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	08/22/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of facility policy, the facility failed to properly document the transfer/discharge for one of three residents (Resident (R) 102) reviewed for discharge from a sample 34 residents. The deficient practice had the potential for the resident and/or resident representative to be uninformed on the transfer and appeal process. Findings include:Review of the facility's policy titled, Transfer and Discharge, Including Against Medical Advice (AMA) with a revision date of March 2025, reads in part, For Emergency Transfers to Acute Care the facility will obtain a physician's order for emergency transfer or discharge stating the reason for the transfer or discharge is necessary on an emergency basis.contact information of the practitioner who was responsible for the care of the resident; resident representative information including the contact information; information necessary to meet the resident needs such as diagnoses, allergies, baseline and current mental, behavioral, and functional status, and reason for transfer. Medications (including last does received) recent labs, immunizations; special instructions and/or precautions for ongoing care.Provide notice of transfer and facility's bed hold policy notice to the resident and representative as indicated.Review of R102's admission Record located on the resident's electronic medical record tab titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included drug induced myopathy (muscle disease caused by certain drugs), rhabdomyolysis (damage skeletal muscle tissue breakdown), and diabetes mellitus type II.Review of R102's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/04/2024 located in the resident EMR tab titled MDS, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 points out of 15, which indicated the resident was cognitively intact. The resident was assessed to require substantial to maximal assistance with most of her activities of daily living (ADLs).Review of R102's discharge MDS with an ARD of 8/11/2024 located in the resident's EMR tab titled MDS, revealed the resident was an unplanned discharge to a short-term acute hospital. The resident was expected to return to the facility.Review of R102's Nurses Notes, dated 8/11/2024, located in the resident's EMR tab titled Progress Notes, revealed the resident had complained about stomach pains and having a problem with bowel movements. The resident was alert and verbally responsive. Vital signs were stable. The nurse practitioner was made aware of the resident's complaints, and a fleets enema was ordered. The resident had positive results with four large stools. The resident vital signs were rechecked and found to be in normal range. The resident had good oxygen levels, and her skin was warm and dry.There was no further documentation in the progress notes to indicate if R102 had a change in condition that warranted her transfer to an acute care setting. The facility was unable to provide documentation of a physician's order for the resident to be transferred to an acute care setting, or that the resident's responsible party was notified of a change in the resident's condition necessitating the resident's transfer.During an interview on 8/22/2025 at 1:10 PM, the Interim Regional Director of Nursing (DON) was asked to review the resident's EMR to locate the documentation as to why R102 was transferred, transfer order, and notification of the resident's responsible party regarding the transfer. After reviewing the resident's EMR, the DON stated that she was unable to locate any of the requested information. The DON stated that it was an expectation that any time there was a change in the resident's condition, treatment, or need for transfer to an emergency room, it should be documented in the nurses' notes, there should be an order for the transfer. The DON further stated that the nurses were responsible for making the resident aware of the transfer in progress and the bed hold policy. The DON stated the nurses were responsible for sending a copy of the resident's medications, physicians' orders, and the resident's code status.During an interview on 8/23/2025 at 1:45 PM, the Assistant Director of Nursing (ADON) revealed that when a resident was an emergency transfer to the hospital, the bed hold policy was discussed, and a copy of the bed hold notification was given to the resident. The ADON stated copies of the resident's Advance Directive/Code Status, physicians' orders, and medication list were sent with the resident. The ADON stated that she was unable to locate any information regarding R102's transfer.During an interview on 8/23/2025 at 3:00 PM, the Regional Nurse revealed the staff had not followed the facility's policy regarding transfer/discharge to an acute care setting.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and facility policy review, the facility failed to complete a baseline care plan within 48 hours of admission for two of 34 sampled residents (Resident (R) 66 and R99). The deficient practice had the potential to disrupt continuity of care and communication among nursing home staff and the residents. Findings include:Review of the facility's policy titled, Baseline Care Plan, revised April 2025, indicated .2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders and discussion with the resident and resident representatives, if applicable. a. Once gathered, initial goals shall be established that reflects the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident current needs. 1. Record review of R66's admission Record under the Profile tab of the electronic medical record (EMR) revealed R66 was admitted to the facility on [DATE] with a diagnosis of type two diabetes mellitus without complication, heart disease without heart failure, and injury of head. Review of the Baseline Care Plan, dated 8/6/2025, found under the Assessment tab of the EMR, revealed the resident was always incontinent of bowel and bladder and had an indwelling catheter. The baseline care plan did not include interventions. The baseline care plan was incomplete.During an interview on 8/21/2025 at 11:54 PM Licensed Practical Nurse (LPN) 1 stated she was aware of the catheter and nursing was the one responsible for ensuring there was an order when a resident was admitted but was not responsible for the care plan. Interview with the Administrator on 8/21/2025 at 12:56 PM revealed, My expectation is that all residents admitted with indwelling foley catheters have a medical diagnosis to justify the use as well as ensure all care plans have measurable goals and interventions.2. Review of R99's admission Record located in the resident's EMR tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that include displaced intertrochanteric fracture of the left femur, abnormalities of gait and mobility, and generalized muscle weakness.Review of R99's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/5/2024 located in the resident's EMR tab titled MDS, revealed a Brief Interview for Mental Status (BIMS) score of 15 out 15, which indicated the resident was cognitively intact. The resident was assessed to have impairment of the lower extremity. The resident required substantial to maximal assistance with toileting, personal hygiene, and shower.Further review of R99's EMR failed to contain a baseline care plan that would address the resident's needs.During an interview on 8/22/2025 at 10:30 AM, the Assistant Director of Nursing (ADON) revealed it was an expectation that a baseline care plan would be completed within 48 hours of the resident's admission.During an interview on 8/22/2025 at 10:55 AM, the Administrator revealed the floor nurses were responsible for starting the baseline care plans which were to be completed within 48 hours of the resident's admission.

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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 record review, staff interviews, and review of facility policy, the facility failed to ensure that one of three residents (Resident (R) 99) reviewed for dependency on staff for activities of daily living (ADLs) received baths/showers and personal hygiene from a sample of 34 residents. The deficient practice had the potential to promote further deterioration of R99's ADLs and hygiene.Findings include:Review of the facility's policy titled, Activities of Daily Living with a revision date of April 2025, directs staff .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.Review of R99's admission Record located in the resident's electronic medical record tab titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that include displaced intertrochanteric fracture of the left femur, abnormalities of gait and mobility, and generalized muscle weakness.Review of R99's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/5/2024 located in the resident's EMR tab titled MDS revealed a Brief Interview for Mental Status (BIMS) score of 15 out 15, which indicated the resident was cognitively intact. The resident was assessed to have impairment of the lower extremity. The resident required substantial to maximal assistance with toileting, personal hygiene, and shower.Review of R99's Comprehensive Care Plan with an initiated date of 6/10/2024 located in the resident's EMR tab titled Care Plans, revealed a care plan for self-care deficit which would address the resident's need for personal hygiene and baths/showers was not developed.Review of R99's Activities for Daily Living documentation for June 2025 and provided by the facility, revealed R99 received personal hygiene on the following days: on the 7AM-7PM shift 5/30/2024 and 5/31/2024; and the 7PM -7AM shift on 5/30/2024. There was no documentation of the resident receiving personal hygiene for the month of June. The staff documented that the resident received a shower only on 6/13/2024 for the month of June.During an interview on 8/19/2025 at 11:15 AM with the assigned bath Certified Nursing Assistant (CNA) 5, after reviewing the R99's bath/shower sheets, CNA5 revealed that the documentation did not show that R99 had received personal hygiene, bath/showers as needed.During an interview on 8/19/2025 at 3:30 PM, the Administrator revealed she reviewed the ADL sheets. The Administrator stated that it appeared the resident did not receive the showers or personal hygiene as needed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure that a resident with a urinary catheter bag was properly positioned in a manner to prevent potential urinary tract infections due to contamination and ensure an order was in place for the use of a catheter for one of two residents (Resident (R) 66) reviewed for urinary catheters and urinary tract infections out of a total sample of 34 residents. The deficient practice had the potential for increased risk of infection and a diminished quality of life for R66.Findings include:Review of the facility's policy titled, Indwelling Cather Use and Removal, revised August 2023, indicated .2. Residents that are admitted with an indwelling catheter or subsequently receives one will be assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that the catheter is necessary.4. If an dwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to.b. Timely and appropriate assessment related to the indications for use of the catheter; as well as criteria for discontinuation of the catheter when the indication for use is no longer present.Review of R66's admission Record under the Profile tab of the electronic medical record (EMR) revealed R66 was admitted to the facility with a diagnosis of type two diabetes mellitus without complication, heart disease without heart failure, and injury of head. Review of the Baseline Care Plan, dated 8/6/2025, found under the Assessment tab of the EMR, revealed the resident was always incontinent of bowel and bladder and had an indwelling catheter. Review of the Physician Order under the Order tab of the EMR revealed there were no orders for the catheter as well as justification for its use. Observation on 8/18/2025 at 2:36 PM revealed R66 was lying in bed while the indwelling foley catheter bag was attached to the second bar of the rolling walker at waist level. Observation on 8/19/2025 at 10:08 AM revealed R66's indwelling foley catheter bag was still at waist level. Observation and interview on 8/19/2025 at 11:30 AM revealed after providing activities of daily living (ADL) care, Certified Nursing Assistant (CNA) 4 returned R66 to bed. CNA4 placed the resident's urinary drainage bag on the second bar of the resident's rolling walker. The drainage tubing was at the same level of the resident's bladder .the tubing had yellow urine with small amount of sediment backing up into the resident's bladder area. Interview with CNA4 during the observation revealed that she provided care to R66 periodically. CNA4 stated the resident preferred to have the drainage bag on the walker so he could go to the bathroom easier. CNA4 stated the urinary drainage bags were positioned on the side of the bed and was not sure how to position the drainage bag lower on the walker to promote proper drainage.During an interview on 8/21/2025 at 11:54 PM, Licensed Practical Nurse (LPN) 1 stated she was aware of the catheter and nursing was responsible for ensuring there was an order when a resident was admitted . At 12:10 PM, LPN1 confirmed there was no order for the catheter.Interview with the Administrator on 8/21/2025 at 12:56 PM revealed, My expectation is that all residents admitted with indwelling foley catheters have a medical diagnosis to justify the use of such and that staff follow policies and procedure for catheter management.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of facility policy, the facility failed to ensure that medications and supplies were not expired in one of one medication rooms and two of six medication carts. The facility also failed to ensure one treatment cart, and two of six medication carts were secured when not being used by staff. The deficient practices increased the risk of residents receiving expired medications and/or access to medications from the medication cart and had the potential to result in residents being subject to unsafe or ineffective treatment or adverse effects leading to serious illness. Findings include:Review of the facility's policy titled, Medication Administration with a revision date of April 2025, directs the staff Keep medication cart clean, organized, and stocked with adequate supplies.Review of facility's policy titled, Medication Storage with a revision date on March 2022, directs the staff .All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms).During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cut.1. During an observation on 8/18/2025 at 12:27 PM, the treatment cart was unlocked, and no staff were in sight. The treatment cart was between room [ROOM NUMBER] and 402. The treatment care supplies contained wound cleanser, several types of wound care supplies, hydrogen peroxide, alcohol wipes, zinc oxide, etc. The Corporate Wound Care Registered Nurse (CWRN) returned to the cart at 12:32 PM During an interview on 8/18/2025 at 12:32 PM, the CWRN acknowledged that she had left the treatment cart unlocked. She stated she was trying to attend to a resident request for pain medications and coffee and forgot to lock the cart.During an interview on 8/18/2025 at 3:30 PM, the Administrator revealed the CWRN had made her aware of the unlocked treatment cart. The Administrator further stated the Assistant Director of Nursing (ADON) was in the process of preparing staff in-service regarding securing the medication and treatment carts. 2. During an observation on 8/18/2025 at 2:52 PM, the medication cart for the 300-hall was left unlocked at the nurses' station. At 2:54 PM there were no staff at the nurses' station to monitor the unsecured medication cart. Several residents and staff members passed by the unsecured cart. At 2:57 PM, the Regional Nurse approached the surveyor to inquire if they needed anything. At that time the Regional Nurse was informed about the unlocked medication cart.During an interview on 8/18/2025, the Regional Nurse stated that the nurses were expected to lock the medication cart when it was not in use.During an interview on 8/18/2025 at 3:10 PM, the WCRN revealed she did not realize that she had left the medication cart unlocked and that she was pulled away by Physical Therapy (PT) to help with a resident.3. Inspection of the medication room located between units 100, 200, 300, and 400 on 8/30/2025 at 4:00 PM revealed 10 of 10 blue top vacuette tubes used for blood labs had an expiration date of 7/1/2025.Interview with the Administrator on 8/20/2025 at 4:15 PM revealed staff were responsible for checking and cleaning the medication room on the night shift. The Regional Director of Nursing (DON) was also present to observe the findings.4. Inspection of the medication cart for the 300 Hall on 8/20/2025 at 4:35 PM with Licensed Practical Nurse (LPN) 3 revealed the following:Two of two [NAME] (BD) Insyte Auto guard Intravenous catheters 24-gauge x .75 inch had an expiration date 2/29/2024.One of one BD Insyte Auto guard intravenous catheter size 22-gauge x 1.00 inch had an expiration date 9/1/2024.One of one BD Insyte Auto guard intravenous catheter size 20-gauge x 1.00 inch had an expiration date 7/1/2022.One bottle of Dr. [NAME] Ultimate Lung and Bronchial Support had an expiration date 6/2025.One bottle of Liquid Protein Supplement had dried sticky residue.One bottle of Geri Tussin DM had dried sticky residue.All the drawers of this medication cart had dirt and trash debris. Also, three yellow pills, two white pills, one dark green pill, one red colored pill, and one oblong white pill (unlabeled) were found in the top drawer. During an interview on 8/20/2025 at 5:24 PM, LPN3 confirmed the findings on the inspection of the medication cart. LPN3 identified the unlabeled pills as Tylenol, aspirin, Motrin, and iron; however, LPN3 was unable to identify the oblong white pills. LPN3 further stated the nursing staff should be cleaning and checking the carts weekly.During an interview on 8/20/2025 at 5:30 PM, the Administrator asked the surveyor what medications were found on the medication cart. The findings were reviewed with the Administrator, and she was given the unlabeled medications. The Administrator stated it was the responsibility of the night nurse to check and clean the medication carts every night. Observation on 8/21/2025 at 6:10 AM revealed the medication cart for the 100-hall was left unlocked and no staff was in sight to observe the unlocked medication cart. At 6:16 AM, LPN4 exited the resident's room, checked her computer, and then locked the cart. An inspection of the

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record review, resident and staff interviews, and review of facility policy, the facility failed to ensure that one of six residents (Resident (R) 9) with nutritional problems in a total sample of 34 was offered a substitute meal after refusing the meal on the menu.Findings include:Review of the facility's undated policy titled Resident Nutrition Services revealed item two reading reasonable efforts will be made to accommodate resident choices and preferences.Review of the Diagnosis located in the electronic medical record (EMR) under the Medical Diagnosis tab revealed R9 was admitted from the hospital to the facility with multiple comorbidities including but not limited to cerebral palsy.Review of the order located under the Orders tab of the EMR, revealed R9's diet order consisted of regular diet, regular texture, and regular liquids as of 8/1/2025.Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/19/2025 and located under the MDS tab of the EMR revealed an eating status of independent. Review of the care plan, located under the Care Plan tab of the EMR dated 6/19/2025 revealed a goal that R9 would improve his current level of function and gain two-three pounds per week through review. The interventions were to update preferences (which was completed) and add med pass 3.0 (liquid supplement) three times a day.Observations on 8/20/2025 at 5:50 PM revealed Certified Nursing Assistant (CNA) 3 removing a tray from R9's room approximately 20 minutes after receiving the tray. CNA3 was returning the tray to the kitchen cart in the corridor when CNA3 was asked if the tray contained R9's meal and if R9 ate anything. CNA3 stated it was the tray containing R9's meal and opened the cover to the plate showing R9 did not eat any part of the meal. When CNA3 was asked if he offered R9 a substitute meal, CNA3 responded no, he never eats anything.During an interview on 8/20/2025 at 5:51 PM, R9 stated that he did not want his meal. R9 stated CNA3 did not ask him if he wanted anything else since he refused him meal.During an interview on 8/21/2025 at 1:10 PM, the Registered Dietitian (RD) revealed she expected staff to offer substitutes to residents who ate less than 25% (percent) of their meals. The RD was not aware that staff were not offering an alternative to residents who refused their meal.Interview with the Administrator on 8/22/2025 at 2:45 PM revealed she expected staff to offer residents substitutes when they did not eat the meal on the menu.Interview with the Director of Nursing (DON) on 8/22/2025 at 2:50 PM revealed she expected CNAs to offer alternatives to residents eating less than 25% of a meal of choice or less.