STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115341	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor Health and Rehabilitation	1110 Burleyson Drive Dalton, GA 30720

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917 Based on record review, staff interviews, and facility policy review, the facility failed to develop and implement a comprehensive person-centered care plan that included trauma-informed care related to the resident's experiences in order to eliminate or mitigate triggers that may cause re-traumatization related to the resident's diagnosis of Post Traumatic Stress Disorder (PTSD) for one of one resident (Resident (R)46) reviewed for person-centered care plans for PTSD out of 21 sampled residents. This failure placed the residents at an increased risk for re-traumatization of emotional distress. Findings include: Review of R46's Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review of R46's annual Minimum Data Set (MDS) located in the resident's EMR, under the MDS tab, with an Assessment Reference Date (ARD) of 12/16/24, revealed R46 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 that indicated resident was cognitively intact. The MDS also revealed R46 had a diagnosis of PTSD. Review of R46's Encounter with PCP at [name of physician's group] located in the EMR under the Documents tab dated 04/26/22, revealed her diagnosis of PTSD was related to her past victimization from domestic violence and neglect, and to avoid triggering her PTSD by not talking about her husband or her past married life. Review of R46's Care Plan located in the resident's EMR, under the Care Plan tab, with a revision date of 10/07/24, revealed her diagnosis of PTSD with interventions to avoid PTSD triggers. However, the Care Plan did not identify the cause was a result of past victimization of neglect, domestic violence, and the triggers that could contribute to affecting her emotional and psychological health. During an interview with Certified Nursing Assistant (CNA)3 on 03/27/25 at 12:20 PM, she stated that she was not aware of the triggers that could contribute to R46's re-traumatization related to her diagnosis of PTSD. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Practical Nurse (LPN)2 on 03/27/25 at 12:30 PM, she stated she was not aware of the triggers that could contribute to R46's re-traumatization related to her diagnosis of PTSD. During an interview with the Director of Nursing (DON) on 03/27/25 at 12:45 PM, she stated she was not aware of the triggers that could contribute to R46's re-traumatization related to her diagnosis of PTSD. She said she would expect the triggers to be documented in R46's care plan and that R46's care staff should be informed of the triggers. Review of the policy titled, Care Plan revealed each resident will have a comprehensive care plan that reflects resident-centered care and services and in effort to attain or maintain the resident' highest practicable physical, mental, and psychological well-being.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917 Based on staff interviews, record review, and facility policy review, the facility failed to ensure three (Residents (R) 5, R15, and R59) reviewed out of 12 residents receiving hospice services out of a total sample of 21 residents had visit notes from the hospice agency. These failures could lead to the risk that the needs of these residents are not addressed. Findings include: Review of the facility policy titled, Hospice Services dated 11/01/19 revealed, Supervision/Coordination of Care Each party is responsible for documenting such communication in its respective clinical records to ensure the needs of hospice patients are addressed and met 24 hours a day. 1. Review of R59's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R59 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, cerebral infarction (stroke), and paraplegia. Review of R59's Orders tab of the EMR revealed an order dated 11/24/23 to admit to hospice services related to ischemic attack (stroke). Review of R59's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD)of 03/11/25 revealed R59 was under hospice care. Review of R59's Care Plan located under the Care Plan tab of the EMR revealed a focus area for hospice services initiated 11/24/23 with an intervention to work cooperatively with hospice team to ensure spiritual, emotional, intellectual, physical and social needs are met. Review of R59's Documents tab of the EMR revealed only Interdisciplinary (IDT) notes, there were no visit notes. 2. Review of R5's Admission Record located in the Profile tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease without dyskinesia, chronic obstructive pulmonary disease (COPD), emphysema, and Alzheimer's disease. Review of R5's quarterly MDS with an ARD of 12/26/24 revealed R5 was under hospice care. Review of R5's Care Plan located under the Care Plan tab of the EMR revealed a focus area for hospice services initiated 04/08/22 related to emphysema with an intervention to work cooperatively with hospice team to ensure spiritual, emotional, intellectual, physical and social needs are met. Review of R5's Documents tab of the EMR revealed only ITD notes, there were no visit notes. 3. Review of R15's Admission Record located in the Profile tab of the EMR revealed R15 was admitted to the facility on [DATE]. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R15's Medical Diagnosis located in the Medical Diagnosis tab of the EMR revealed R15 was admitted with diagnoses including COPD with (acute) exacerbation. Review of R15's Orders tab of the EMR revealed an order dated 05/15/24 to admit to hospice services. Review of R15's quarterly MDS with an ARD of 02/17/25 revealed R15 was under hospice care. Review of R15's Care Plan located under the Care Plan tab of the EMR revealed a focus area for hospice services initiated 05/15/24 with an intervention to work cooperatively with hospice team to ensure spiritual, emotional, intellectual, physical and social needs are met. Review of R15's Documents tab of the EMR revealed only ITD notes, there were no visit notes. During an interview on 03/26/25 at 10:05 AM the Director of Nursing (DON) stated she had to reach out to hospice for copies of hospice records. She stated hospice usually sent them over and then medical records uploaded them to the Documents tab in the EMR. During an interview on 03/26/25 at 10:13 AM the DON reviewed the notes provided by hospice and stated they were IDT notes only. The DON stated the hospice staff documented their visits using an electronic tablet, and facility staff are required to sign off on the tablet, but the hospice staff did not leave a copy of those visit notes. She stated only the IDT notes were sent over to the facility, then scanned in to the EMR later. The DON stated she would have to ask hospice to send visit notes. During an interview on 03/26/25 at 1:30 PM Medical Records (MR) staff stated hospice faxed their IDT notes over and she scanned them into the Documents section of the EMR, but only the IDT documents. She reviewed the hospice documents in the Documents tab for the hospice residents and was unable to find any visit notes. She stated they did not keep any sort of hospice binder on the unit for hard copy of visit notes either. During an interview on 03/26/25 at 2:00 PM, Licensed Practical Nurse (LPN) 3 stated the hospice staff documented care on their own electronic record via an electronic tablet. Then facility staff signed the electronic note, but facility did not get a copy of the visit notes unless the facility requested it. LPN 3 stated they did not maintain a binder with hard copy of visit notes.