STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115611	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Park Health and Rehabilitation	1310 West Gordon Street Douglas, GA 31533

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, record reviews, interviews, and review of the facility's policy titled, Weight and Nutrition Management, the facility failed to ensure timely interventions and assessments were completed after a significant weight loss for one of seven Residents (R) (R115) reviewed for weight loss out of 43 sampled residents. This failure had the potential to lead to additional weight loss concerns and malnutrition.Findings include:Review of the facility's policy titled, Weight and Nutrition Management, reviewed 12/27/202024, revealed It is the intent of this center to review and assess nutritional aspects related to significant weight changes. Review of the Face Sheet located under the Resident Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted with diagnoses that included but not limited to Parkinson's disease and dementia. Review of the quarterly Minimum Data Set (MDS) for R115 located under the MDS Assessment Resident MDS List tab of the EMR with an Assessment Reference Date (ARD) of 8/12/2025 revealed a staff assessment for mental status was conducted with the resident assessed to have severely impaired cognition. The resident's weight was 179 pounds. Review of the physician orders for R115 located under the resident summary Orders tab of the EMR, revealed Diet: Regular Easy Chew. GR [ground] Meat., dated 6/12/2024, and Nutritional Treat. with Meals, dated 12/15/2024. Review of the care plan for R115, dated 6/5/2025 and provided by the facility, revealed a problem of risk for altered nutrition status. Interventions included monitor weight, dated 4/8/2024. Observe intake, dated 2/21/2024. Provide meal alternatives as needed, dated 5/19/2024. Provide supplements as ordered and flavor of choice, dated 2/22/2024. Review of the weights for R115 located under the resident summary Weights tab of the EMR, revealed:-8/7/2025: 179 pounds.-9/2/2025: 170 pounds. (This was a 5% triggered weight loss in one month) Review of the RD [Registered Dietitian] Nutritional Progress Note and Recommendations for R115 located under the resident data collection section under the Clinical Assessment List tab of the EMR, revealed the last RD assessment was conducted on 11/30/2024. Review of the Nutritional Screen for R115 located under the resident data collection section under the Clinical Assessment List tab of the EMR, revealed the last Dietary Manager (DM) note was conducted on 8/11/2025. Review of the EMR for R115 revealed, no progress notes, assessments, or patient at risk (PAR) notes were conducted after the weight loss trigger on 9/2/2025 through 9/10/2025. During a breakfast observation on 9/10/2025 at 8:30 am, R115 received yogurt, eggs, milk, coffee, berry magic cup, ground sausage, toast, and juice. She was able to tell the staff what foods she wanted and didn't want. She received staff assistance to eat. She ate 100% of the berry magic cup, spoons of yogurt, eggs, and sausage, along with sips of milk and coffee. There was no consumption of toast or juice. During a lunch observation on 9/10/2025 at 1:38 pm, R115 received pudding, berry magic cup, cookie, tomato soup, juice, ground pork with no gravy, lima beans, and pinto beans. She received staff assistance to eat. She ate 100% berry magic cup, spoons of ground pork, lima beans, pinto beans, about 50-60% tomato soup, about 75% cookie, and sips of juice. During an interview on 9/10/2025 at 10:20 am, the DM stated she went to the weekly PAR meeting, Wednesdays after the morning meetings. She stated the RD did not go to the meetings. The DM stated she was the one who conducted the weight loss portion of the meetings. She stated she did the weekly and monthly weights, and the system would trigger the weight loss percentage. During an interview on 9/10/2025 (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 10:34 am with the RD and the DM, the RD stated she charted weight losses for one-, three-, and six-month losses. She stated she was in the facility last week, charting. She stated they were still getting the monthly weight losses, and she was waiting to see if the weight was accurate. The DM stated there was no PAR meeting the previous week and that R115 was on the list for PAR this Friday (10 days after the significant weight loss trigger). The DM reviewed the food interventions put into place and verified no new interventions since February 2024. The DM acknowledged they did not get the reweight and it should have been requested on the same day as the weight loss, last Tuesday. She stated they just obtained the reweight this date at 170 pounds (8-days after the significant weight loss trigger). During an interview on 9/10/2025 at 2:02 pm, the Director of Nursing (DON) stated they had PAR meetings weekly on Wednesdays, and they did one last week. She stated the monthly weights were put in last week The DON stated if the weight was triggered on Tuesday, they would do a reweight to make sure the weight was accurate. She stated a reweight the same day would depend on the resident. She stated the person who put the weights in the system would be the first to see the significant weight loss. The DON stated the DM was the one who put the weights in the system. She stated the DM would review the weights and reach out to the RD. She stated the DM was not present at the PAR meeting the week before. She confirmed the last RD note was dated 11/30/2024, prior to the one placed today, in which she recommended additional supplementation. The DON stated she became aware of R115's weight loss today, in preparation for the PAR meeting this Friday.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and review of the facility's policy titled, Meal Service, the facility failed to ensure ready-to-eat food was not touched with bare hands during meal assistance for one of seven Residents (R) (R115) reviewed for weight loss out of a total sample of 43 residents. This failure had the potential to lead to the spread of infection and food borne illness. Findings include: Review of the facility's policy titled, Meal Service, reviewed 12/27/2024, revealed Associates should not need to wear gloves with distributing foods to patients or when assisting residents to dine unless touching ready to eat foods.During a lunch observation on 9/10/2025 at 1:47 pm, Certified Medication Aide (CMA) 1 assisted R115 with feeding. She picked up a cookie with her bare right hand and placed the cookie in the resident's mouth. She picked up the cookie again with her bare right hand and placed the cookie in the resident's mouth. She kept her fingers on the cookie and proceeded to give the resident another bite. Her finger and thumb were pressed into the soft cookie and proceeded to give the resident another bite. During an interview on 9/10/2025 at 1:54 pm, the CMA1 revealed, she was taught not to use gloves during meal assistance and did not know what else she could have used to feed the resident the cookie. During an interview on 9/10/2025 at 2:02 pm, the Director of Nursing (DON) confirmed that the staff should have used a fork, spoon, or gloves for the bite sized pieces of food.