

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115689	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER Gold City Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 222 Moore Drive Dahlonega, GA 30533	

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 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)

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews, record review, and facility policy review, the facility failed to prevent resident to resident abuse for one of three residents (Resident (R)10) reviewed in a total sample of 20. This failure resulted in R9 having unsupervised access to R10 providing opportunity for R9 to pull R10's arm inappropriately and attempt to kiss R10's hands. Findings include: Review of the facility's policy Abuse, Neglect and Exploitation with an implementation date of 12/19/2022, provided by the facility indicated under Definitions: Definition of sexual abuse is non-consensual sexual contact of any type with a resident. Under III. Prevention of Abuse, Neglect and Exploitation-The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually relationship. Review of R9's admission Record found under the Profile tab of the electronic medical record (EMR) revealed diagnoses of Alzheimer's disease, dementia, hypertension, anxiety disorder, major depressive disorder, and high-risk heterosexual behavior. Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/8/2025 found under the MDS tab of the EMR indicated that R9 Brief Interview for Mental Status (BIMS) score was 3 of 15, indicating R9 had severe cognitive impairment. The MDS indicated physical behavior, directed toward others one to three days, other behavioral symptoms - occurred one to three days. Review of R9's Care Plan found under the Care Plan tab of the EMR with a revised date of 7/3/2025, revealed that R9 had a care plan for a behavior problem related to inappropriate sexual behavior toward other residents with interventions to intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and monitor behavior episodes and attempt to determine underlying cause. Review of R10's admission Record found under the Profile tab of the EMR diagnoses of Alzheimer's disease, dementia, restlessness and agitation, chronic pain, spinal stenosis, and hypertension. Review of R10's admission MDS with an ARD of 3/24/2025 found under the MDS tab of the EMR indicated that R10's BIMS was not assessed, no score was entered. Review of R10's Care Plan found under the Care Plan tab of the EMR with a revised date of 8/19/2025 revealed that R10 had a care plan for self-care deficit, verbal and physical aggression when redirected, wandering, resistive to care, and impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease. Review of R10's Progress Note, dated 8/21/2025 found in the Progress Notes tab of the EMR, authored by Licensed Practical Nurse (LPN)1 revealed LPN1 witnessed R9 holding onto R10's hand and attempting to kiss his hands and arms. R10 attempted to disentangle himself without success. LPN1 separated R10 and R9. Another staff member assisted R10 away from the area at this time. No apparent injuries or distress noted at this time. Placed on 30-minute checks for R10's safety. Review of a Facility Incident Report Form provided by the facility dated 8/22/2025 indicated an incident on 8/21/2025 involving R9 touching R10's arm and kissing his hand while R10 was attempting to pull away. During an interview on 8/29/2025 at 3:26 PM, LPN1 stated that the incident occurred at shift change. LPN1 stated that she had just left her office and as she entered the area around the nurses' station, she saw R9 and R10. R9 was holding R10's arm and R9 attempted to pull away but was unable. R9 was seated in a wheelchair facing R10 who was standing. R9 attempted to pull on R10's arm which created a back-and-forth motion as R10 attempted to pull his arm back. LPN1 stated that R9 attempted to kiss R10's hand but was unsuccessful. LPN1 stated the certified nurse aides (CNAs) were making rounds and no staff member was at the nurses' station. R9 became upset when R10 was escorted to his room and attempted to follow R10. LPN1 stated that she stood between R9 and the entrance to R10's hallway at the double doors so that R9 could not follow R10. During an interview on 8/29/2025 at 5:30 PM, the Administrator stated that her expectations of staff were to meet the basic needs of residents, know their characteristics and behaviors, strategize their interventions, and talk to family members to glean more clues about resident interventions. The Administrator stated she would educate staff, hold impromptu care plan meetings, and provide an individualized supervision approach in the care and protection of the residents.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and facility policy review, the facility failed to develop a comprehensive person-centered care plan that included specific interventions to ensure psychosocial well-being and safety for one of three residents (Resident (R) 4) reviewed in a sample of 20 residents. Findings include: Review of the facility policy titled, Comprehensive Care Plans with an implementation date of 4/1/2025 indicated under Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Review of R4's admission Record, found in the Profile tab of the electronic medical record (EMR) revealed an admission date to the facility on [DATE] with diagnoses of cerebral palsy, schizoaffective disorder, bipolar disorder, major depressive disorder, anxiety disorder, suicidal ideations, paraplegia, Review of R4's admission Minimum Data Set (MDS) located in the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/25/2024 indicated a Brief Interview for Mental Status (BIM) score of 15, which indicated R4 was cognitively intact. Review of R4's Care Plan revised on 06/15/25 and located in the EMR under the Care Plan tab revealed a plan for a behavior problem related to having auditory and visual hallucinations at time and has a history of suicidal ideations and suicidal attempts. Interventions initiated on 06/16/2025 were to perform 15-minute resident safety checks, resident to have only plastic silverware, resident moved to a room with a roommate, and the room was cleared of items that are potentially harmful. Review of Progress Note dated 5/20/2025 indicated the R4 called out to the nurse tearfully and stated that she was suicidal and drank hand sanitizer. Review of a Progress Note, dated 6/3/2025, authored by Licensed Practical Nurse (LPN)3 indicated that LPN3 found R4 with a plastic bag over her head loosely and stated she was trying to kill herself. Observation on 8/26/2025 at 4:05 PM revealed R4 in her electric wheelchair attempting to get an item from inside the personal refrigerator that was on the floor. Observed clear trash liners in R4's roommate's trash can and in R4's trash can. In an interview on 8/26/2025 at 4:45 PM Certified Nurse Aide (CNA)1 stated that it would be ok to have a trash liner in the trash can if it was not in reach of the resident. In an interview on 8/26/2025 at 4:49 PM CNA2 stated that it would be ok to have a trash liner in the trash can. In an interview on 8/29/2025 at 5:30 PM, when asked about specific care plan interventions and how to communicate those interventions to staff, the Administrator stated it didn't matter what the changes were, they should document the specific interventions that relate to the situation, and then ensure they monitor for effectiveness. The Administrator stated going forward, all care plans would have to be reviewed and triaged regarding negative potential impact on residents.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure a resident was evaluated for appropriate bed rail use and that alternative measures were attempted prior to installation of bed rails for one of one resident (Resident (R) 4) reviewed for bed rails out of a total sample of 20. The lack of alternate bed rail measures had the potential to lead to safety concerns related to bed rail use. Findings include:Review of the facility's policy titled Bed Safety and Bed Rails, provided by the facility, with a revision date of August 2022 indicated, Use of Bed Rails.The use of bed rails or side rails (including temporarily) raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.Review of R4's admission Record, found in the Profile tab of the electronic medical record (EMR) revealed diagnoses of cerebral palsy, schizoaffective disorder, bipolar disorder, major depressive disorder, anxiety disorder, suicidal ideations, and paraplegia, Review of R4's admission Minimum Data Set (MDS) located in the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/25/2024 indicated a Brief Interview for Mental Status (BIM) score of 15, which indicated R4 was cognitively intact.Review of R4's Care Plan dated 11/14/2024 and located in the EMR under the Care Plan tab revealed an Activity of Daily Living self-care performance deficit related to cerebral palsy care plan with a side rail intervention initiated on 1/28/2025. Quarter rails up on both sides to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition as necessary to avoid injury. Review of R4's medical record did not reveal an initial bed rail assessment; documented alternatives tried prior to consideration of bed rail or a consent for bed rails.Observation on 8/25/2025 at 5:30 PM revealed a bedrail in the lowered position on the right side of the bed and the bed pushed against the wall on the left side.During an interview on 8/26/2015 at 2:15 PM, Licensed Practical Nurse (LPN)2 acknowledged that there was a bed rail on R4's bed and stated that she had not seen R4 use it.In an interview on 8/29/2025 at 10:00 AM, the Administrator confirmed that R4's bed rail evaluation, consent for use, and alternatives tried before installing the bed rail were not done.In an interview on 8/29/2025 at 5:30 PM, the Administrator and Director of Nursing (DON) stated that they did not know how the alternatives tried documentation, assessment by nurses and interdisciplinary (IDT) review and documentation were missed. The Administrator stated that her expectations going forward would be for more communication between nurses, IDT members and herself prior to installing bed rails to ensure that they were appropriate for resident use and safety.</p>		