STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115606	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canton Center for Nursing and Healing LLC	321 Hospital Road Canton, GA 30114

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, resident family and staff interviews, and review of the facility policy titled, Notification, the facility failed to notify the responsible party of a change in medication and to provide a psychiatric evaluation for one of 50 sampled residents (R) (R2).Findings include:Review of the facility policy titled Notification dated January 2023 revealed under Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: . 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. b. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute condition. iii. erbation of a chronic condition. Review of the electronic medical record (EMR) revealed the following diagnoses that include but not limited to generalized anxiety disorder, unspecified, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, delirium due to physiological condition.Review of the Physician Orders for R2 dated 8/22/2025 revealed that the medication was reordered on this date for the lesser amount of 25mg (milligrams) after consultation with family to increase the dose.Telephone interview conducted with R2's family member (responsible party) on 12/22/2025 at 10:37 am revealed he could not understand why the facility never called to inform him R2 was no longer taking the medication or receiving a psychiatric consultation. He stated the medication had dropped off and his family member had been without for nearly three weeks, causing an increase in anxiety and depression and R2 being sent to the hospital.Interview with the NP AA on 12/23/2025 at 10:26 am revealed confirmed that she should have followed up with this order and the resident.Interview on 12/23/2025 at 9:31 am with the Director of Nursing (DON) revealed that nurses should follow the physician orders as written.

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
	115606	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canton Center for Nursing and Healing LLC	321 Hospital Road Canton, GA 30114

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on record review and resident family and staff interviews, the facility failed to document behavior monitoring correctly and follow up administration of antidepressant medication for one of 50 sampled Residents (R) (R2) related to the use of antidepressant medication. Findings include:Review of the electronic medical record (EMR) revealed R2 was admitted with diagnoses to include but not limited to generalized anxiety disorder and unspecified dementia.Review of August 2025 Medication Administration Record (MAR) for R2 revealed a physician order for behavior monitoring for antidepressant medication: Sertraline. The behavior monitoring section of the MAR documented no behaviors through 8/22/2025. Nurses Notes and Progress Notes revealed crying, suicidal ideation, anxiety and R2 was sent to the local hospital for these diagnoses.Review of the Physician Orders dated 8/22/2025 document that the medication was reordered on this date for the lesser amount of 25mg after consultation with family to increase the dose.Review of the Physician Orders dated 7/17/2025 revealed there was no order for a consultation with psychiatric services. Telephone interview conducted with the R2's family member (responsible party) on 12/22/2025 at 10:37 am revealed the family stated that Nurse Practitioner (NP) AA had been consulted for the resident's depression and anxiety increase and the medication (Sertraline) was increased from 25mg to 50mg, and a psychiatric consultation was ordered.Interview with the NP AA on 12/23/2025 at 10:26 am revealed that R2 was ordered 25mg of Sertraline on admission, the NP discussed with the daughter and the dose was increased to 50mg and consultation for psychiatric services ordered. The dose of 50mg was in effect from 7/17/2025 to 8/1/2025 where it was dropped and R2 did not receive any medication until it was reordered on 8/22/2025, which was for the lower dose of 25mg. R2 was sent to hospital on 8/22/2025. (Resident went 22 days without the anti-depressant ordered.) NP AA confirmed that she should have followed up with this order and the resident. Interview on 12/23/2025 at 9:31 am with the DON revealed that the nurses should follow the physician orders as written. She revealed that behavior notes should be a red flag. She stated that recently they have started going over behavior notes in the morning clinical meeting and NP AA and they had a new psychiatric service who also attended the meetings.