STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115663	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Park Health and Rehabilitation	1212 Broadrick Drive Dalton, GA 30720

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled, HLTC Advance Directives for Health Care Policy, the facility failed to establish mechanisms for documenting and communicating the resident's choices for code status (advanced directives) to staff responsible for the resident's care for one of 34 sampled residents (R) (R1). The deficient practice had the potential to prevent R1 from expressing her right to formulate an advanced directive.Findings include:A review of the facility policy titled HLTC Advance Directives for Health Care Policy revised [DATE], documented under Purpose: Support the resident's right, in accordance with Georgia law, to formulate Advance Directives, honor existing Advance Directives, and revoke Advance Directives. Under Policy and Procedure: 1. The facility will promote the resident's right to formulate an Advance Directive, including the right to accept or refuse medical or surgical treatment, and revise or revoke an existing Advance Directive at any time. Under Policy and Procedure: .7. The facility will inform direct care staff and the resident's physician of any Advance Directives or changed to Advance Directives.Review of R1's electronic medical record (EMR) revealed R1 was originally admitted to the facility with pertinent diagnoses including but not limited to, acute and chronic respiratory failure with hypoxia, acute kidney, chronic diastolic (congestive) heart failure, chronic systolic (congestive) heart failure, Alzheimer's disease, dysphagia, need for assistance with personal care, chronic kidney disease (stage 4, severe), and cognitive communication deficit.Review of R1's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicates R1 had moderate cognitive impairment.Review of R1's care plan dated [DATE] indicated a focus of a Do Not Resuscitate (DNR) code status. Goals included but were not limited to R1's wishes to be observed during the review period and cardiopulmonary resuscitation (CPR) will not be performed in the event of cardiac or respiratory arrest. Interventions included but were not limited to a DNR status and to not initiate CPR in the event of cardiac or respiratory arrest and allow natural death.Review of R1's electronic medical record (EMR) on [DATE] revealed the main page of the resident's profile included the name of the resident, photo identification of the resident, and other identifiable information. The section marked Code Status did not indicate full code or do not resuscitate. An interview with Certified Nursing Assistant (CNA) BB on [DATE] at 1:39 pm revealed that to determine a resident's code status, staff used to look at code status on the EMR, but now she believed they had to dig through the care plan, as the code status section was no longer visible to CNAs. When asked what she would do in the event of an emergency code situation, she stated that she just knew which residents were full codes based on working with them for so long. When asked if there was any paper reference for code status, she stated that there may be something in the nurses' station, but it was not accessible to CNAs.An interview with CNA HH on [DATE] at 1:50 pm revealed that if a resident was coding, CNAs were to look at the kiosk, but she was not sure exactly where it was but would show this surveyor. When asked if there was any paper reference for code status, she re-stated that they would have to look at the kiosk. While showing the kiosk to this surveyor, CNA HH could not locate the code status on the CNA kiosk and stated that CNAs would have to ask the nurse. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked what she would do in the event of an emergency and could not locate a nurse, she re-stated that she would have to ask the nurse. She stated that there were no paper references for resident code statuses.An interview with Licensed Practical Nurse (LPN), Unit Manager on [DATE] at 1:57 pm revealed she assisted CNA HH in looking for the code status on the CNA kiosk. She confirmed she could not find any CNA access to resident code statuses on the kiosk. When asked where nurses would determine resident code statuses, she stated that she would open the EMR to look for the code status on the main page of the resident's profile. She further stated she had no idea why the CNAs do not have access to that, but she thinks it has always been like that. She further stated there was no paper reference for code status to look at and confirmed that it was all on computer. While showing this surveyor R1's EMR, she confirmed the code status for R1 was not listed where it should be and was not sure what the code status was for R1. When asked whose responsibility it was to place the code status, she stated that it wast he responsibility of the nurses. She further stated that the code status may have been changed during her last hospitalization which was a few months ago. After searching through the EMR, she identified that R1's code status was do not resuscitate (DNR) effective [DATE]. LPN FF then updated the code status on the R1's EMR to reflect a DNR status. She stated that potential negative outcomes of not having the correct code status listed could lead to someone passing away when they should be full code or CPR would be performed on a DNR resident. An interview with the Director of Nursing (DON) on [DATE] at 9:52 am, she revealed that most CNAs were CPR certified and would perform as needed and as applicable. She was not aware if the code statuses were listed anywhere other than the EMR. She stated that the main page of the resident's profile on the CNA's kiosk should show the residents' allergies, code status, and any special instructions for care. She stated that yesterday she checked and confirmed code statuses were not visible for CNAs on their kiosk. She brought this issue to upper management and had the issue resolved yesterday. She stated that she expected residents' code statuses to be determined on admission, that social services will obtain any DNR forms as applicable as well as obtaining resident wishes, and that nursing staff would then put the orders in the EMR for staff to see, which was where the staff should find a resident's code status. The DON further stated that if no code status was listed, or if the incorrect code status was listed, potential negative outcomes could be the resident's wishes would not be honored and unexpected deaths could occur without the potential to perform CPR. An interview with the Social Services Coordinator (SSC) on [DATE] at 10:45 am revealed she would talk to cognitive residents to see where their mental status was to see if they could understand code status preferences. She would ask what their preference wasf or code status and would provide education on it as needed. She did not require an answer for code status at the time, but she would verify if residents were a full code or DNR. If they have an advanced directive, she would request a copy. They would discuss in the quarterly meetings if there were any changes in code statuses or preferences. She stated that she or the Business Office Manager could scan and upload advance directives in the EMR. She cannot make the code status change in the EMR, only the nurses did that.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, resident and staff interviews, record review and review of the facility's policy titled, Care Planning, the facility failed to implement the care plan for risk of falls for one of 34 residents sampled (R) (R17). This deficient practice had the potential to place the resident at risk of decreasing the resident's practicable physical, mental and psychological well-being.Findings include:Review of the facility's policy titled Care Planning dated 11/1/2019, documented under Policy: .D. Care Plan Reviews.1. The resident's comprehensive care plan will be reviewed, revised, and updated on a PRN basis, as determined by new and/or temporary resident condition changes that do not meet the significant change MDS criteria, yet require care plan updates per policy.Review of care plan for R17 dated 11/2/2020 revealed that staff are to assist R17 with toileting and stay in attendance during toileting as indicated. An additional review of the care plan revealed that staff are to respond promptly to all requests for assistance.During an observation of R17 on 8/13/2025 at 10:14 am, R17 was noted to be sitting on the toilet unattended with the emergency alarm sounding and flashing. R17 alerted her call light and was waiting for assistance. During this observation, it was noted that Licensed Practical Nurses (LPN) and Registered Nurses (RN) were sitting at the nursing station while R17 call light continued to alarm. Certified Nursing Assistants (CNA) BB and CNA CC attended the alarm at 10:16 am.Interview with MDS Coordinator EE on 8/13/2025 at 11:50 am revealed that some care plans were revised daily when changes occurred or when new information was received about a resident during team meetings. MDS Coordinator EE revealed that nursing staff and CNA staff could update a resident's care plan if needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled, Hand Hygiene, the facility failed to ensure that staff used proper infection control practices as evidenced by staff not performing appropriate hand hygiene between glove changes during catheter and perineal care for one of four residents (R) (R3) with catheters. The deficient practice had the potential to transfer pathogens and increase the risk of infection transmission for R3.Findings include:Review of the facility's policy titled titled Hand Hygiene with a revision date of 3/20/2024 revealed under Policy:.A. Hand Hygiene.1. Hand hygiene will be performed by washing hands with soap (anti-microbial) or using alcohol-based hand rub (ABHR) on hands. 2. Healthcare personnel (HCP) will perform hand hygiene with ABHR or soap and water for the following clinical indications that include but are not limited to after removing gloves or other personal protective equipment. Review of the electronic medical record (EMR) for R3 revealed that he was admitted to the facility with diagnoses that included but were not limited to osteomyelitis of ankle and foot, methicillin resistant staphylococcus aureus infection (MRSA), acute respiratory failure with hypoxia, traumatic hemorrhage of the cerebrum, and neuromuscular dysfunction of bladder.Review of the physician's orders revealed that there was an order for indwelling Foley catheter for diagnoses of neurogenic bladder.Review of the Minimum Data Set (MDS) assessment dated [DATE] a Brief Interview for Mental Status (BIMS) score of 13, which means that he is cognitively intact. Review of section H (Bladder and Bowel) revealed that he has an indwelling catheter.Review of the care plan for R3 revealed that he is at risk for a multi-drug-resistant organism (MDRO) related to the presence of a foley catheter and Enhanced Barrier precautions (EBP) were implemented for that risk.An observation of perineal and catheter care occurred on 8/14/2025 at 11:11 am. Certified Nursing Assistant (CNA) AA provided catheter and perineal care for R3. CNA AA removed a soiled pair of gloves after cleaning the resident's perineal area. Without performing hand hygiene, she then put on a new pair of gloves and continued care by wiping and then disposing of the soiled cleaning wipes. She then removed her gloves a second time and donned (put on) another pair without performing hand hygiene. She concluded the procedure by adjusting the resident's incontinence brief and completed care without any visible hand hygiene between glove changes.An interview on 8/14/2025 at 10:25 am with CNA AA confirmed that she did not perform hand hygiene between glove changes.An interview with the Director of Nursing (DON) on 8/14/2025 at 10:35 am revealed that it was her expectation that hand hygiene was performed between glove changes.