease without dyskinesia, obesity, and age-related osteoporosis. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R22 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had intact cognition, and that R22 was coded at a one for toileting hygiene, indicating the resident does none of the effort to complete the activity, and the assistance of two or more staff members are required.A review of the care plans dated 7/16/2025 documented that R22 was dependent on staff for toileting assistance.A review of the document titled Device Activity Report revealed that on 12/3/2025 at 2:21 pm, R22 initially pressed her call button. It was revealed that the call button was cleared at 3:57 pm, confirming the call light was on for 96 minutes and 24 seconds.A review of the requested documentation provided by the Administrator regarding camera activity on 12/3/2025 outside of R22's room revealed the following:Licensed Practical Nurse (LPN) HH walked into R22's room on 12/3/2025 at 2:23 pm.An unknown Certified Nursing Assistant (CNA) walked into R22's room at 2:24 pm and exited the room at 2:24 pm.LPN HH exited R22's room at 2:28 pm.Two unknown CNAs were standing outside of R22's room at 2:41 pm.At 3:44 pm, CNA II went into R22's room and exited.At 3:54 pm, CNA II went into R22's room and exited the room at 4:13 pm with soiled linen/trash bags.During an observation and interview on 12/4/2025 at 12:15 pm, R22 was observed lying in bed. She revealed that on 12/3/2025 at 2:21 pm, she pressed her call button to be changed (receive incontinence care). She stated that LPN HH walked into her room to ask what she needed, and she told LPN HH that she needed to be changed. She stated that LPN HH informed her that she would find a CNA to come and assist her. R22 stated that she was not changed until after 4:00 pm due to the 3:00 pm shift change. R22 stated that it is not uncommon to have to wait long periods of time for assistance and that she sometimes has to wait over an hour to be changed due to CNAs and LPNs not answering the call lights.During an interview on 12/4/2025 at 12:35 pm, LPN HH revealed she initially answered the call light for R22 on 12/3/2025 and that R22 stated she needed to be changed. She stated that she told R22 that she would find a CNA to assist her. LPN HH stated she found the CNA assigned to R22, but the CNA was busy with another resident. LPN HH confirmed that she did not return to R22, and she did not provide incontinent care for R22 because she was busy hanging gastrostomy tubes (G-tubes). LPN HH stated it took her approximately 10 minutes to finish the process of hanging G-tubes, and once she finished hanging the G-tube, she went to the CNA assigned to R22 to remind her to provide incontinent care for the resident. LPN HH revealed nurses can provide incontinent care for residents if CNAs are busy, but nurses are not responsible for providing care. LPN HH revealed she could not remember the name of the day shift CNA assigned to R22.During an interview on 12/4/2025 at 1:39 pm, R22 revealed she urinated on herself when she initially pressed the call button, but by the time staff came in to help her, she had a bowel movement as well. R22 stated that the incident of being left sitting in urine and feces for multiple hours made her feel really bad. She further stated that she felt as if she did not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115275	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A.G. Rhodes Home, Inc, The	350 Boulvard, S.E. Atlanta, GA 30312

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	matter and the staff did not care about her.During an interview on 12/4/2025 at 4:44 pm, CNA II revealed she arrived at the facility on 12/3/2025 at 3:00 pm and that LPN JJ informed her that R22's call light was on. CNA II stated she went into the resident's room and informed her that she would be back to change her once she got her supplies. CNA II stated she went to grab the supplies needed to provide incontinent care and went back to R22's room to change her. She said that R22 had urinated and had a bowel movement and that R22 was very upset about not being changed for over two hours. She stated that R22 was very upset and had told her that she was waiting to be changed since 2:20 pm.During an interview on 12/4/2025 at 5:20 pm, LPN JJ revealed she began her work assignment at 2:55 pm on 12/3/2025 and that she noticed R22's call light was on while making initial rounds. She stated that she went to check on her, and R22 told her that she needed to be changed. She stated that R22 told her she had been waiting on someone from the day shift to change her. LPN JJ stated she informed R22 that she would have the CNA assigned to her to come and change her. LPN JJ stated she began looking at who was working that evening so that she could make assignments. LPN JJ revealed she told CNA II upon arrival to go to R22's room to change her.During an interview on 12/4/2025 at 5:30 pm, the Director of Nursing (DON) revealed that call lights are expected to be answered within five minutes. The DON revealed that if a call light cannot be answered within five minutes, staff must explain to the residents why the service cannot be provided at that time. The DON confirmed nurses can perform incontinent care if they are not busy with another resident and stated that if there is a request by a resident, communication must be had with the resident and other staff members to ensure the needs are met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115275	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A.G. Rhodes Home, Inc, The	350 Boulvard, S.E. Atlanta, GA 30312

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of relevant facility documentation, and review of the facility policy titled Call Light Accessibility and Timely Call Light Response, the facility failed to ensure all components of the nurse call system were fully functional in 10 of 25 resident rooms (rooms 101, 108, 113, 112, 106, 107, 111, 105, 118, and 119).Findings included:A review of the facility policy titled Call Light Accessibility and Timely Response, revised 6/26/2023, revealed that it is the purpose of this policy to ensure the community is adequately equipped with a call light at each elder's bedside, toilet, and bathing community to allow elders to call for assistance. Call lights will directly relay to a staff member or a centralized location to ensure an appropriate response.1. During an observation/interview with the resident in room [ROOM NUMBER]-B on 12/2/25 at 11:24 am, the resident stated that sometimes staff respond timely and sometimes not. The resident was asked to engage the nursing call system, which did not turn on immediately. After four attempts, the call light turned on with lights visible on the unit itself, outside the room, and was audible at the nurse's station. Once the call light was cancelled, it intermittently turned on by itself and could not be turned off. The resident stated she thought it might have an electrical shortage. The Maintenance Director (MD) arrived and confirmed that the cord was frayed from the unit. He determined the unit needed to be replaced immediately. During an interview with the MD on 12/2/2025 at 11:35 am, he stated his staff checks each room for call light functionality monthly and repairs or replaces malfunctioning units as needed. He stated that they document concerns in a logbook. 2. During an observation on 12/2/2025 at 11:45 am, the call light in room [ROOM NUMBER]-A did not light up on the wall panel, outside the room, and was not audible at the nurse's station. In addition, the call light in the resident's bathroom did not function. 3. During an observation on 12/2/2025 at 3:48 pm, the call light in room [ROOM NUMBER]-B did not light up inside or outside the room and was not audible at the nurse's station. 4. During an observation on 12/2/2025 at 3:55 pm, the call light in the bathroom of resident room [ROOM NUMBER] was not functioning. 5. During an observation on 12/2/2025 at 4:02 pm, the call light in room [ROOM NUMBER]-B did not light up inside or outside the room and was not audible at the nurse's station. 6. During an observation on 12/2/2025 at 4:16 pm, the call light in room [ROOM NUMBER]-A did not light up inside or outside the room and was not audible at the nurse's station.7. During an observation on 12/3/2025 at 9:14 am, the call light in room [ROOM NUMBER]-P did not light up inside or outside the room and was not audible at the nurse's station. In addition, the call light in the resident's bathroom did not function. 8. During an observation on 12/3/2025 at 10:12 am, the call light in the resident's bathroom in room [ROOM NUMBER] was not functioning. 9. During an observation on 12/3/2025 at 10:20 am, revealed that the bathroom call light in room [ROOM NUMBER] was not functioning.10. During an observation on 12/3/2025 at 10:25 am, the call light in room [ROOM NUMBER]-B did not light up inside or outside the room and was not audible at the nurse's station.During a review of the electronic maintenance system logbook revealed that monthly monitoring of the resident's bedside call light was conducted from January 2025 through October 2025, but there was no documentation of bathroom call monitoring and function.During an interview on 12/3/2025 at 11:15 am, the MD stated that the call light cord has two links, which sometimes come loose from resident or staff use. In addition, residents and staff often dislodge the call system from the wall base, which would cause it to malfunction. He stated he leaves a manual bell at the bedside if the repair or replacement will take longer than five minutes. During an observation/interview with the Licensed Practical Nurse (LPN) DD on 12/3/25 beginning at 12:00 pm, she confirmed the call light malfunctions in each identified resident room and bathroom. She stated staff have been trained to report any malfunctions to the MD by speaking directly to him or one of his staff or using the electronic reporting system. In addition, she stated she had not observed the call light malfunctions for herself before this observation but would be more diligent about monitoring the call light function (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115275	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A.G. Rhodes Home, Inc, The	350 Boulvard, S.E. Atlanta, GA 30312

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the future.During an observation/interview with the MD and the Administrator on 12/3/2025 at beginning at 12:20 pm, the MD confirmed the call light malfunctions in the identified rooms and bathrooms. He stated he and his staff monitor call light function monthly and repair or replace individual units as needed. He stated the facility had a plan to replace the system and was still evaluating costs. He stated his staff monitors the bathroom call lights monthly as well, but had not documented those events.The Administrator stated she had hired additional maintenance staff to assist with the multiple upgrading and repair projects that are in progress throughout the facility. She stated she expected that the Maintenance staff would document all monitoring and repair activities and maintain accurate records.