STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115670	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockdale Healthcare Center	1510 Reniassance Drive Conyers, GA 30012

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview, record review, and review of the facility's policy, the facility failed to ensure the residents were allowed to receive mail/packages without staff opening and obtaining copies of the documents without the resident's/resident's representative's permission for one of 14 Residents (R) (R3) interviewed about receiving mail unopened.Findings include:Review of the facility's policy titled, Mail, dated 11/2017, revealed, . residents are allowed to communicate privately with the persons of their choice and may send and receive their personal mail unopened unless otherwise advised by the attending physician or resident and documented in the residents' medical records . Review of R3's admission Packet, signed by the resident on 2/6/2024, revealed under the section titled Mail that the resident shall be afforded reasonable privacy in communications, including the timely sending and receiving of mail and electronic communications.Review of R3's Diag (Diagnosis) tab of the EMR revealed R3 had diagnoses which included cerebral infarction and slurred speech.Review of R3's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 4/4/2025 and located under the MDS tab of the electronic medical record (EMR), revealed R3 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated she was moderately cognitively impaired.During an interview on 6/30/2025 at 1:02 pm, R3 and her daughter were interviewed. During the interview they stated the Sherrif had delivered copies of private documents on two occasions, and on each occasion the Social Worker (SW) took the documents and made copies of them without the resident's permission. The resident and the resident's daughter stated the SW told them they needed to keep copies in the resident's file just in case something comes up.Review of R3's power of attorney (POA) documents, located in the Misc section of the EMR, revealed the daughter who had been interviewed on 6/30/2025 at 1:02 pm along with the resident was the designated POA.During an interview on 6/30/2025 at 3:08 pm, the Administrator stated a police officer brought the papers to his office, and the social worker made copies of the papers and then walked the police officer to the resident's room and delivered the paper to the resident. The Administrator stated he did not remember the date of the incident; however, he did provide a folder with a copy of the documents. Review of the documents revealed they were dated 11/25/2024 and 1/28/2025.During an interview on 7/2/2025 at 10:50 am, the SW stated the police met with the Administrator and then she walked the officer to the resident's room, and he gave R3 the papers. She stated the resident told her she was expecting the documents. The SW confirmed she did copy the documents prior to obtaining the resident's permission.

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
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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and review of the facility's policy titled, Discharging/Transferring the Resident, the facility failed to notify the resident's responsible party on the day the resident was discharged and transported out of the facility for one of three Residents (R) (R7) reviewed for discharge out of a total sample of 20.Findings include:Review of the facility's policy titled, Discharging/Transferring the Resident, dated 6/2025, revealed it was the facility's policy to notify the responsible party of the transfer or discharge.Review of R7's admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 2/19/2025 and located in the Aspen MDS Viewer, revealed R7 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease, dementia, and aphasia.Review of R7's Progress Note, dated 6/10/2025 at 4:39 pm and located under the Progress Notes tab of the electronic medical record (EMR), revealed a progress note written by the previous Social Worker (SW) that recorded the SW had spoken to the family member about R7's transfer. It was recorded the family agreed to the transfer and did not voice any concern. The note was silent about why, where, or when R7 was being transferred.Review of a Nurse's Note, written by the Infection Preventionist Nurse, dated 6/11/2025 at 11:41 am, and located under the Progress Notes tab of the EMR, revealed R7 was discharged to (Name of Nursing Home) via non-emergency transport. It was recorded that the report was called into the nurse at (Name of Nursing Home), and all medications had been sent with the resident. The note did not indicate the family member was notified of the discharge/transfer. During an interview on 7/1/2025 at 10:55 am, Resident Representative (RR) 7 stated she was confused about why they discharged R7 and moved her to a sister facility. She stated she was called on 6/10/2025 by the Social Worker and was told R7 would have to be transferred to a different facility on 6/13/2025, and she was not offered the option to keep R7 at her current facility. RR7 stated that when she arrived at the facility on 6/11/2025, R7 was not in the facility and had already been moved to a different facility, and no one had called/notified her the resident was being transferred on 6/11/2025.During an interview on 7/1/2025 at 11:43 am, the Infection Preventionist Nurse stated she was shocked when a private transport arrived to pick up R7 because she was not aware R7 was being discharged /transferred to another nursing facility. She stated she stopped by the SW's office and asked her about it, and the SW told her she had contacted the resident's representative, and the representative was aware of the transfer. She stated she stopped by the SW's office a second time as R7 was being transported out, and the SW again stated the representative was notified of the discharge/transfer.During an interview on 7/3/2025 at 11:10 am, the Administrator verified RR7 had not been contacted on the day R7 was discharged and transferred to a different facility.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 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, interview, and review of the facility's policy titled, Prevention of Resident Abuse, Neglect, Misappropriation or Misappropriation of Property, the facility failed to ensure the resident's right to be free from verbal/mental abuse for one of eight Residents (R) (R) (R11) reviewed for abuse out of a total sample of 20.Findings include:Review of the facility's policy titled, Prevention of Resident Abuse, Neglect, Misappropriation or Misappropriation of Property, dated 8/22/2022, revealed it was the policy of the facility that each resident be free from verbal, sexual, physical, and mental abuse, and mistreatment of any kind. Under the Definitions section of the policy, it defined mental abuse as the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.Review of R11's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 4/7/2025 and located in the ASPEN MDS Viewer, revealed R11 was readmitted to the facility on [DATE]. It was recorded R11 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact.Review of R11's Diag (Diagnosis) tab of the electronic medical record (EMR) revealed R11 had diagnoses which included depression, dementia, psychotic disturbance, mood disorder, and anxiety.Review of R11's Care Plan, revised 1/7/2025 and located under the Care Plan tab of the EMR, revealed focus areas of expressing mood problems/symptoms, tearfulness, and a history of depression. It was recorded that the resident received psychoactive medications due to a mood disorder. During an interview on 6/30/2025 at 3:08 pm, the Administrator stated the facility did not have a social worker (SW) because she was terminated for a violation of resident's rights.During an interview on 7/1/2025 at 1:37 pm, R11 stated one day a lady came into her room and told her she had to move because she was a hoarder and did not keep her room clean. She stated she was very upset and worried about it. R11stated she was happy they let her stay because she liked living in the facility and did not want to move.On 7/1/2025 the Administrator provided a copy of the SW's termination documents which included the following:a. An Employee Status Change Form and a State of Georgia Department of Labor Separation Notice, each signed by the Administrator and dated 6/12/2025, recorded the SW was terminated for Questionable behavior practices, violating resident rights.b. A printed email from the Administrator to the facility's Regional Human Resources Director, dated 6/12/2025 and with a subject line of Permission to Terminate, revealed he recommended the termination of the SW. The report recorded that on 6/10/2025 they received a compliance call stating the SW had told R11 that she would be moved to another facility in the morning because she was a hoarder and kept her room dirty. The resident was crying and upset, and the resident and the family called the compliance line because of this. He wrote This is considered improper Transfer and/or Discharge.c. An undated written statement, completed by the Administrator, detailing his conversation with R11 on Wednesday 6/11/2025 at 9:55 am. He asked R11 what happened last night, and she told him a lady came in her room and told her she was being transferred/moved to another facility because her room was dirty and she was a hoarder. The resident stated she told the lady No, I don't want to go, and the lady told her she would be moving to (Name of the sister facility) in the morning. In the statement the Administrator wrote, Just an FYI . [R11] was admitted to the facility on [DATE] and has a BIMS of 15. He stated he interviewed Registered Nurse (RN) 1, Licensed Practical Nurse (LPN) 1 and Certified Nursing Assistant (CNA) 1, and all their stories of what happened were the same.d. Review of a written statement, dated 6/11/2025 and signed by RN1 (the 3:00 pm to 11:00PM Supervisor) who recorded that on 6/10/2025, she was approached by a CNA and an LPN who told her that R11 was in her room crying and upset, telling them that she had been told that she had to leave the facility in the morning. RN1 wrote she immediately went to the resident's room and upon entering the room the resident was crying and told her that the social worker told her she had to leave the facility in the morning because she was nasty. She wrote that the resident was upset because she was not given any type of notice to prepare for the leave. When asked if she wanted to go, R11 replied No and stated she was told she was being transferred to (Name of the sister facility). RN1 wrote that R11stated she was not given a choice. RN1 wrote R11 was crying unconsolably and had to be reassured that she would not be forced to go anywhere without her consent. She wrote the resident kept saying this is not right, this is not right. She wrote she had seen the social worker go into the resident's room around supper time and this was reported to her later in the evening. She wrote she reported it to the Director of Nursing who said she would follow up in the morning and instructed her to tell R11 to calm down because she did not

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 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 interview, record review, and facility's policy titled, Prevention of Resident Abuse, Neglect, Misappropriation or Misappropriation of Property, the facility failed to report an allegation of verbal/mental abuse to the State Survey Agency within two hours after the allegation was made for one of eight Residents (R) (R11) reviewed for abuse out of a total sample of 20.Findings include:Review of the facility's policy titled, Prevention of Resident Abuse, Neglect, Misappropriation or Misappropriation of Property, dated 8/22/2022, revealed it was the policy of the facility that each resident be free from verbal, sexual, physical, and mental abuse, and mistreatment of any kind. The policy indicated abuse is to be reported to the Administrator and the State Survey Agency within two hours of the allegation being made.Review of R11's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 4/7/2025 and located in the ASPEN MDS Viewer, revealed R11 was readmitted to the facility on [DATE]. It was recorded R11 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact.During an interview on 6/30/2025 at 3:08 pm, the Administrator stated the facility did not have a social worker (SW) because she was terminated for a violation of resident's rights.During an interview on 7/1/2025 at 1:37 pm, R11 stated one day a lady came into her room and told her she had to move because she was a hoarder and did not keep her room clean. She stated she was very upset and worried about it. R11 stated she was happy they let her stay because she liked living in the facility and did not want to move.On 7/1/2025 the Administrator provided a copy of the SW's termination documents which included the following:a. An Employee Status Change Form and a State of Georgia Department of Labor Separation Notice, each signed by the Administrator and dated 6/12/2025, recorded the SW was terminated for Questionable behavior practices, violating resident rights.b. A printed email from the Administrator to the facility's Regional Human Resources Director, dated 6/12/2025 and with a subject line of Permission to Terminate, revealed he recommended the termination of the SW. The report recorded that on 6/10/2025, they received a compliance call stating the SW had told R11 that she would be moved to another facility in the morning because she was a hoarder and kept her room dirty. The resident was crying and upset, and the resident and the family called the compliance line because of this. He wrote This is considered improper Transfer and/or Discharge.c. An undated written statement, completed by the Administrator, detailing his conversation with R11 on Wednesday 6/11/2025 at 9:55 am. He asked R11 what happened last night, and she told him a lady came in her room and told her she was being transferred/moved to another facility because her room was dirty and she was a hoarder. The resident stated she told the lady No, I don't want to go, and the lady told her she would be moving to (Name of the sister facility) in the morning. In the statement the Administrator wrote, Just an FYI . [R11] was admitted to the facility on [DATE] and has a BIMS of 15. He stated he interviewed Registered Nurse (RN) 1, Licensed Practical Nurse (LPN) 1 and Certified Nursing Assistant (CNA) 1, and all their stories of what happened were the same.d. Review of a written statement, dated 6/11/2025 and signed by RN1 (the 3:00 pm to 11:00 pm Supervisor) who recorded that on 6/10/2025, she was approached by a CNA and an LPN who told her that R11 was in her room crying and upset, telling them that she had been told that she had to leave the facility in the morning. RN1 wrote she immediately went to the resident's room and upon entering the room the resident was crying and told her that the social worker told her she had to leave the facility in the morning because she was nasty. She wrote that the resident was upset because she was not given any type of notice to prepare for the leave. When asked if she wanted to go, R11 replied No and stated she was told she was being transferred to (Name of the sister facility) RN1 wrote that R11stated she was not given a choice. RN1 wrote R11 was crying unconsolably and had to be reassured that she would not be forced to go anywhere without her consent. She wrote the resident kept saying this is not right, this is not right. She wrote she had seen the social worker go into the resident's room around supper time and this was reported to her later in the evening. She wrote she reported it to the Director of Nursing who said she would follow up in the morning and instructed her to tell R11 to calm down because she did not have to go anywhere.During an interview on 7/1/2025 at 4:38 pm, RN1 confirmed what she wrote in her written statement. She stated that the resident was very upset that the SW had told her she had to leave in the morning, and she told her she did not have to go anywhere she could stay in the facility. She stated she felt it was abuse and should have been investigated.During an interview on 7/2/2025 at 10:19 am, the Administrator stated he did not report this treatment of R11 to the State Survey Agency because he did not consider it to be abuse. He confirmed she

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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, review of the facility's policy titled, Prevention of Resident Abuse, Neglect, Mistreatment, or Misappropriation of Property, the facility failed to ensure allegations of abuse were thoroughly investigated for two of eight Residents (R) (R1 and R14) reviewed for a total sample of 20. Findings include: Review of the facility's policy titled, Prevention of Resident Abuse, Neglect, Mistreatment, or Misappropriation of Property, dated 8/22/2022, revealed it was the policy of the facility to ensure all suspected cases of abuse be fully investigated by the Administrator, Abuse Coordinator, or designee. Under the investigation section of the policy, it stated to . Interview all associates, residents, and family members involved . 1. Review of R1's admission tab in the electronic medical record (EMR) revealed she was admitted to the facility with diagnoses that included dementia, psychotic disturbance, mood disturbance, anxiety, mental disorder, depression, muscle weakness, difficulty in walking, and adult failure to thrive. It was recorded R1 discharged to the hospital on [DATE]. Review of R1's Progress Note, dated 11/24/2024 at 12:05 am and located in the Progress Notes tab of the EMR, revealed the resident was alert and oriented to person, place, and time, communicated verbally, had clear speech and was able to understand and to be understood. Review of R1's Physical Therapy notes, dated 11/20/2024 and provided by the Director of Nursing (DON), revealed the resident was dependent on one staff for bed mobility. Review of a Facility Incident Report Form, dated 11/22/2024 and completed by the Administrator, revealed on 11/22/2024 at 5:45 pm, R1 alleged Certified Nurse Aide (CNA) 2, who worked the day shift, was mean to her. She alleged CNA2 was rough while changing her brief. CNA2 was suspended pending the investigation. Review of a right wrist x-ray completed on 11/23/2024 revealed she had a nondisplaced oblique fracture through the fourth metacarpal with no abnormal soft tissue swelling. Review of a letter with the letter head of (Name of Facility) dated 12/02/2024 and addressed to the Georgia Department of Community Health, Long Term Care Section and signed by the Administrator, confirmed the resident had a fractured fourth metacarpal and recorded the resident's family member stated the finger had been broken previously and the rough handling could have reaggravated the old injury. The investigation summary stated the resident complained of right arm pain and had bruising on her right arm and hand upon admission. The report stated CNA2 had been employed by the facility for 11 years and there had been no past accusations or allegations of abuse. The report concluded that the allegation of abuse was unsubstantiated. The report stated the staff was reeducated on abuse, kinds of abuse and preventing abuse and dealing with residents with dementia. Review of the investigation revealed the only witness statements were from the alleged perpetrator (CNA2) dated 11/25/2024, from Registered Nurse (RN) 1, and from Licensed Practical Nurse (LPN) 5. Review of the schedule and interview with RN1 revealed both of the nurses worked the 3:00 pm to the 11:00 pm shift and were not working at the time the alleged abuse occurred. According to the statement written by LPN5 and dated 11/22/2024, R1's family member reported to her that around noon today (11/22/2024) someone taking care of R1 was rough with her. According to the family member, someone snatched a cup from her and popped her on the arm. The statement from RN1, dated 11/22/2024, revealed RN1 stated R1 reported CNA2 was rough today during incontinence care. She wrote R1 was asking CNA2 to be gentle because she was rubbing her too hard and then the CNA grabbed her right hand and held it tight and then hit her several times on the left hand. The resident told her CNA2 threw a box of tissues at her and tossed a teddy bear as well. During an interview on 7/10/2025 at 4:38 pm, RN1 stated she was the RN supervisor on the 3:00 pm to 11:00 pm shift, and she was not working at the time of the alleged incident. She stated LPN 5 was also working on the 3:00 pm to 11:00 pm shift and had not worked the day shift. RN1 stated LPN5 had informed her of the alleged abuse after R1 had reported it to LPN5. Review of the staffing schedule for the date and time of the alleged incident was reviewed and revealed there were no witness statements from any of the staff that was working on the shift of the alleged abuse, and no resident statements were included. During an interview on 7/3/2025 at 11:10 am, the Administrator was asked if he had any additional witness statements related to this alleged abuse, and he stated the did not. He stated they did not get statements from the residents CNA2 had cared for that evening, and they did not obtain any from the staff working with CNA2 on the day of the alleged incident. He stated it was his expectation that the staff on duty at the time of the alleged abuse should have given a witness statement for the day and residents should have been interviewed. 2. Review of R14's admission Record, located in the EMR under the admission tab, revealed she was admitted to the facility with

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 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 interview, record review, and review of the facility's policy and procedure titled, Documentation of Transfers/Discharges, the facility failed to ensure residents were not inappropriately transferred or discharged against the resident's/residents' representatives wishes for two of three Residents (R) (R7 and R4) reviewed for discharge out of a total sample of 20.Findings include:Review of the facility's policy and procedure titled, Documentation of Transfers/Discharges, dated 6/2025, revealed, . when a resident is transferred or discharged , his or her medical records shall be documented as to the reasons why such action was taken . The policy indicated should the resident be transferred or discharged because the safety of individuals in the facility would be endangered the basis of the discharge . must be documented in the resident's clinical record by a physician . The policy indicated the documentation must include at minimum: the reason for the discharge, that an appropriate notice be provided to the resident/representative; the resident/representative participate in a pre-discharge orientation program; the date and time of the discharge; and the new location of the resident.Review of the facility's policy titled, Notice of Transfer/Discharge, dated 6/2025, revealed, . The facility shall provide a resident/resident's representative with a thirty (30)-day written notice of an impending transfer or discharge . with an exception being if the safety of the individuals in the center was endangered. The policy was silent as to what notice would be given if the resident was transferred or discharged as a result of the residents in the facility being endangered.1. Review of R7's admission Record, located in the admission tab of the electronic medical record (EMR), revealed R7 was admitted to the facility with diagnoses that included cerebrovascular disease, traumatic hemorrhage of right cerebrum, dementia, psychotic disturbance, mood disturbance, and anxiety. It was recorded R7 was discharged on 6/11/2025.Review of R7's significant change of condition Minimum Data Set (MDS), with an assessment reference date (ARD) of 4/9/2025 and located under the MDS tab of the EMR, revealed R7 had a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. It was recorded R7 was dependent on staff for all her activities of daily living.Review of R7's Progress Note, dated 6/10/2025 at 4:39 pm, written by the previous Social Worker (SW), and located under the Progress Notes tab of the EMR, revealed the SW had spoken with the resident's family member about transferring R7. It was recorded the family member had agreed to the transfer and did not voice any concern. The note did not indicate why or where R7 was being transferred.Review of R7's Nurse's Note, written by the Infection Preventionist (IP) Nurse, dated 6/11/2025 at 11:41 am, and located under the Progress Notes tab of the EMR, revealed R7 was discharged to (Name of Nursing Home) via non-emergency transport. It was recorded report was called to the nurse at (Name of Nursing Home), and all medications had been sent with non-emergent transport.During an interview on 6/30/2025 at 3:08 pm, the Administrator stated they did not have a social worker because she was terminated for a violation of a resident's rights.Review of an email from the Administrator to the Regional Human Resource Director, dated 6/12/2025 at 3:24 pm and provided by the Administrator, revealed the Administrator was asking for the termination of the SW's employment. One reason listed for her termination was that on 6/11/2025, the facility received a compliance call stating the SW told R7's family member that they would be moving R7 to (Name of Nursing Home) on Friday 6/13/2025, and the resident was moved on Wednesday 6/11/2025. The Administrator wrote that the family member had stated that she was not given an option to decline the offer of transfer. The Administrator wrote, . This is considered improper Transfer and/or Discharge .During an interview on 7/1/2025 at 10:55 am, Resident Representative (RR) 7, the family member of R7, stated she was confused about why they discharged R7 and moved her to a sister facility. She stated she was called on 6/10/2025 by the Social Worker and was told R7 would have to be transferred to a different facility on 6/13/2025. RR7 stated she was not offered the option to keep R7 at her current facility. RR7 stated when she arrived at the facility on 6/11/2025, R7 was not in the facility and had already been moved to a different facility, and no one had called/notified her about the move that had occurred earlier that day.During an interview on 7/1/2025 at 11:05 am, the facility's former SW stated she did call R7's family member (RR7) on 6/10/2025 and told her R7 had to be transferred to a sister facility on Friday 6/13/2025 because she was in a short-term bed, and they needed it to admit a short-term resident into. She stated R7 was transferred on 6/11/2025 while she was off, and the nurse should have contacted RR7. She stated she did not document the reason for the discharge in the medical record because she was too busy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115670	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockdale Healthcare Center	1510 Reniassance Drive Conyers, GA 30012

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 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)

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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	Based on interview, record review, and review of the facility's policy and procedure titled, Documentation of Transfers/Discharges, the facility failed to notify the resident and the resident's representative of the reasons for a discharge/transfer, failed to notify the Office of State Long-Term Care Ombudsman of the discharge/transfer, and failed to record the reasons for the transfer/discharge in the resident's medical record for two of three Resident (R) (R7 and R4) reviewed for discharge out of a total sample of 20.Findings include:Review of the facility's policy and procedure titled, Documentation of Transfers/Discharges, dated 6/202025, revealed, . when a resident is transferred or discharged , his or her medical records shall be documented as to the reasons why such action was taken . The policy recorded should the resident be transferred or discharged because the safety of individuals in the facility would be endangered the basis of the discharge . must be documented in the resident's clinical record by a physician . The policy stated the documentation must include at minimum: the reason for the discharge, that an appropriate notice was provided to the resident/representative; the resident/representative participated in a pre-discharge orientation program; the date and time of the discharge; and the new location of the resident.Review of the facility's policy titled, Notice of Transfer/Discharge, dated 6/2025, revealed, . The facility shall provide a resident/resident's representative with a thirty (30)-day written notice of an impending transfer or discharge . The policy recorded an exception would be if the safety of the individuals in the center were endangered. 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The EMR was silent for the reason the resident was being transferred/ discharged and was silent for physician documentation of the transfer/discharge.During an interview on 6/30/2025 at 3:08 pm, the Administrator stated they did not have a social worker because she was terminated for a violation of a resident's rights.Review of an email from the Administrator to the Regional Human Resource Director, dated 6/12/2025 at 3:24 pm and provided by the Administrator, revealed the Administrator was asking for the termination of the SW's employment. One reason listed for her termination was that on 6/11/2025, the facility received a compliance call stating the SW told R7's family member that they would be moving R7 to (Name of the Facility) on Friday 6/13/2025, and the resident was moved on Wednesday 6/11/2025. The Administrator wrote that the family member had stated that she was not given an option to decline the offer of transfer. The Administrator wrote, . 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