

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115571	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2025
NAME OF PROVIDER OR SUPPLIER  Cartersville Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Opal Street Cartersville, GA 30120	

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)
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on resident and staff interviews, record review, and facility policy review, the facility failed to provide written notice of a room change prior to changing residents' rooms within the facility, which affected 4 (Residents #1, #7, #11, and #12) of 4 residents reviewed for multiple room changes.</p> <p>Findings include:</p> <p>A facility policy titled, Change of Room or Roommate, revised 07/2023, revealed, It is the policy of this facility to conduct changes to room and/or roommate assignments when considered necessary and/or when requested by the resident or resident representative. The policy also revealed, 4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required.</p> <p>1. According Resident #1's admission Record, the resident had a medical history that included diagnoses of end stage renal disease with dependence on renal dialysis, congestive heart failure, atrial fibrillation, diabetes mellitus, chronic pain syndrome, and traumatic subarachnoid hemorrhage (bleeding in the space below one of the thin layers that cover and protect the brain) without the loss of consciousness. The admission Record revealed the facility discharged the resident on 09/11/2024.</p> <p>Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/17/2024, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>Review of Resident #1's Census report revealed the resident changed rooms on the following dates since their admission on [DATE]: 04/15/2024; 06/03/2024; and 07/05/2024.</p> <p>Review of Resident #1's Progress Notes revealed no documentation of written notification of a room change being provided to the resident or their responsible party on or prior to 04/15/2024.</p> <p>(continued on next page)</p>

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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's Progress Notes revealed a note, dated 06/03/2024 at 11:22 AM and electronically signed by the Social Services Director (SSD), that revealed the SSD left a voicemail to update Resident #1's responsible party on a room change. The Progress Notes revealed no documentation of prior written notice being provided to the resident, or of a return call or conversation with the resident's responsible party.</p> <p>Review of Resident #1's Progress Notes revealed no documentation that a written notification of a room change was provided to the resident or their responsible party on or prior to 06/03/2024 or 07/05/2024.</p> <p>2. Review of Resident #7's admission Record indicated the facility originally admitted the resident on 06/28/2021 and most recently readmitted the resident on 01/24/2024. According to the admission Record, the resident had a medical history that included diagnoses of congestive heart failure, schizophrenia, sick sinus syndrome, and paroxysmal atrial fibrillation.</p> <p>Review of an annual MDS with an ARD of 04/10/2025, revealed Resident #7 had a BIMS score of 8, which indicated the resident had moderate cognitive impairment.</p> <p>Review of Resident #7's Census List report revealed the following dates the resident changed rooms following their readmission on [DATE]: 02/06/2024 (two different room changes on the same day); 02/07/2024; 02/08/2024; 09/06/2024; 09/11/2024; 09/12/2024; 09/17/2024; and 12/10/2024.</p> <p>Review of Resident #7's Progress Notes, for the timeframe from 2/01/2024 through 2/10/2024, revealed no documentation of written notifications of room changes being provided to the resident or their responsible party.</p> <p>Review of Resident #7's Progress Notes, for the timeframe from 09/01/2024 through 09/11/2024, revealed no evidence that prior written notification of transfer was provided to the resident or responsible party prior to or on 09/06/2024 or 09/11/2024.</p> <p>Review of Resident #7's Progress Notes revealed a Social Service note, dated 09/12/2024 at 4:24 PM and electronically signed by the Social Services Director (SSD), that revealed a telephone call was made to Resident #7's responsible party to notify them the resident had been moved to another room, however, the Census List report revealed a different room number than that in the note. Resident #7's Progress Notes, revealed no evidence that a written notification of a room change was provided to the resident or their responsible party prior to or on 09/17/2024.</p> <p>Review of Resident #7's Progress Notes revealed a Social Service note, dated 12/10/2024 at 2:38 PM and electronically signed by the SSD, which revealed a telephone call was placed to Resident #7's family member; however, there was no answer and no voicemail was left. The notes revealed no evidence the resident or responsible party was provided written notification of a room change prior to or on 12/10/2024.</p> <p>During an interview on 04/24/2025 at 10:40 am, Resident #7 stated the facility staff had moved them from room to room so many times I cannot remember them all. The resident stated the facility staff did not always give them the choice or tell the resident beforehand. Resident #7 stated the staff come in here and say they have talked to my family about it [the move] and that I am moving. The resident stated that they had never received written notice of a room change.</p> <p>(continued on next page)</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of Resident #11's admission Record indicated the facility admitted the resident on 12/16/2023. According to the admission Record, the resident had a medical history that included diagnoses of schizophrenia, diabetes mellitus, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of a quarterly MDS with an ARD of 03/19/2025, revealed Resident #11 had a BIMS score of 14, which indicated the resident had intact cognition.</p> <p>Review of Resident #11's Census List report revealed the following dates the resident changed rooms since their admission on [DATE]: 01/01/2024; 01/11/2024; 02/28/2024; 02/29/2024; and 08/15/2024. The Census List indicated the resident was transferred to a hospital on [DATE] and readmitted to the facility on [DATE] (nine days later), then changed rooms on 10/24/2024.</p> <p>Review of Resident #11's Progress Notes revealed no documentation on or prior to each of the room changes that the resident or their responsible party was notified in writing of a room change.</p> <p>During an interview on 04/24/2025 at 10:20 am, Resident #11 stated they had been moved several times within the facility and had never been given written notice of the move. The resident also stated that they were often not given any notice of the intent to move from room to room and that staff would just show up and get you and your belongings and don't really give you time to say goodbye.</p> <p>4. Review of Resident #12's admission Record indicated the facility admitted the resident on 03/10/2023. According to the admission Record, the resident had a medical history that included diagnoses of congestive heart failure, diabetes mellitus, and atrial fibrillation.</p> <p>Review of a quarterly MDS with an ARD of 04/15/2025, revealed Resident #12 had a BIMS score of 15, which indicated the resident had intact cognition.</p> <p>Review of Resident #12's Census List report revealed the following dates the resident changed rooms since January 2024: 01/05/2024 and 01/07/2024.</p> <p>Review of Resident #12's Progress Notes revealed no documentation on or prior to 01/05/2024 or 01/07/2024 that the resident or their responsible party was notified in writing of a room change.</p> <p>During an interview on 04/24/2025 at 10:24 am, Resident #12 stated they had been moved several times from room to room in the facility and had never received a written notice of the room change at any point, either before or after the move. The resident stated, I have never even been given advanced notice of a move or the option to give my opinion about the moves. The staff show up and I am basically told I need to move to a new room because of new admissions or something, and it has never been presented as optional to me. Resident #12 stated there had been times when they (Resident #12) did not want to leave their roommate at the time and would have preferred to stay where they were instead of being moved.</p> <p>During an interview on 04/24/2025 at 10:16 am, Certified Nurse Aide (CNA) #5 stated that during a room-to-room transfer, she helped Resident #12 pack up their belongings and helped get them to the new room. She stated she had never seen a resident get any kind of written notification of a room change.</p> <p>(continued on next page)</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/24/2025 at 10:23 am, CNA #6 stated when there was a room transfer in the facility, she helped the resident pack their belongings and take them to the new room. She stated she had never seen a resident get any kind of written notification of the room change. noted she had completed many room changes.</p> <p>During an interview on 04/24/2025 at 9:51 AM, Licensed Practical Nurse (LPN) #1 stated that when a resident was being transferred from room to room in the facility, they notified the family and the resident and helped to move their belongings from room to room. She stated there was not any paperwork completed that she was aware of, noting the room number was just changed in the electronic health record (EHR).</p> <p>During an interview on 04/24/2025 at 10:05 am, LPN #3 stated that during an in-house room transfer, she notified the nurses' station associated with the new room, ensured medications were transferred over to the new unit, and contacted the unit manager and the family to let them know. She stated she had never seen any paperwork filled out for a room transfer or written notification of the change given to a resident. She stated the staff just changed the room number in the EHR.</p> <p>During an interview on 04/24/2025 at 10:09 am, Registered Nurse (RN) #4, a unit manager, stated that for a room-to-room transfer, she ensured a CNA knew to assist the resident with the move and that the family was notified of the new room number. She stated she changed the room number in the EHR, took the resident's medications and treatments to the new nurses' station, and gave report to the new nurse. RN #4 stated there was no paperwork involved in a room-to-room transfer, and she had not seen any written notification of the change given to a resident.</p> <p>During an interview on 04/23/2025 at 3:16 pm, the Social Services Director (SSD) stated she was the process owner for room transfers. She stated if a room transfer were to occur, she notified the family of residents whose BIMS scores were low and talked to the residents and asked if they were ready to move that day. She stated they resident was given an option of when the room change would take place. She stated there was not a written notice given to the residents or the family regarding room transfers, noting she was not aware that doing so was a federal regulation.</p> <p>During an interview on 04/24/2025 at 12:17 pm, the Director of Nursing (DON) stated her expectation for a room-to-room transfer was for staff to consider the personalities of the residents prior to the move. She stated that staff were to ask the resident their opinion of a transfer and if a resident was unable to make a decision, staff were to notify the resident's family. The DON stated the SSD documented room changes in the EHR, but there was not currently any paperwork that was filled out or handed out.</p> <p>During an interview on 04/24/2025 at 12:37 pm, the Administrator stated that for room-to-room transfers, they notified the resident and the family verbally and staff made the move as accommodating as possible. He stated he was not aware of a written notice of transfer given to the residents. He stated that EHR documentation was all that the facility had ever completed for room transfers.</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>Based on resident attorney, medical records company representative, and staff interviews, record review, and facility policy review, the facility failed to provide a written copy of the residents' medical records within two working days of the initial written request for three (Residents #2, #9, and #10) of three residents reviewed for timely access to their medical records.</p> <p>Findings include:</p> <p>An undated facility policy titled, Release of Medical Records indicated, Medical records will be released with a valid request and in accordance with state and federal laws. The policy indicated, 2. Requests for records should be referred to the Director of Nursing or Administrator, or Medical Records Designee, previously designated by [the corporation's name]. The policy revealed, 5. Records Requests/Compliance should be notified of the request for records through the records request email. Records should not be released prior to discussion with a records request/compliance team member, to further validate authenticity of the request. 6. Upon receipt of the authorization request form for medical records, [the corporation's name] should notify the requesting party of the cost for obtaining records [sic] Copies should not be released prior to the receipt of payment for associated charges. 7. Fees for copying medical records are determined according to state regulations. The policy revealed, 8. Once a request for records is received, all records for that resident should be gathered and secured in a place inaccessible to anyone except the records request/compliance team, Administrator, Director of Nursing, or designee. The policy further indicated, Access Rights to Medical Information are as Follows 1. The resident (current resident) - the resident's record is accessible to him/her within 24 hours (excluding weekends and holidays) notice, following an oral or written request. The policy revealed, The resident or his/her legal representative may receive a copy of his/her record within 2 working days after the request has been made. If we need more time to process your request, we can take another 30 days if we notify you that additional time is needed. The policy revealed, 12. Attorneys - the resident or his/her legal representative's authorization must be obtained prior to release of information to attorneys.</p> <p>1. Review of Resident #2's admission Record indicated the facility admitted the resident on 03/07/2018. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, vascular dementia, and diabetes mellitus. The admission Record indicated the facility discharged the resident on 07/13/2023.</p> <p>Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/19/2023, revealed Resident #2 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term member problems per a staff assessment of mental status (SAMS).</p> <p>Review of Resident #2's Care Plan Report included a focus area, initiated 09/16/2019, that indicated the resident had impaired cognitive function and impaired thought processes related to diagnoses of vascular dementia with behaviors and Alzheimer's disease. Interventions directed staff to use the resident's preferred name, identify themselves during each interaction, face the resident when speaking, and to make eye contact (initiated on 04/30/2020); administer medications as ordered (initiated 09/16/2019); and to anticipate and meet resident's needs (initiated 08/22/2022).</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 04/22/2025 at 4:46 pm, Attorney #7 stated their law firm had sent a Letter of Representation to the facility at the beginning of September 2024 and had given them 30 days to produce the requested medical records. Attorney #7 stated that after 30 days had past, a paralegal attempted to reach out to the facility a couple of times without being able obtain Resident #2's medical record for the timeframe from 08/20/2019 through their discharge date .</p> <p>Review of a letter from a law firm to the facility, dated 09/09/2024, indicated they were representing Resident #2 and requested the resident's medical records be sent to them within 30 days. The letter indicated it was sent via first class mail and certified mail and listed the return receipt tracking number.</p> <p>Review of a United States Postal Service request for proof of delivery, dated 09/26/2024 and matching the tracking number listed on the request for Resident #2's medical record, indicated the request was delivered to the facility and signed for by a front desk/receptionist on 09/12/2024 at 12:46 pm.</p> <p>Review of an email dated 10/10/2024 at 10:37 am and sent from the Senior Compliance Officer (SCO) of the facility's hired compliance office to the former facility owners, who owned the facility through 08/19/2024, revealed the SCO shared with them a medical record request and requested confirmation that they received the email and asked if the former owners would like to produce Resident #2's records for the timeframe the facility was under their operations.</p> <p>Review of an email dated 10/10/2024 at 4:39 pm from Medical Records (MR) #12 at the facility to the facility's Records Request email with an attached scanned document revealed the scanned document included the letter from the law firm sent to the facility requesting Resident #2's record. The scanned document also included a HIPAA [Health Insurance Portability and Accountability Act] Compliant Medical Authorization Form, signed by Resident #2's legal representative and dated 08/01/2024, and a signed Affidavit of Kinship signed by Resident #2's family member and dated 08/01/2024.</p> <p>Review of an email dated 10/10/2024 at 4:50 pm from the SCO to MR #12 revealed she informed MR #12 a legal request was signed by Resident #2's next of kin and asked her to ensure all hard copy records had been scanned into the electronic health record (EHR). The email indicated the SCO asked MR #12 to clarify when the request was received at the facility, because the request was dated 09/09/2024, which brought the facility to the 30-day legal response period.</p> <p>Review of an email dated 10/18/2024 at 12:49 pm indicated that the former facility owners forwarded the email from the SCO that was sent on 10/10/2024 to their own Quality Assurance Director in response to Resident #2's record request.</p> <p>Review of an email dated 10/21/2024 at 8:35 am from the SCO to MR #12 indicated that Resident #2's medical records from the current owners had been prepared as requested for the law firm, and the requested certification would need to be notarized prior to the release of the records. The email indicated that an invoice was also attached, and that once the facility received payment, the records and notarized certification could be released to the law firm.</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an email dated 10/21/2024 at 8:35 am from the previous facility owners to Paralegal #8 indicated that they received the letter of request for records on Friday, 10/18/2024, and had gathered all of Resident #2's electronic records through 08/19/2024. The email requested a response from Paralegal #8 and indicated that they would then provide a link and password to access the requested records.</p> <p>Review of an email dated 10/21/2024 at 3:09 pm from the former owners to Paralegal #8 included the link and password to access Resident #2's medical record for one week to download or print as needed. The entire process took 39 calendar days to obtain Resident #2's medical record.</p> <p>2. Review of Resident #9's admission Record indicated the facility admitted the resident on 12/03/2024. According to the admission Record, the resident had a medical history that included diagnoses of atrial fibrillation and chronic obstructive pulmonary disease (COPD).</p> <p>Review of an admission MDS with an ARD of 12/09/2024, revealed Resident #9 had a BIMS score of 15, which indicated the resident had intact cognition.</p> <p>Review of Resident #9's Care Plan Report included a focus area, initiated 12/03/2024, that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to weakness and debility. Interventions indicated the resident required one to two staff for bed mobility (initiated 12/03/2024), set up assistance for eating (initiated 12/03/2024), and required one to two staff for transfers (initiated 12/03/2024).</p> <p>Review of the form, Release of Information, dated 02/04/2025, revealed a law firm representing Resident #9 had faxed a medical records request to the facility and included a HIPAA [Health Insurance Portability and Accountability Act] Release Form. The HIPPA Release Form was signed by Resident #9 and dated 01/24/2025. A Facsimile (fax) coversheet indicated the request for Resident #9's records was sent on 02/04/2025 at 6:30 am.</p> <p>Review of an email, dated 02/14/2025 at 7:41 am and sent from Medical Records (MR) #12 to Records Request, indicated that they had received a request for records. An email within the same email chain, dated 02/17/2025 at 8:18 AM, from the SCO of a third party company used by the current facility owners to prepare medical records requests to MR #12 indicated the facility had received a legal request for records for Resident #9 and requested that she ensured all hard copy records had been scanned into the EHR.</p> <p>Review of an email from the same email chain, dated 03/11/2025 at 3:09 am, from the SCO to MR #12 indicated that Resident #9's medical record had been prepared as requested by the law firm. The email indicated that a link was provided for the law firm to access the EHR, and an invoice was attached to the email. The email provided instructions that revealed, Once the facility has received payment, you may release the records.</p> <p>The entire process from the initial request for Resident #9's medical record took 35 calendar days for the requester to have the ability to access the records.</p> <p>3. Review of Resident #10's admission Record indicated the facility admitted the resident on 12/01/2023. According to the admission Record, the resident had a medical history that included diagnoses of diabetes mellitus, obesity, and hyperlipidemia (high cholesterol).</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly MDS with an ARD of 04/15/2024, revealed Resident #10 had a BIMS score of 4, which indicated the resident had severe cognitive impairment.</p> <p>Review of Resident #10's Care Plan Report included a focus area, initiated 12/07/2023, that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to urinary tract infections, diabetes, kidney failure, obesity, arthritis, and neuropathy. Interventions indicated the resident required assistance from one to two staff for bed mobility (initiated 12/07/2023), set up assistance with eating (initiated 12/07/2023), and assistance from one to two staff for toileting (initiated 12/07/2023). Interventions also indicated the resident required the use of a mechanical lift for transfers (initiated 12/07/2023).</p> <p>Review of a letter to the facility dated 08/09/2024 from Resident #10's next of kin (NOK) indicated the NOK requested Resident #10's medical records. The letter indicated it was sent via certified mail.</p> <p>Review of a second letter from a law office representing Resident #10 and their NOK, dated 11/21/2024, provided proof of representation and listed multiple attempts by the law office to contact someone from the facility to assist in obtaining the medical records for Resident #10. The letter indicated the attempts to contact the facility that were unsuccessful were as follows: 09/25/2024, 09/26/2024, 09/30/2024, 10/03/2024, 10/18/2024, 10/22/2024, 10/30/2024 (facility receptionist said they would take the message to medical records staff, but no return call was received), 11/04/2024, and 11/14/2024.</p> <p>Review of an email dated 12/02/2024 at 1:19 pm from Medical Records (MR) #12 to the facility's Records Requests email indicated that she had just received a medical records request for Resident #10 that day.</p> <p>Review of an email dated 12/02/2024 at 1:32 pm from the SCO of a third party company used by the current facility owners to prepare medical records requests to MR #12 indicated that they had received the record request for Resident #10 that was sent in August of 2024. The email indicated that the notice referenced multiple attempts to make contact with the facility regarding the status of the request. The email indicated that the compliance office would get the record together as soon as possible to avoid a complaint and potential fine from the Office of Civil Rights. The email indicated that the facility had only 30 days to process a valid request. The email indicated that if there were still hard copy records, they needed to be sent to the SCO by the end of the business day that day (12/02/2024).</p> <p>Review of an email dated 12/03/2024 at 9:32 AM from the SCO to MR #12 indicated Resident #10's medical record was ready as requested by the law firm and included an attachment of the record. The email requested MR #12 send the invoice for payment that day [12/03/2024], as they were already past the 30-day regulated response time. The email indicated that once payment was received from the law firm, the facility could release the record.</p> <p>From the initial request for Resident #10's medical record to when the record was available for the law firm to access took a total of 116 calendar days.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115571	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2025
NAME OF PROVIDER OR SUPPLIER  Cartersville Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE  78 Opal Street Cartersville, GA 30120	
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)		
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/24/2025 at 10:16 am, the SCO, who stated she represented the compliance company hired by the facility to compile medical record requests, especially legal chart requests, stated the compliance company attempted to meet the 30-day response time given to them by an attorney's office. She stated that if there were circumstances in which they were busy and not able to meet those deadlines, the company tried to reach out to the lawyer's office to give an explanation for the delay. The SCO stated that when a medical records request was made, the facility received the initial request, then the medical records staff at the facility contacted the compliance company and forwarded the request. The SCO stated that she then contacted the facility's medical records staff and made sure all the hard copy records, if there were any, had been scanned into the electronic health record (EHR) prior to her gaining access to it. She stated the compliance company had remote access to the facility medical records system and was able to pull the information needed, once the EHR was completed from the facility's end. She stated that once the chart was verified as complete by the medical records staff at the facility, the turnaround time for processing a legal medical records request on the compliance end was between 15 and 21 days; however, there had been instances when it took longer. The SCO stated that not only was the compliance office compiling the record into a timeline format, but they were also scanning the documents for areas of liability, informing the company that owned the facility of any potential issues, and verifying the validity of the requestor of the record. She stated verifying was to ensure, for residents with a low BIMS score, that an unauthorized person was not seeking access to the resident's record without the proper permissions. After discussing the federal regulation for providing a resident's medical record to them in full within 48 business hours, the SCO stated it was her company's understanding, after having a conversation with a representative of the Office of Civil Rights (OCR) of Georgia, that the 48 hours regulation only applied to residents who were still actively residing in the facility. She stated that if a resident had been discharged from the facility and requested records afterwards, a 30-day rule applied to provide them with access to the record, like the timeframe provided by most lawyers' offices. She stated the compliance company had never met the 48-hour rule for outside requests for this facility, and often did not even get the initial medical record request from the facility within the 48-hour mark.</p> <p>During an interview on 04/24/2025 at 12:17 pm, the Director of Nursing (DON) stated she knew that when a medical record request was made, the corporate office was notified, who reviewed the record. She stated a resident had to fill out a form to request the record, and she was unsure how long the process usually took.</p> <p>During an interview on 04/24/2025 at 12:37 pm, the Administrator stated residents completed a form for a record request, the form was sent to medical records staff at the facility, and then the request was sent to a third-party company to process. He stated that once the record was compiled for the resident and sent back to the facility, the facility collected the charges for copying the file and then released it to the resident or representative.</p>		