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	06/17/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review,staff interviews and a review of the facility policy title Accident and Incident Prevention, Reporting, and Response and Care Plan-Comprehensive, the facility failed to ensure that appropriate care plan interventions were developed and implemented to meet the needs of two of three residents care plan reviewed. Specifically, the facility failed to develop post fall interventions for one Resident (R1) following three separate falls. In addition, the facility failed to implement and establish care plan interventions for Activities of Daily Living (ADL) for R3.Review of the policy titled Accident and Incident Prevention, Reporting, and Response, dated 05/2026. Purpose: To ensure a safe environment for all residents by implementing a proactive and systematic approach to preventing accidents and incidents in accordance with federal regulations, facility policies, and resident-centered care principles. D. Corrective Actions and Prevention: Develop and implement interventions based on the investigation findings. Revise the resident's care plan as needed to reflect new interventions.Review of the policy titled Care Plan-Comprehensive, dated 9/2025. Policy: A Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs shall be developed for each resident. Policy Interpretation and Implementation: Care plans are revised as changes in the resident's condition dictate.Review of R1's Electronic Medical Record (EMR) revealed an admission date of 07/07/2025 with diagnoses of but not limited to lumbar compression fracture, left fracture of the distal femur.Review of the resident's most recent Minimum Data Set (MDS) quarterly/Medicare 5-day assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was assessed as three which indicated severe cognitive impairment. Section GG Functional Abilities assessed the resident as dependent on staff for transfer. Section J resident assessed as a fall with a fracture.Review of the Risk Assessment Reports provided to the surveyor revealed R1 had an unwitnessed fall with no injury on 04/20/2026.Review of the Risk Assessment Reports provided to the surveyor revealed R1 had an unwitnessed fall with no injury on 05/17/2026.Review of the Risk Assessment Reports provided to the surveyor revealed R1 had an unwitnessed fall with no injury on 05/21/2026.Review of the care plan initiated 06/1/2021 revealed that R1 is at risk for falls. Further review of the care plan revealed no documented updated interventions implemented for the fall on 04/20/2026, 05/17/2026, or 05/21/2026.Review of R3's EMR revealed an admission with diagnoses, of but not limited to, need assistance with personal care and osteoarthritis.Review of the resident's most recent MDS quarterly assessment dated [DATE] revealed a BIMS was assessed as eight which indicated moderately impaired. Section GG Functional Abilities assessed the resident as staff does more than half of personal hygiene.Review of the care plan initiated 06/1/2021 revealed that R3 has an ADL self-care performance deficit. With an intervention one staff participation with bathing and dressing.An interview on 06/16/2026 at 11:51 AM with the family of R3, the family stated they had voiced formal concerns to the facility management on two separate occasions regarding R3 requiring more assistance with ADLs. The family stated that on two separate occasions during a visit they discovered R3 left unattended with a basin of water sitting in front of her and unclothed. The family (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated water had spilled on the floor. The family expressed concerns regarding the residents' safety knowing that leaving the R3 unsupervised and unclothed with spilled water on the floor could create a slip and fall hazard.An interview on 06/17/2026 at 9:00 AM with the Unit Manager (UM) BB, stated it is her responsibility to make rounds to ensure that the residents are receiving ADLs per the plan of care.An interview on 06/17/2026 at 2:13 PM with the MDS-Coordinator CC stated, all resident falls are discussed in the morning clinical management meeting. She stated during the meeting interventions are discussed and the care plan is updated. The MDS-Coordinator confirmed that no new interventions were implemented for R1 for the fall on 04/20/2026, 05/17/2026, and 05/20/2026.An interview on 06/17/2026 at 2:52 PM with the Administrator revealed he is part of the clinical management meeting. He stated all resident falls are discussed during the meeting. He stated interventions are discussed and the care plan is updated in real time. The Administrator stated that he oversees the clinical management meeting and ensures that the care plans are updated. The Administrator did not answer when asked what happened to updating R1's care plan for three falls.Refer to F-Tag 677 and 689

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, including a review of the Certified Medication Aide job description, the facility failed to ensure that professional standards of practice were maintained with one of three sampled Resident (R) (R2) during a scheduled medication pass. Specifically, the Certified Medication Aide (CMA) DD failed to maintain direct visual observation during the medication administration process, resulting in the resident being discovered holding a white pill that was actively dissolving in their hand. Findings include: A review of the Certified Medication Aide job description revealed: observe and verify that medication is ingested as directed. Review of R2's Electronic Medical Record (EMR) revealed an admission date of 4/29/2026 with diagnoses of but not limited to Alzheimer's Disease and type 2 diabetes mellitus without complications. Review of the resident's most recent Minimum Data Set (MDS) admission assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) assessed as eleven which indicated moderately impaired. Section N medication assessed the resident as taking anticoagulant, antipsychotic, and diuretic. Review of the resident's Order Summary Report revealed the current active physician orders for the following scheduled medications: Acetaminophen ordered for pain; Allopurinol ordered for the diagnosis of gout; Atorvastatin Calcium ordered for the diagnosis of hyperlipidemia; Carvedilol ordered for the diagnosis of hypertension; Eliquis ordered as an anticoagulant/blood thinner; Lasix ordered for edema; Multaq ordered for the diagnosis of arterial fibrillation; Rexulti ordered for the diagnosis of major depression disorder; and Trazodone ordered for the diagnosis of insomnia. An observation on 6/16/2026 at 10:16 am R2 was observed holding a white pill in her hand that was actively dissolving. An interview on 6/16/2026 at 10:18 am with CMA DD stated she administered R2's morning medications. The CMA stated R2 was given Acetaminophen, Allopurinol, Carvedilol, and Eliquis. The CMA stated the resident swallowed all the medications that were given. An observation on 6/16/2026 at 10:20 am of the residents' medication bubble packs was conducted alongside the CMA. The observation revealed three of the four administered morning medications (Acetaminophen, Allopurinol, Carvedilol, and Eliquis) were round white tablets. An interview on 6/17/2026 at 9:00 am with the Unit Manager (UM) BB stated the CMAs are educated on medication administration upon hire and annually thereafter. She stated the Staff Development Coordinator is responsible for the CMAs training and daily oversight. She stated the CMAs are educated not to leave medication at the residents' bedside and remain with the residents until all medications are fully consumed. The UM stated the physician was notified of R2 holding dissolved pills in her hand. She stated the physician ordered a speech therapy evaluation to ensure that the resident was not experiencing any underlined swallowing difficulties. The UM stated the resident's comprehensive care plan was also updated to reflect the incident and interventions were implemented to ensure safe medication administration moving forward. Done VRQ

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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 observations, resident, family and staff interviews, record review and a review of the facility's policy titled Accommodation Of Needs the facility failed to provide activities of daily living (ADL) for one resident (R) (R3) out of three dependent on staff for care.Findings include:Review of the policy titled Accommodation Of Needs, dated 12/2025. Policy: Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. Procedure: 1. The resident's individual needs and preferences are accommodated to the extent possible. In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in accordance with the residents' wishes. B. Arranging toiletries and personal items so that they are in easy reach of the resident.Review of the document titled Grievance/Complaint Form dated 04/15/2026 revealed the family of R3 filed a grievance regarding their mom (R3) who was found sitting on the side of the bed with the gown on the floor with a basin of water on the table. The Family expressed that they were concerned that the resident may fall.Review of the document titled Grievance/Complaint Form dated 04/30/2026 revealed the family of R3 filed a grievance regarding their mom (R3) not receiving care and found sitting in a chair undressed with a basin of water sitting on the table.Review of R3's Electronic Medical Record (EMR) revealed an admission with diagnoses, of but not limited to, need assistance with personal care and osteoarthritis.Review of the resident's most recent Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was assessed as eight which indicated moderately impaired. Section GG Functional Abilities assessed the resident as staff does more than half of personal hygiene.Review of the care plan initiated 06/1/2021 revealed that R3 has an ADL self-care performance deficit with an intervention of one staff participation with bathing and dressing.An observation on 06/16/2026 at 10:44 AM of R3 sitting on the side of the bed dressed in a gown trying to put on shoes. Further observation of the overbed table located at the foot of the bed with a basin of clear water. The resident's wheelchair was out of the residents reach in front of the nightstand.An interview on 06/16/2026 at 10:30 AM with Certified Nursing Assistant (CNA), CNA AA stated R3 is independent with ADLs. The CNA stated she provides the resident with a basin and water and the resident can complete her ADLs and dress herself.An interview on 06/16/2026 at 10:45 AM with R3, she stated on most days the staff will place a basin of water on the overbed table and leave the room and do not return. She stated she does use soap and deodorant but in order to reach the supplies she would have to stand and move the wheelchair that was blocking the nightstand where the supplies are located. The resident stated because she has had two falls she is afraid to try to get up and move the wheelchair. The resident stated she is able to wash her face and underarms. She stated she needs assistance with her back and legs and putting on her clothes. The resident stated she would like assistance with her bath and putting her clothes on.An interview on 06/17/2026 at 9:00 AM with the Unit Manager (UM) BB, she stated the staff are educated in-house and the online training system on ADL care. The Unit Manager stated R3 can partially complete her ADLs. The UM stated she expect staff to stand by when providing R3 with supplies for ADLs and assist the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and the facility policy titled Accident and Incident Prevention, Reporting, and Response, the facility failed to ensure that an environment free from accident hazards was maintained, and failed to provide adequate supervision and sufficient individualized interventions to prevent accidents for one Resident (R) (R1) who was identified as a high risk for falls and a history of recurrent falls. Specifically, the facility failed to develop and implement effective post-fall safety interventions following three separate falls sustained by R1 resulting in a major injury including a lumbar two (L2) compression fracture and a left distal femur fracture.Findings include: Review of the policy titled Accident and Incident Prevention, Reporting, and Response, dated 05/2026. Purpose: To ensure a safe environment for all residents by minimizing accident hazards, providing adequate supervision and assistive devices, and implementing a proactive and systematic approach to preventing, investigating, and mitigating accidents and incidents in accordance with federal regulations, facility policies, and resident-centered care principles. The facility is committed to: Promptly identifying, reporting, documenting, investigating, and mitigating all incidents or accidents involving residents. An observation on 06/17/2026 at 10:00 AM R1 was observed neatly dressed in street clothes independently propelling herself down the hallway in a wheelchair. When approached by the surveyor and asked where she was traveling the resident presented with a pleasant demeanor and clearly stated that she was looking for a facility activity to attend. Review of R1's Electronic Medical Record (EMR) revealed an admission with diagnoses,of but not limited to, lumbar (L2) compression fracture, left fracture of the distal femur. Review of the resident's most recent Minimum Data Set (MDS) quarterly/Medicare 5-day assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was assessed as three which indicated severe cognitive impairment. Section GG Functional Abilities assessed the resident as dependent on staff for transfer and to put on/take off. Section J resident assessed as a fall with a fracture. Review of the care plan updated on 03/12/2026 revealed that R1 is at risk for falls. With an intervention ensure non-skid footwear in place and provide toileting. On 06/16/2026 R1's care plan was updated with an intervention to provide activities that promote exercise and strength building where possible. Review of R1's Fall Risk Assessment revealed: 1/24/26 Complete 13.03/11/26 Complete 17.0 4/20/26 Complete 20.0 5/18/26 Full Assessment 17.0A score of 10 or more, the resident should be considered at high risk for potential falls. Review of the Risk Assessment Reports provided to the surveyor revealed R1 had an unwitnessed fall with no injury on 04/20/2026. The resident heard calling out for help from her room. The resident was noted in seated position on the floor at bedside. Bed rails in position and bed in lowest position. Resident calling out for help stating, I feel like I'm ice skating. Regular socks were on both feet. Resident stated she was trying to use the bathroom but feels like ice skating. There was no documentation noted on why the resident did not have non-skid footwear on per the care plan. The physician and responsible party were notified. Review of the Risk Assessment Reports provided to the surveyor revealed R1 had an unwitnessed fall with no injury on 05/17/2026. The resident observed sitting on buttocks on the floor with back against the bed. Siderails x 2 remained down in place. Resident stated, I was trying to go to the bathroom. The physician and responsible party were notified. Review of the Risk Assessment Reports provided to the surveyor revealed R1 had an unwitnessed fall with a major injury on 05/21/2026. The resident observed sitting on buttocks on the floor with back against the bed. Siderails x 2 remained down in place. Resident stated, I was trying to go to the bathroom. The resident complained of left leg pain and was transferred to the hospital. The physician and responsible party were notified. Review of the __ Hospital Progress notes dated 05/21/2026 revealed: R1 was transfer to the hospital for ground level fall and left femur fracture. Per report, patient had a ground-level fall at her living facility this morning. The computed tomography (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scan of abdomen showed a new lumbar (L2) compression fracture. The x-ray of the left knee showed an acute displaced periprosthetic and a fracture of the distal femur. An interview on 06/17/26 at 12:07 PM with the Administrator stated that when a resident sustains a fall in the facility, the incident must be immediately entered into the risk management system. The Administrator specified that a new intervention must be put in place at the time the fall is logged into the system. The Administrators stated the clinical management team meets every morning to review and discuss all recent falls. He stated the purpose of this daily team meeting is to verify that appropriate individualized safety interventions are in place. The Administrator stated that the team reviews and revise interventions as needed. He stated the interventions are documented in the risk management system and the residents care plan is updated in real time. Following this the Director of Nursing ensures that the designated interventions were fully implemented by the clinical staff. The Administrator stated he is responsible for the final review of the record to ensure that interventions are in place before locking the risk management file for that resident. An interview on 6/17/2026 at 2:13 PM with the MDS-Coordinator CC stated all resident falls are discussed in the morning clinical management meeting. She stated during the meeting interventions are discussed and the care plan is updated. The MDS-Coordinator confirmed that no new interventions were implemented for R1 for the fall on 04/20/2026, 05/17/2026, and 05/21/2026. During a follow-up interview on 06/17/2026 at 2:52 PM the Administrator reviewed R1's fall history alongside the surveyor. Review of the risk management fall report established that the resident sustained a total of 5 falls in 2026. The review focused specifically on R1's last three consecutive falls on 04/20/2026, 05/17/2026, and 05/21/2026 all which occurred while the resident was attempting to get up independently to use the bathroom. When asked by the surveyor to explain why the facility failed to update and revise R1's care plan interventions following the last three consecutive falls. The Administrative failed to provide an answer or clinical justification of why the care plan was not updated.