

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115521	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER A.G. Rhodes Home, Inc - Cobb		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Wylie Road Marietta, GA 30067	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on staff interviews, record review, and review of the facility policies titled, Incident and Accidents and Abuse Prohibition Policy, the facility failed to ensure allegations of potential abuse were thoroughly investigated for one of three residents (R) (R6) who had an allegation of abuse. Findings include: Review of the facility policy titled Incident and Accidents last revised 8/28/2023, documented under Compliance Guidelines: .4. Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed and reported according to the community's abuse and prevention policy. Review of the facility policy titled Abuse Prohibition Policy last revised 5/22/2023 revealed under Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: .b. Establish policies and procedures to investigate any such allegations.V. Investigation of Alleged Abuse, Neglect and Exploitation.4. Identify and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations.6. Providing a complete and thorough documentation of the investigation. Review of R6's electronic medical record (EMR) revealed admission to the facility with medical diagnoses that included, but not limited to chronic pulmonary disease, osteoporosis without current pathological fracture, dementia, and type 2 diabetes. Review of R6's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/21/2024 located in the resident's EMR under the MDS tab indicated the facility assessed R6 to have a Brief Interview for Mental Status (BIMS) score was 6 out of 15, indicating R6's cognition was severely impaired. Review of the Facility 5-day follow up to facility incident report #202501357 documented on 2/6/2025, R6 complained of leg and foot pain but was unable to specify which leg was hurting. Following an assessment, the Nurse Practitioner (NP) ordered a mobile x-ray, which revealed an acute minimal fracture to the distal tibia and distal fibula, along with osteopenia. The Medical Director (MD) and R6's family were promptly informed. R6 was sent to the emergency room (ER) for treatment. Review of the Facility 5-day follow up to facility incident report #202501357 documented on 2/6/2025, staff written statements from nursing aide staff and nurses on 2/6/2025 on the 7:00 AM to 3:00 PM shift. This is the shift that acknowledged and reported R6's leg pain. Review of the file did not reveal any other written statements from other shifts prior to 2/6/2025. Interview on 7/10/2025 at 11:05 am with the Director of Nursing (DON) revealed they completed the investigation regarding R6's leg pain and fracture. The DON stated nursing staff notified her of the x-ray results and that was when the investigation was initiated. The DON stated the investigation was completed by the team reviewing R6's EMR to see if anything stood out to explain the fracture. The DON stated they also spoke to care partners (nurses aides) and nurses who worked on 2/6/2025 and got statements from them. The DON stated while reviewing R6's chart, they noticed R6 had restlessness on 2/3/2025 and they spoke to the CNA who worked on 2/3/2025. The DON stated they did not have the CNA who worked on 2/3/2025 write a statement because her story coincided with the nurse's late progress note written for 2/3/2025. The DON stated a lot of her interviews with staff were verbal and not written so she did not have documentation of them. Interview on 7/10/2025 at 1:45 PM with the Administrator revealed they were the Abuse and Neglect Coordinator, and all allegations were expected to be reported to them. The Administrator stated they reported all reportable instances to the state within the required timeframes. The Administrator stated all her investigations were done as a team and the team consisted of herself, the DON and the Social Services Director (SSD). The Administrator stated they went over everything as a team and the SSD would type of the investigation summary. The Administrator stated that sometimes their interviews were done verbally and transcribed onto the investigation follow-up summary.</p>		