STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115689	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gold City Health and Rehab	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policies titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation and Use of Restraints, the facility failed to report an allegation of abuse timely involving one of three sampled residents (R) (R1) to the State Survey Agency. This deficient practice resulted in delayed investigation, placing facility residents at risk for continued or unaddressed abuse.Findings include:A review of the facility's policy dated 12/19/2022 titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation revealed under Policy: .all allegations of abuse/neglect.are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current stated and federal regulations within prescribed timeframes.A review of the facility's policy dated April 2017 titled Use of Restraints revealed under Policy Interpretation and Implementation: 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2.If the resident cannot remove a device in the same manner in which the staff applied tit given that resident's physical condition(i.e., side rails are put back down, rather than climbed over), and this restricts his /her typical ability to change position or place, that device is considered a restraint. 3. Examples of devices that are /may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chair geriatric chair), and lap cushions and trays that the resident cannot remove. 4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted including: . c. placing a resident in a chair that prevents the resident from rising. A review of the electronic medical record (EMR) for R1 revealed admission to the facility with diagnoses including but not limited to Down syndrome, cerebral palsy unspecified, type 2 diabetes mellitus congestive heart failure, chronic atrial fibrillation, epilepsy, benign prostatic hyperplasia, chronic kidney disease stage 3, anxiety, restlessness and agitation, lumbar compression fractures, abdominal distension, obstructive uropathy and presence of urogenital implants.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R1 was assessed with a Brief Interview for Mental Status (BIMS) score of 99 (could not be conducted). The resident was assessed as having severely impaired short- and long-term memory and severely impaired cognitive skills for daily decision-making. Section GG, Functional Abilities) indicated no impairment in upper or lower extremity function, and the resident utilized a manual wheelchair for mobility. Section P, Restraints and Alarms, indicated that bed rails, trunk, limb, or other restraints, bed alarms, and chairs that prevent rising were not in use.Review of the care plan for R1 dated 12/02/2025 revealed that R1 has limited mobility, requires staff supervision to ambulate up to 10 feet, uses a wheelchair for locomotion, and requires staff assistance with documentation as needed.Review of the Facility-Reported (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Incident (FRI) documentation, the police report, medical records, and staff interviews, the following sequence of events was identified:On 10/26/2025 at approximately 5:00 AM, two day shift Dietary Staff members FF and GG observed R1 reclined in a Broda chair at the nurses' station and the resident appeared to be secured at the wrists and feet. However, they did not recognize this observation as a reportable allegation of abuse at that time.At approximately 06:45 AM, Infection Control Licensed Practical Nurse (LPN) AA observed R1 resting in a Broda chair and instructed night shift staff that the chair could be considered a restraint and that the resident should be transferred to his personal wheelchair. No wrist or ankle restraints were observed at that time.On 10/28/2025, Dietary Staff FF and GG reported their concerns to the Dietary Manager during the morning meeting and were instructed to submit written statements and report to administration.On 10/28/2025 at 10:30 AM, the Administrator was notified. At 11:43 AM, on the same date, the Administrator reported the Facility-Reported Incident to the State Agency.The Administrator initiated an internal investigation, notified the resident's family, physician, and the police, and interviewed the involved staff. Based on the investigation, it was determined that restraints were not used. Night shift staff stated the Broda chair was used for resident comfort and that no wrist or ankle restraints were applied.On 10/29/2025, the Interdisciplinary Team (IDT) was unable to determine whether restraints had been used.On 11/04/2025, a police investigator interviewed all involved staff and reported the case to the State Agency.During an interview with the Administrator on 02/03/2026 at 4:00 PM, the Administrator was asked to have Certified Nursing Assistant (CNA) HH, who was involved in the incident, contact the surveyor. The Administrator also stated that LPN II, who had provided care to R1, was no longer employed by the facility. Attempts to contact the facility on 02/03/2026 at 08:00 PM and 08:30 PM to reach CNA HH were unsuccessful. On 02/04/2026 at 09:30 AM, the Administrator stated the facility was experiencing intermittent internet and phone issues and was unable to explain why the calls were not answered.During an interview with Dietary Staff member GG on 02/04/2026 at 10:04 AM, she stated that she typically arrived at work around 05:00 AM. She reported that upon arrival at the facility to clock in, she observed R1 seated in a medical chair. She stated the resident asked her for tea and appeared to have immobile arms. She stated she believed the resident's hands were secured at the wrists with Velcro; however, she could not state this with certainty due to dim lighting at the time. She reported the resident was wearing disposable underwear, with his waist covered by a sheet. When asked why she did not immediately report the observation to administration, she stated that she was not aware at the time that the practice observed was not considered normal at the facility, explaining that she was not medical staff and worked in the kitchen. She further stated that she reported her observations on 10/28/2025, when she shared the information with her Dietary Supervisor. Upon receiving the report, the Dietary Supervisor instructed her to provide a written statement and immediately reported the concern to the Administrator.In an interview with Dietary Aide FF on 02/04/2026 at 10:30 AM, she stated that she typically arrived at work around 04:50 AM. She reported observing R1 reclined in a chair near the nurses' station and covered with a white blanket. She stated the resident appeared unable to move his arms or legs and that only his head was moving forward. She reported the resident stated, I am done, I am done. When asked why she did not immediately report the observation to administration, she stated she reported her observations to nursing staff, who informed her that the resident had not slept that night, had been awake throughout the night, and would remain in the chair for a bit.In an interview with the Infection Control LPN AA on 02/03/2026 at 3:30 PM, she stated that when she arrived at work on 10/26/2025 at approximately 06:45 AM, she observed R1 reclined in a Broda chair with his feet elevated. She stated she understood that a reclined Broda chair may be considered a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restraint and instructed LPN II to assist the resident to his regular wheelchair. She stated that she did not observe R1 to be restrained or in distress.During an interview with Physical Therapy Assistant (PTA) JJ on 02/05/2026 at 11:54 AM, she explained that a regular wheelchair was designed to allow independent mobility and repositioning, whereas a Broda chair was a positioning chair intended to provide postural support for residents with poor sitting posture. She further stated that, unlike a standard wheelchair, a Broda chair may limit a resident's ability to rise without assistance and could function as a restraint.During a joint interview on 02/05/2026 at 12:55 PM with LPN AA, the MDS Coordinator-Registered Nurse (RN), Interim Director of Nursing (DON) EE, and the Administrator, LPN AA stated that use of a recliner may be considered a restraint if a resident was unable to get out of it independently. She stated she could not confirm with certainty whether R1 would be able to independently propel himself out of the Broda chair. LPN AA further stated that staff were expected to immediately report any allegations of potential abuse, including the use of restraints, to their supervisors and/or the Abuse Coordinator. She stated that this reporting should have occurred immediately. The Administrator confirmed she served as the Abuse Coordinator and was available 24/7 (24 hours a day, 7 days per week); if unavailable, the DON was the designated point of contact. She further stated that all staff, including nursing and non-nursing staff, were trained in the reporting process and were expected to immediately report any suspected abuse or restraint, even if uncertain.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled, Functional Impairment-Clinical Protocol, the facility failed to ensure that one of three sampled residents (R) (R1) was assessed for use of a medical device (Broda (specialized seating designed for individuals with mobility challenges, physical disabilities, or those requiring enhanced postural support) chair) prior to its use. This deficient practice placed R1 at risk for use of medical equipment without assessment to determine appropriateness, need, and safe use.Findings include:A policy regarding assessment of residents prior to the use of mobility devices was requested but not provided.Review of the facility's policy titled Functional Impairment - Clinical Protocol, dated September 2012 under the section Assessment and Recognition, stated, Upon admission to the facility, at any time a significant change in condition occurs, and periodically during a resident's stay, the physician and staff will assess the resident's physical condition, functional decline, and risk for additional functional decline . The policy further stated: . 3. The physician should order consultations and professional evaluations appropriate to the resident's condition. 6. The physician and staff will review the results and implications of these evaluations and use them to guide subsequent care planning. 7. A physician, nurse, or therapist may initiate screening for the potential to benefit from rehabilitative services, such as physical or occupational therapy. 8. Following the screening, the therapist will document whether the resident may benefit from a more detailed rehabilitation evaluation or from unskilled therapy.A review of the electronic medical record (EMR) revealed that R1 was admitted to the facility with diagnoses including but not limited to Down syndrome, cerebral palsy unspecified, type 2 diabetes mellitus congestive heart failure, chronic atrial fibrillation, epilepsy, benign prostatic hyperplasia, chronic kidney disease stage 3, anxiety, restlessness and agitation, lumbar compression fractures, abdominal distension, obstructive uropathy and presence of urogenital implants.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed that R1 was assessed with a Brief Interview for Mental Status (BIMS) score of 99 (not conducted, able to complete). The resident was assessed as having severely impaired short- and long-term memory and severely impaired cognitive skills for daily decision-making. Section GG, Functional Ability, indicated no impairment in upper or lower extremity function, and the resident utilized a manual wheelchair for mobility. Section P, Restraints and Alarms, indicated that bed rails, trunk, limb, or other restraints, bed alarms, and chairs that prevent rising were not in use.Review of R1's care plan dated 12/02/2025 revealed limited mobility, requiring staff supervision to ambulate up to 10 feet and use of a wheelchair for locomotion. The care plan addressed fall risk and safety concerns, with goals focused on maintaining safety and preventing falls. Interventions included staff supervision, environmental safety measures, and fall precautions.In an interview with LPN AA on 02/03/2026 at 3:30 PM, when asked whether R1 had been assessed for use of the Broda chair prior to its use, Licensed Practical Nurse (LPN) AA stated he had not.In an interview with a Restorative Certified Nursing Assistant (CNA) II on 2/4/2026 10:30 am, she stated revealed she was not aware of R1 using a Broda chair, as he is using a regular wheelchair, stating that R1 is able to stand and prefers to stand.In an interview with a Physical Therapy Assistant (PTA) JJ on 02/05/2026 at 11:54 AM, she stated that when use of a Broda chair was being considered, nursing staff were expected to submit a referral to physical therapy (PT) for an assistive device evaluation. She stated that PT would complete the evaluation to determine whether a Broda chair was appropriate and provide recommendations to nursing staff. She reported that R1 did not have a referral for PT, was currently using a regular wheelchair, and that she had never observed R1 using a Broda chair. She further stated that nursing staff may initiate use of a Broda (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chair if they believed it was in the resident's best interest; however, a PT referral was still required for assessment. She stated that without an evaluation, it was difficult to determine whether R1 would be able to independently transfer out of a Broda chair, noting this would depend in part on the degree of recline.During a joint interview with the Infection Preventionist, MDS nurse, and Administrator on 02/05/2026 at 12:55 PM, LPN AA stated they used a Broda chair for comfort and not as a mobility device, but they should have sent a referral to PT to see if it was appropriate. We should have initiated a PT referral then, but it was not done. When asked whether discussing the use of a Broda chair with the family and including it in the resident's care plan was sufficient without an assessment, Registered Nurse (RN) EE stated that even if it was used for comfort and positioning rather than mobility, this was not sufficient and that an assessment should have been completed, if that is what the policy states. The Administrator agreed with RN EE that a therapy assessment should have been initiated.