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	08/28/2024

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 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** 03115 Based on staff interview, record review, and review of the facility's policy titled Advanced Directives, the facility failed to ensure one of 43 sampled residents (R) (R16) reviewed for advanced directives had a medical record that accurately reflected her request to not have cardiopulmonary resuscitation (CPR) in the event she should experience cardiopulmonary failure. The deficient practice had the potential to result in the resident receiving CPR against her wishes. Findings include: The facility's policy titled, Advanced Directives, dated [DATE] revealed, the resident had a right to formulate an advance directive. The policy revealed the resident's wishes were communicated to the residents' direct care staff and physician by placing the advanced directive documents in a prominent, accessible location in the medical record. Review of R16's the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located in the MDS tab of the electronic medical record (EMR) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated she was cognitively intact. Review of the Diagnosis tab of R16's EMR revealed diagnoses which included unspecified psychosis, personal history of transient ischemic attack and cerebral infarction, transient cerebral ischemic attack, and subarachnoid hemorrhage affecting left side. Review of R16's EMR revealed it was documented that she was a FULL CODE, meaning to attempt CPR in the event of cardiopulmonary failure, in capital letters on the dashboard section of the EMR. Review of R16's Admission Record, dated [DATE] and located in the paper record, identified her as a full code. Review of R16's paper record/chart revealed a sticker located on the inside of the chart cover that read DNR (Do Not Resuscitate) and a document titled, Do Not Resuscitate for Resident with Decision Making Capacity, signed and dated by the resident on [DATE] and located at the front of the chart, revealed CPR was not to be initiated in the event of cardiopulmonary failure. In addition, the Advanced Directive Checklist, signed by the resident on [DATE] had DNR order check marked. (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

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	08/28/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician's orders located under the Orders tab of the EMR revealed she had a current physician's order with a start date of [DATE] for DNR. During an interview on [DATE] at 1:28 pm, the Assistant Director of Nursing (ADON) verified the dashboard in the EMR and the Admission Record in the paper chart were inaccurate. She stated in the event the resident experienced cardiorespiratory failure the staff would know not to start CPR because they would have checked the advanced directive paper in the paper chart.

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 08/28/2024
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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 03115 Based on observation, staff and resident interviews, record review, and review of the facility's policy titled Abuse, Neglect, and Exploitation, and Abuse, Neglect, Exploitation and Misappropriation Prevention Program, the facility failed to protect the residents' right to be free from mental/verbal abuse for four of 13 residents (R) (R53, R11, R122, and R71) and free from physical abuse for one of one resident (R48) reviewed for abuse out of a total sample of 43 residents. Specifically, R19 verbally harassed R53 and verbally insulted R11. Also, R16 verbally harassed R53 and verbally disrespected R122 and R71. This failure had the potential to cause psychosocial harm to the residents. Findings include: Review of the facility's policy titled, Abuse, Neglect, and Exploitation, dated 12/19/2022, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . The policy continued, . the facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, revealed, . residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms 1. Review of R19's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/29/2023 and located under the MDS tab of the electronic medical record (EMR), revealed R19 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating no cognitive decline; and had diagnoses that included diabetes and acute kidney failure. Review of R19's Misc (Miscellaneous) tab, located in the EMR revealed a Care Plan, initiated on 1/3/2019 related to behaviors. Interventions included not arguing with R19 and for Social Services to visit with R19 as needed. Review of R53's annual MDS, located under the MDS tab and with an ARD of 5/22/2024, revealed R53 had severely impaired cognitive skills; had long-term and short-term memory problems; was dependent on a wheelchair for mobility; and had diagnoses which included dementia with behavioral disturbances, cognitive communication deficit, and Alzheimer's disease. (continued on next page)

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 08/28/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Facility Incident Report Form, dated 10/24/2023 and provided by the facility, revealed on 8/30/2024, R19 was talking to R53 and accusing her of stealing. R19 tried to move away when their wheelchairs became interlocked. R19 then began accusing R53 of stealing again, and R53 then struck R19 in the face with magazines. There were no injuries noted to R19. The immediate steps taken to prevent further incidents were the facility separated the residents, the police were called, the State, physician, Ombudsman, and resident representatives were notified, and the abuse coordinator initiated an investigation. The follow-up investigation revealed the facility substantiated an incident between R53 and R19. Review of a post-incident Behavior PAR (Patient at Risk) Tracking Documentation form, dated 10/26/2023 and provided by the facility, revealed R19 was having his behavior tracked due to taunting other residents causing another resident (R53) to hit him. The Intensity of Behavior section was filled with typically severe. The Goals section was filled with to monitor and redirect negative behaviors. R19 was monitored for five weeks post incident with the following indications: Week One: No changes in medications per pharmacy and R19 was informed that it was not good behavior to taunt other residents. Week Two: R19 was making fun of another resident in the dining room. Week Three: R19 had a mellow week. Week Four: R19 continued to make upsetting comments to residents. Week Five: No aggressive or demeaning comments. Review of a [Name of psychiatric services] Subsequent Medication Evaluation report, dated 11/20/2023 and located under the Misc tab in the EMR, revealed R19's behavior was recorded as appropriate, with the report summary stating there was nothing new reported, R19 was stable, no medication side effects were noted, and a gradual dose reduction (GDR) of medications were not indicated. There were no Care Plan updates for the 10/24/2023 incident with R53. The CP was reviewed and continued on 11/23/2023, and no new interventions were identified or implemented related to R19's behaviors. Review of R11's quarterly MDS, with an ARD of 10/17/2023 and located under the MDS tab of the EMR, revealed R11 was admitted to the facility on [DATE] and had a BIMS score of 99, which indicated staff was unable to assess the resident's cognitive status. Review of the Facility Incident Report Form, dated 12/19/2023 and provided by the facility, revealed on 12/19/2023, R19 entered the room of R11 and made inappropriate remarks related to R11's body, not knowing a staff member was behind the curtain in the room. The staff member asked R19 to leave the room. The immediate steps taken to prevent further incidents were the facility separated the residents, the police were called, the State, physician, Ombudsman, and resident representatives were notified, R19 refused to be sent to the hospital for evaluation, and the abuse coordinator initiated an investigation. The follow-up investigation revealed the facility substantiated an incident between R19 and R11. The facility followed time frames and requirements for incident. (continued on next page)

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 08/28/2024
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 - Some	Review of R11's Progress Note, dated 12/20/2023 and located under the Prog tab of the EMR, R19 had wheeled himself into R11's room and made inappropriate comments related to R11's body. R19 did not notice the staff in the room and was immediately confronted about what he said, and R19 tried to quickly change the subject. R19 was escorted from the room, and incident protocol was initiated. Review of a Behavior PAR Tracking Documentation form, dated 12/21/2023 revealed R19 was having his behavior tracked due to making sexually inappropriate comments to R11. The Frequency of Behavior section was filled with often (multiple times weekly), and the Intensity of Behavior section was filled with typically severe. The Goals section was filled with to monitor and redirect, educate resident on inappropriate statements, and to have [psychiatric services] re-evaluate R19. R19 was monitored for four weeks post incident with the following indications: Week One: sexually inappropriate comments. Week Two: continued to slander facility, staff, and other residents because of the reported incident with R11. Week Three: continued to make negative comments towards other residents. Week Four: Negative behaviors continued. Review of a [Name of psychiatric service] Subsequent Medication Evaluation report, dated 2/5/2024 and located under the Misc tab of the EMR, revealed R19's behavior was indicated to be appropriate and R19's weight was discussed, but not his behaviors. There were no Care Plan updates for the 12/20/2023 incident with R11, and no new interventions were identified or implemented related to R19's behaviors. Interview on 8/27/2024 at 11:30 am with Licensed Practical Nurse (LPN) 4 stated that R16 and R19 have not liked R53 for a long time. LPN4 stated R16 and R19 will say things quietly, thinking the staff are not aware and so only R53 can hear them, just to get her to react. LPN4 added that R16 and R19 go around to other residents saying that R53 is a thief trying to turn the residents against R53. LPN4 added R53 is normally calm and sweet until R16 and R19 instigate something. During a Resident Council meeting on 8/27/2024 at 2:00 pm, no resident raised concerns related to fear or distrust of other residents. R16 and R19 were present during the Resident Council meeting and were antagonistic towards the Resident Council President for praying before the meeting. Interview on 8/28/2024 at 12:45 pm with the Administrator, who started July 2024, verified R19's care plan had not been updated with new interventions each time R19 was involved in an inappropriate behavior situation. The Administrator stated she was not sure why ([psychiatric) Services evaluation forms indicated R19 was stable on most of his encounters, with no behavioral issues brought to the physician's attention and stated she would contact [psychiatric service]. On 8/28/2024 at 1:30 pm, the ADON was asked for any documented behavior monitoring or 15-minute checks for R19. The documentation was not received before the end of the survey. (continued on next page)

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 08/28/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R16's Face Sheet, located in the EMR under the Profile tab, revealed R16 was admitted to the facility on [DATE] with diagnoses which included tobacco use, psychosis, restlessness and agitation, major depressive disorder, and generalized anxiety disorder. Review of R16's quarterly MDS, with an ARD of 8/8/2024 and located under the MDS tab of the EMR, revealed R16 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R16's paper Plan of Care, provided by the facility, dated 3/14/2017, and last reviewed 5/9/2024, revealed R16 had a problem with displaying verbally aggressive behaviors at times. The care plan problem recorded, .I make inappropriate comments to other residents and staff members during smoke breaks. I have been educated on my behaviors . Under the approach section of the care plan, the care plan recorded to remove R16 from public areas when the behavior was disruptive and unacceptable. An entry, dated 03/03/24, in the approach section of the plan of care recorded the resident continued to be verbally abusive to other residents. Review of R53's annual MDS, located under the MDS tab of the EMR and with an ARD of 5/22/2024, revealed R53 had severely impaired cognitive skills; had long-term and short-term memory problems; was dependent on a wheelchair for mobility; and had diagnoses which included dementia with behavioral disturbances, cognitive communication deficit, and Alzheimer's disease. Review of a complaint summary, completed by the former Administrator, titled [Name of the Facility], dated 7/19/2023 and provided by the Administrator, revealed the document was a follow up to the self-reported incident #202306917. The document recorded that on Wednesday 7/12/2023 at approximately 2:25 pm, LPN8 and the Social Service Director (SSD) came to the Abuse Coordinator/Administrator and informed him that LPN6 reported to them that she overheard R16 asking R53 multiple times if she wanted to get raped. According to the report, it was reported to the Department of Health, police, physician, ombudsman, and the responsible party. According to the written statement from LPN6 on 7/12/2023 at 2:00 pm, she was in the dining room passing medications when she heard R16 ask R53 twice if she knew Kyane [NAME] and R53 did not respond and then ask her if she knew Bow-Wow twice and again R53 did not respond. Then R16 stated yeah you know Bow-Wow he got raped, 'Do you want to be raped?' and then she repeated it and said to her again do you want to be raped so they can suck your face. According to the statement, LPN6 told R16 that was not the kind of thing to say and to not say it again. R16 told LPN6 that R53 knew all the rappers and LPN6 told R16 that R53 did not and to not repeat it again. The complaint summary stated they were immediately separated. According to the report and attached documents, the police questioned R16, and she admitted to police that she asked R53 if she wanted to be raped and should not have said it and apologized. The report concluded there was a verbal altercation between the two residents and R16 did speak inappropriately to R53. The facility obtained a new consultation for psychiatric services for R16. Review of R16's Care Plan revealed no new interventions were identified or implemented related to the resident's behaviors. Interview on 8/27/2024 at 12:58 pm, with the SSD via telephone revealed, the incident was reported to her by an agency nurse, and R53 did not seem bothered by it. She stated she did consider it to be verbal abuse, and R16 had a history of vulgar behavior. (continued on next page)

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 08/28/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/27/2024 at 5:44 pm, LPN4 stated she had heard R16 speak inappropriately to other residents and at times try to irritate other residents. She stated when she saw it, she immediately redirected and separated them and reported it to the SSD and the charge nurse. Review of R122's annual MDS, with an ARD of 4/18/2024 and located under the MDS tab of the EMR, revealed R122 was admitted to the facility on [DATE] and had a BIMS score of 13 out of 15, which indicated he was cognitively intact. According to the admission/discharge record, located in the Profile tab of the EMR, R122 was discharged from the facility on 6/21/2024. Review of R71's annual MDS, with an ARD of 4/12/2024 and located under the MDS tab of the EMR, revealed R71 was admitted to the facility on [DATE] and had a BIMS score of 15 out of 15, which indicated she was cognitively intact. According to the admission/discharge record, located in the Profile tab of the EMR, R71 was discharged from the facility on 6/21/2024. Review of a Resident Incident Report, dated 2/21/2024 at 3:00 pm and provided by the Administrator, revealed the SSD had reported to the Administrator that R122 had reported that R16 was being verbally abusive to him and R71 on 2/20/2024 at approximately 7:00 pm to 8:00 pm. Review of the abuse summary titled, [Name of the Facility] dated 2/28/2024 and provided by the Administrator, revealed that on 2/21/2024 at approximately 3:00 pm, it was reported to the SSD and then to the previous Administrator/Abuse Coordinator that on 2/20/2024 between approximately 7:00 pm and 8:00 pm, R16 allegedly called R122 queer and R71 a lesbian. Review of R122's Progress Note, dated 2/21/2024 at 3:34 pm, written by LPN7, and located under the Prog Note tab of the EMR, revealed R122 reported to LPN7 that on 2/20/2024 around 7:30 pm that he and R71 were sitting in the hall when R16 rolled up to them and spoke verbal insults to them, including calling him a queer and R71 gay. According to the note, R16 denied it happened. Review of R16's Care Plan revealed no new interventions were identified or implemented related to the resident's behaviors. On 8/28/2024 at 12:24 pm, a telephone interview was conducted with LPN7. LPN7 stated she did not witness the incident. She stated R122 reported it to her the next day. She stated she felt R16 had a history of saying a lot of inappropriate comments to other residents but she had a history of being discreet about it so there were no witnesses. 3. Review of the Facility Incident Report Form dated 8/30/2023 and provided by the facility revealed at 3:45 pm on 8/30/2023 R53 struck R48 on the arm with a very thin lightweight green plastic plate. There were no injuries noted on R48 and she denied any pain. The immediate steps taken to prevent further incidents were the facility separated the residents, the police were called, R53 was sent to the hospital for observation, the State, physician, Ombudsman, and resident representatives were notified, and the abuse coordinator initiated an investigation. The follow-up investigation revealed R53 was by the bingo prize table during activities when R48 came up to her and told R53 that she [R53] could not have any prizes. R53 then hit R48 with the plastic plate in the arm. The facility followed time frames and requirements for incident. Review of the Census tab located in the electronic medical record (EMR) revealed R48 was admitted on [DATE]. (continued on next page)

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 08/28/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Med Diag [Medical Diagnoses] tab located in the EMR revealed R48 had diagnoses including post-stroke affecting the right dominant side and aphasia. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/2023 revealed R48 had a Brief Interview for Mental Status (BIMS) score of eight out of 15 indicating a moderate decline in cognition. Review of the Prog Note [Progress Note] tab of the EMR revealed a historical note dated 8/30/2023 that stated bingo had ended in activities and R48 began telling R53 to get away from the prize table and that she [R53] could not have anything. R53 then took a plastic plate and hit R48 in the arm. Review of the Census tab located in the EMR revealed R53 was admitted on [DATE]. Review of the Med Diag tab located in the EMR revealed R53 had diagnoses including Alzheimer's disease with late onset, cognitive communication deficit, and dementia. Review of the quarterly MDS with an ARD of 8/23/2023 located in the EMR revealed R53 had a BIMS score of 99 out of 15 indicating the interview could not be completed due to R53's cognitive decline. Review of the Misc [miscellaneous] tab located in the EMR revealed a Care Plan (CP) with a concern related to negative behaviors initiated on 5/16/2022 with interventions including redirection, observation for root cause, and behavior documentation. Review of the Prog Note tab located in the EMR revealed a note dated 9/1/2023 that stated R53 had hit R48 in the arm with a plastic plate during activities. During a Resident Council meeting on 8/27/2024 at 2:00 pm, no resident raised concerns related to fear or distrust of other residents.

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 08/28/2024
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 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** 39540 Based on staff interviews, record review, and review of the facility's policy titled Abuse, Neglect, and Exploitation, the facility failed to ensure an allegation of abuse was reported within two hours of occurrence for two of 12 residents (R) (R6 and R36) sampled for abuse out of a total sample of 43. The deficient practice had the potential for timely intervention to not be implemented for the protection of the residents. Findings include: Review of the facility's policy titled Abuse, Neglect, and Exploitation, dated 12/19/2022 revealed, Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . Review of R6's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R6 had diagnoses that included Alzheimer's disease, vascular dementia, paranoid schizophrenia, delusional disorder, unspecified dementia with behavioral disturbances, and major depressive disorder. Review of R6's annual Minimum Data Set (MDS), located in the EMR under the MDS tab and with an Assessment Reference Date (ARD) of 7/25/2024, revealed R6 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated staff was unable to assess his cognitive state. It was recorded R6 was severely cognitively impaired and rarely/never made decisions. Review of R36's Admission Record, located in the EMR under the Profile tab, revealed R36 was readmitted to the facility on [DATE] with diagnoses that included bipolar disease, seizures, schizophrenia, and vascular dementia. Review of R36's annual MDS, located in the EMR under the MDS tab and with an ARD of 2/20/2024, revealed R36 had a BIMS score of 5 out of 15, indicating R36 was severely cognitively impaired. Review of a Progress Note for R36, provided by the facility and dated 4/27/2024 at 3:20 pm, revealed . reported to staff that a male resident had entered the room sometime during the night, seated in a wheelchair, began touching [R36] all over, pulling off her blankets and yelling at [R36] to get up. [R36] roommate stated it was about 6:00 am when this occurred . Review of a Progress Note, for R36, provided by the facility and dated 4/27/2024 at 3:57 pm, revealed, . it was reported to this nurse [Licensed Practical Nurse (LPN) 2] at approximately 11:00 am on 4/27/2024 by the dayshift CNA [Certified Nurse Aide] that a female resident [R36] reported [R6] had been in her room at approximately 6:00 am on 4/27/2024. [R36] reported to the night shift CNA that [R6] entered her room and wheeled himself over to her bedside. [R36] stated that [R6] began feeling around on her blanket and touched her and he started yelling at her to get out of bed . (continued on next page)

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 08/28/2024
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/2024 at 5:34 pm, LPN2 stated that at approximately 11:00 am on 4/27/2024, CNA7 reported to her that R6 had went into R36's room about 6:00 am on 4/27/2024, propelled himself to R36's bed, and began feeling around on the bed, pulling off the covers, and demanding R36 get out of the bed. LPN2 stated she then reported the incident to the Assistant Director of Nursing (ADON). LPN2 confirmed the incident should have been reported earlier. LPN2 stated the incident was not included in the change of shift report the day it occurred. Review of the facility's investigation of the incident revealed a handwritten document by CNA7, dated 4/27/2024 at 7:26 pm, who was present at the time of the incident and removed R6 from the room of R36. The statement recorded, . at approximately 6:30 am, I heard yelling coming from A hall, A 3 bed B, [R36] was yelling 'stop, don't touch me' and I found [R6] touching her. My first instinct was to pull [R6] out of her room. After that I went back to make sure [R36] was okay. I asked her what happened. [R36] told me that he was touching her legs and arms and yelled at her to 'get out of his bed.' Around 6:40-6:45 am, I went to the nurse's station to tell the charge nurse because I thought [R6] was under her care. I did not make sure the nurses heard me and that was my mistake. I just wanted to be sure [R36] was okay and charted the actions [R6] made. I am not sure who heard my statement this morning. During an interview on 8/27/2024 at 11:54 am, the Administrator confirmed the incident on 4/27/2024 between R6 and R36 was not reported to the abuse coordinator until five and one-half hours after the incident occurred. The Administrator confirmed there was a delay in reporting and that the incident should have been reported when it occurred.

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 08/28/2024
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38517 Based on resident and staff interviews, record review, and review of the facility's policy titled, Abuse, Neglect and Exploitation, the facility failed to thoroughly investigate an allegation of staff to resident abuse involving one of 12 residents (R) (R68) reviewed for abuse out of a total sample of 43. This failure increased the risk of ongoing staff to resident abuse. Findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 12/19/2022, revealed, . Written procedures for investigations include . Providing complete and through documentation of the investigation . Review of R68's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed admission to the facility on [DATE] with diagnoses including type 2 diabetes, monoplegia of lower limb, and depression. Review of R68's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/8/2024 and located in the MDS tab of the EMR, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was cognitively intact. Review of R68's nursing Progress Note, dated 6/7/2024 and located under the Notes tab of the EMR, revealed R68 had reported to the Certified Nursing Aide (CNA) staff that the night shift CNA was rough with her. It was recorded R68 stated that CNA2 pushed her wheelchair out of reach and that she made her lie in her own urine in bed. It was recorded R68 stated CNA2 shoved her, and this was immediately reported to the abuse coordinator and a police report was made. It was recorded R68 was assessed for injury, with scratches on her wrists and bruising to her shins noted. It was recorded that the incident was under investigation. Review of the facility's investigative file for the incident, provided by the Administrator, revealed: An interview with R68, dated 6/7/2024, that recorded, Interview with [R68] on 6/7/2024, abuse coordinator along with the police officer interviewed [R68]. [R68] stated 'the CNA on my hall at night was very rude and pushed me around.' The police officer asked if she knew the CNA and she stated, '[CNA 2], the skinny black girl.' When asked how she pushed her around she stated, 'She was just rude, and she pushed my chair on the other side of the room so I could not get up.' There was no documentation R63 was asked about the scratches on her wrists or the bruising on her shins. An investigation summary conclusion, dated 6/6/2024, recorded, The facility investigated the incident, and abuse could not be substantiated. [CNA2] was suspended immediately while investigation underway. [CNA2] was informed of her suspension and quit without notice via text message shortly after. [R68] was assessed for injuries, a few bilateral scratches to her wrist and bilateral bruise to shins probably occurred while attempting to self-ambulate in her room as she is non-compliant at times. Nursing completed skin assessments on all residents on hall with no concerns noted. (continued on next page)

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 08/28/2024
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview with R68, dated 6/11/2024, recorded, On 6/11/2024 the abuse coordinator/administrator, along with the social worker went to interview [R68] and [R68] stated 'CNA' was very rude to me, pushed me down in the bed and pushed my wheelchair to the other side of the room and then left the room and said you are my responsibility. Review of R68's interview did not reveal any documentation that R68 was asked about the scratches on her wrists or the bruising on her shins. Review of facility's investigation revealed no documentation R68 was asked about the scratches on her wrists or the bruising on her shins. During an interview on 8/26/2024 at 3:11 pm, R68 stated CNA2 was rough while assisting her to bed one night. R68 stated after she was placed in bed, CNA2 moved her wheelchair to the opposite side of the room so she could not reach it. R68 stated it was a while ago, and she could not recall the whole incident. R68 stated CNA2's employment was terminated, and she had no other abuse or neglect concerns since. R68 denied any marks or bruises currently and could not remember scratches related to the incident. During an interview on 8/26/2024 at 5:52 pm, the Administrator stated she was not employed during the abuse investigation for R68. The Administrator stated she felt that R68 should have been asked about the scratches and bruises that were documented as being observed during the investigation.

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 08/28/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on resident and staff interviews, record review, and review of the facility's policy titled, Transfer and Discharge, the facility failed to provide the resident and the responsible party with notice of the transfer and the reasons for the transfer in writing and in a language and manner they understand for one of two residents (R) (R4) reviewed for hospitalization out of a total sample of 43. The deficient practice had the potential to result in the resident and/or responsible party not knowing the resident was transferred to the hospital and the reasons for the transfer. Findings include: Review of the facility's policy titled, Transfer and discharge date d 12/19/2022, revealed a transfer notice would be provided to the resident and representative when a discharge was initiated by the facility for medical reasons to an acute care setting such as a hospital. Review of R4's Face Sheet, located under the Profile tab of the electronic medical record (EMR), revealed R4 was readmitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, psychosis, chronic kidney failure, intellectual disabilities, and lobar pneumonia. Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/2024 and located under the MDS tab of the EMR, revealed he had a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident had moderately impaired cognition. During an interview on 8/25/2024 at 8:48 pm, R4 was asked if he had been hospitalized in the past six months. He stated, Yes, but he could not remember any details related to the hospitalization or if he received any written notices. Review of the Prog (Progress) Notes tab of the EMR, dated 6/12/2024 at 10:32 am, revealed R4 was discharged to the hospital emergency roiagnom on [DATE] at 8:20 am after he had problems breathing and his oxygen levels dropped. A progress note, dated 6/17/2024 at 6:33 pm, revealed he returned to the facility on [DATE] at 5:30 pm. Review of the EMR and hard chart revealed no transfer/discharge notices. During an interview on 8/28/2024 at 5:52 pm, the Business Office Manager (BOM) stated they did not send a written transfer/discharge notice with the resident or to the resident's responsible party; however, the ombudsman was notified of the transfer.

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 08/28/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39540 Based on staff interviews, record review, and review of the facility policy Abuse, Neglect, and Exploitation, the facility failed to provide adequate supervision to prevent accidents for four of four residents (R) (R6, R3, R23, and R36) reviewed for supervision out of a total sample of 43. Specifically, R6 had diagnoses of severe dementia, delusions, and paranoid schizophrenia and exhibited aggressive behaviors towards R3, R23, and R36. As a result of this deficient practice the residents in the facility had the potential for harm from the aggressive behaviors from R6. Findings include: Review of the facility policy Abuse, Neglect, and Exploitation, dated 12/19/2022 revealed, The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect . Identifying, correcting and intervening in situations in which abuse, neglect, . with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. 1. Review of facility incident reports revealed a resident-to-resident altercation occurred between R6 and R3 on 11/22/2023. Review of R6's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R6 had diagnoses that included Alzheimer's disease, vascular dementia, paranoid schizophrenia, delusional disorder, unspecified dementia with behavioral disturbances, and major depressive disorder. Review of R6's Care Plan, located in the EMR under the Misc (Miscellaneous) tab and dated 8/11/2023, revealed, . [R6] have [sic] negative behaviors. [R6] can be combative at times. The interventions included, . Observe for wander/elopement behavior I am physically aggressive towards staff members at times I am verbally aggressive at times I enjoy coffee and books to help me when [R6 is] angry . Review of R6's annual Minimum Data Set (MDS), located in the EMR under the MDS tab and with an Assessment Reference Date (ARD) of 9/22/2023, revealed R6 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated staff was unable to assess his cognitive status. It was recorded R6 was severely cognitively impaired and rarely/never makes decisions. Review of R3's Admission Record, located in the EMR under the Profile tab, revealed diagnoses that included major depressive disorder, unspecified intellectual disabilities, and seizures. Review of R3's quarterly MDS, located in the EMR under the MDS tab and with an ARD of 9/22/2023, revealed R3 had a BIMS score of 6 out of 15, indicating R3 was severely cognitively impaired. (continued on next page)

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 08/28/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R6's Patient at Risk (PAR), flow sheet, provided by the facility and dated 11/10/2023, revealed R6 had been agitated since some medications were reduced and taken away, and had exhibited some behaviors of kicking another resident's wheelchair. It was recorded that the medications were added back due to agitation and aggressive behaviors. Review of R6's Progress Note, provided by the facility and dated 11/22/2023 at 12:45 pm, revealed, . resident witnessed having altercation with [R3] in the dining room during lunch. Witness saw [R6] with tray cover [used to keep food warm] in hand and very upset, hitting [R3] and other residents in the dining room stated that R6 hit R3 on the top of the head. Review of R3's Progress Note, provided by the facility and dated 11/22/2023 at 2:43 pm, revealed, [R3] in dining room for lunch at 12:45 another resident [R6] took his tray lid and hit resident over the head three times. No apparent injury. No c/o [complaint of] of [sic] pain just scared. [R3] was removed from the dining room to prevent any further contact . Review of R6's Care Plan, located in the EMR under the Misc tab, revealed no new interventions were identified or implemented after the incident on 11/22/2023. 2. Review of facility incident reports revealed there was a resident-to-resident altercation between R6 and R23 on 4/26/2024. Review of R23's Admission Record, located in the EMR under the Profile tab, revealed an admitted [DATE] with medical diagnoses that included anxiety and dementia. Review of R23's annual MDS, located in the EMR under the MDS tab and with an ARD of 3/25/2024, revealed R23 had a BIMS score of 99, which indicated staff was unable to assess R23's cognitive status. It was recorded R23 was severely cognitively impaired and rarely/never makes decisions. Review of R23's Progress Note, provided by the facility and dated 4/26/2024 at 3:18 pm, revealed, It was reported to this nurse that in the dining room, shortly after lunch [R23] ran into another resident [R6] with her w/c [wheelchair]. [R6] then struck [R23] in the face. [R23] redirected and assessed for injury. No apparent [injury]. During an interview on 8/28/2024 at 9:59 am, the Activities Director (AD) recalled the incident between R6 and R23 had happened so fast. The AD stated R23 propelled her wheelchair backwards. The AD stated she saw R23 was going to run into R6, and she jumped up right then but was not quick enough to prevent the incident. The AD stated she should have been able to stop the incident. 3. Review of facility incident reports revealed there was a resident-to-resident altercation between R6 and R36 on 4/27/2024. Review of R36's Admission Record, located in the EMR under the Profile tab, revealed R36 had diagnoses that included bipolar disease, seizures, schizophrenia, and vascular dementia. Review of R36's annual MDS, located in the EMR under the MDS tab and with an ARD of 2/20/2024, revealed R36 had a BIMS score of 5 out of 15, indicating R36 was severely cognitively impaired. (continued on next page)

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 08/28/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R36's Progress Notes, provided by the facility and dated 4/27/2024 at 3:20 pm, revealed, . reported to staff that a male resident had entered the room sometime during the night, seated in a wheelchair, began touching [R36] all over, pulling off her blankets and yelling at [R36] to get up. [R36] roommate stated it was about 6:00 am, when this occurred . Review of R6's Progress Notes, provided by the facility and dated 4/27/2024 at 3:57 pm, documented R6 was assessed and sent to the local medical center for evaluation. Review of R6's Care Plan, located in the EMR under the Misc tab and updated 4/27/2024, revealed, . Monitor behaviors. On Q [every]15-minute check x 72 hours. Notify [psychiatric services] of current behaviors . Review of R6's Progress Notes, provided by the facility and dated 4/28/2024 at 1:11 am, revealed, . [R6] was returned to the facility, placed in room B 14B with no new orders. Will continue 15-minute checks and continue to monitor . During an interview on 8/26/2024 at 10:52 am, the Business Office Manager (BOM) confirmed the room change for R6 occurred on 4/27/2024, and R6 was moved from room A 10B to room B 14B. During an interview on 8/27/2024 at 5:34 pm, Licensed Practical Nurse (LPN) 2 explained R6 did enter the room for R36 and began feeling around the bed, removing the covers, and saying get out. LPN2 explained R6 had recently changed rooms and was on the wrong hallway looking for his room. LPN2 stated R6 was confused, on the wrong hallway, went into a room he thought was his, and thought that someone else was in his bed. LPN 2 confirmed R6 should have been monitored and redirected to the correct hallway after the room change. On 8/27/2024 at 3:00 pm, the facility was asked to provide the [psychiatric services] consultation report following the resident-to-resident interaction on 4/27/2024. The report was not provided by the end of the survey. 4. Review of facility incident reports revealed there was a resident-to-resident altercation between R6 and R23 on 5/11/2024. Review of R23's Progress Notes, dated 5/11/2024 at 2:30 pm, revealed R23 was propelling backwards in the wheelchair in the front lobby when the chair ran over the foot of R6, who then hit R23 on the shoulder with a closed fist. Review of R23's Progress Notes, dated 5/11/2024 at 3:44 pm, revealed, . this nurse was walking out of another resident's room when the receptionist notified me, she witnessed [R23] wheelchair ran over the foot of [R6] and then [R6] punched [R23] in the left shoulder. Both residents were separated and assessed for injury. No injury was found . Review of R6's Care Plan, located in the EMR under the Misc tab and updated 5/11/2024 revealed, . Monitor behaviors. On Q [every] 30-minute check x 72 hours . Review of R6's PAR flow sheet, provided by the facility and dated 5/17/2024, revealed, . recently had an altercation where he hit another resident after being bumped into [with a wheelchair]. [R6] will be redirected and monitored to try to prevent altercations . (continued on next page)

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 08/28/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/2024 at 11:50 am, the Assistant Director of Nursing (ADON) confirmed the facility needed to provide monitoring of R6 all the time. The ADON stated staff were aware of R6's behaviors and were on alert to monitor R6 when he came out of his room. The ADON stated after the incident on 4/27/2024, every 15-minute monitoring should have remained in place until the [psychiatric services] consultation was completed.

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 08/28/2024

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46592 Based on staff interview and review of the facility provided form titled Daily Nursing Staff Report(s), the facility failed to maintain Registered Nurse (RN) coverage for eight consecutive hours seven days a week on 8/10/2024, 8/11/2024, 8/24/2024, and 8/25/2024. This failure had the potential to render all 68 residents without the necessary medical assistance that only an RN could provide, leading to adverse outcomes. Findings include: Review of the Daily Nursing Staff Report(s), dated 8/10/2024, 8/11/2024, 8/24/2024, and 8/25/2024 that was provided by the Administrator, indicated the absence of RN coverage during each shift of each day listed. The form revealed, report contains nursing staff directly responsible for resident care. The form continued, daily posting of this information is required for nursing homes participating in Medicare and Medicaid programs. During an interview on 8/28/2024 at 11:25 am, the Administrator [interim since July 2024, but familiar with facility] verified that there should have been RN coverage for at least eight consecutive hours every day of the week. She acknowledged that not having an RN during each day had the potential for negative outcome situations.

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 08/28/2024

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46592 Based on staff interview and review of the facility provided form titled Daily Nursing Staff Report(s), the facility failed to indicate the daily census in the space provided on the daily posted form. This failure had the potential for resident family, friends, or other visitors to not know the ratio of nursing staff to residents causing uncertainty of ability and availability of the staff for residents' needs. The facility census was 68 residents. Findings include: Review of the Daily Nursing Staff Report(s) from 7/29/2024 through 8/26/2024 that was provided by the Administrator, presented a space, but the facility census information was not filled in. The form revealed, report contains nursing staff directly responsible for resident care. The form continued, daily posting of this information is required for nursing homes participating in Medicare and Medicaid programs. During an interview on 8/28/2024 at 11:25 am, the Administrator [interim since July 2024, but familiar with facility] verified that the Daily Nursing Staff Report(s) posted daily in the front of the facility should have had the census indicated in the space provided.

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 08/28/2024
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on staff interview, record review, and review of the facility's policy titled, Antipsychotic Medication Use, the facility failed to monitor for adverse consequences and behaviors related to antidepressant use for one of five residents (R) (R24) reviewed for unnecessary medications out of a total sample of 43. The deficient practice had the potential to place the resident at risk of untreated adverse consequences to the medication. Findings include: Review of the facility's policy titled, Antipsychotic Medication Use dated July 2022 revealed, . The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician: a. General anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation. b. Cardiovascular: orthostatic hypotension, arrhythmias. c. Metabolic: increase in total cholesterol triglycerides, unstable or poorly controlled blood sugar, weight gain; or d. Neurologic: akathisia, dystonia, extrapyramidal effects, akinesia; or tardive dyskinesia, stroke, or TIA [transient ischemic attack] . Review of R24's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with diagnoses that included bipolar disorder and generalized anxiety disorder. Review of R24's admission Minimum Data Set (MDS), located in the EMR under the MDS tab and with an Assessment Reference Date (ARD) of 7/29/2024, revealed R24 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R24 was cognitively intact. Review of R24's Physician Order, located under the Orders tab in the EMR and dated 7/22/2024, revealed R24 was to receive sertraline HCl (Zoloft, an antidepressant) 100 milligram (mg) orally every day for depression. (continued on next page)

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 08/28/2024
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R24's Care Plan, located under the Care Plan tab in the EMR and dated 8/2/2024, revealed, . The resident uses psychotropic medications [related to] Bipolar . Interventions included, . Monitor/document/report PRN (as needed) any adverse reactions of psychotropic (antidepressant) medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person . Review of R24's Medication Administration Record (MAR), Treatment Administration Record (TAR), and the TASKS tab (information completed by the certified nursing assistants (CNAs) of the EMR revealed no documentation of adverse consequence or behavior monitoring for R24. During an interview on 8/28/2024 at 10:40 am, the Assistant Director of Nursing (ADON) confirmed R24 was prescribed an antidepressant and, after reviewing the EMR, the ADON confirmed there was no documentation the resident was being monitored for behaviors or adverse consequences. The ADON confirmed the monitoring should be documented.

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 08/28/2024
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38517 Based on observation and staff interviews, the facility failed to ensure that one of three medication carts (B Hall) was secure when left unattended and out of the site of the nursing staff. The deficient practice had the potential to allow residents and/or visitors unauthorized access to medications. Findings include: Review of the facility's policy titled, Security of Medication Cart dated April 2007 under the section titled Policy Interpretation and Implementation revealed, 4. Medication carts must be securely locked at all times when out of the nurse's view. Observation on 8/27/2024 at 12:20 pm revealed a medication cart on the B hallway between rooms B5 and B78. The cart was out the sight of the nurse. The medication cart was unlocked, and inside the drawer were residents' liquid medications and vials of residents' insulin. The drawers to the cart were easily accessible to anyone walking down the hall. R56 and R61 and were both within 2-3 feet of the unlocked cart. The cart remained unlocked until 12:37 pm, when the Assistant Director of Nursing (ADON) was observed locking it. During an interview on 8/27/2024 at 1:11 pm, Licensed Practical Nurse (LPN) 2 stated she was moving too fast and forgot to lock the cart before proceeding to another hall. LPN2 stated R61 notified her that the surveyor opened the cart and that it was left unlocked. LPN2 stated it was important to ensure that the medication cart remained locked so that residents were safe. During an interview on 8/27/2024 at 1:28 pm, the Director of Nursing stated she expected medication carts to be locked and secured when not in sight or being used. The DON stated nursing staff had been educated on keeping the medication carts locked, but she did not know the last time.

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 08/28/2024
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03115 Based on observation, staff interviews, record review, and review of the facility's policies titled Dishwashing and Temperature Log Guidelines, the facility failed to ensure the chemical level of the low temperature dishwasher was maintained at a level that would sanitize the soiled dishes with the potential to affect 68 of 68 residents. The deficient practice had the potential to result in the spread of infections/viruses and food borne illness. Findings include: Review of the facility's undated policy titled, Dishwashing revealed the low temperature dishwasher rinse temperature should be in the temperature range of 120 degrees Fahrenheit (F) to 150 degrees F and the chlorine should be 50 part per million concentration minimum to 100 PPM concentration maximum. Review of the facility's undated policy titled, Temperature Log Guidelines revealed the dish machine log should have been completed three times daily to ensure the temperatures and the sanitizer levels were properly maintained and controlled. During an observation on 8/25/2024 at 7:04 pm, Dietary Aide (DA) 3 was observed running the dishes from the evening meal through the dishwasher. DA3 stated the dishwasher was a low temperature dishwasher. The sanitizer level of the rinse water of the dishwasher was checked and when the test strip was placed in the rinse water of the dishwasher it did not change color indicating it was at zero (0) parts per million (PPM) concentration level of chlorine. DA3 stated she probably needed to prime the machine. She pushed the primer button three times, ran the dishwasher repeatedly, and it tested at zero PPM. The sanitizer was checked a third time while she continually pushed the primer button throughout the wash and rinse cycles and the sanitizer was still measuring zero parts per million. She continued to wash the dishes without telling anyone about the dishwasher not dispensing any sanitizer into the rinse cycle of the dishwasher with DA2 continuing to remove the dishes from the racks on the clean end of the dishwasher and putting them away in the kitchen. During continued observation on 8/25/2024 at 7:29 pm, the sanitizer was checked for a fourth time and was zero PPM. DA3 stated she had worked a double shift and the last time she checked the sanitizer level of the dishwasher was at 8:14 am that morning and the test strip turned purple indicating it was between 50 and 100 PPM of chlorine sanitizer. When queried about what she was supposed to do if the sanitizer was not testing at the correct level, she stated she was supposed to tell the Dietary Manager (DM). When asked when she would be telling the DM, she stated in the morning after the DM arrived at work. She stated they were supposed to check the levels three times a day and write it down on the temperature log. The temperature logbook located on a shelf in the dishwasher room was provided by DA2. The book contained instructions for testing the level of the sanitizer and a log titled Dishwasher Temperature. The log had a space for the temperature and the sanitizer levels. Review of the log revealed it was not completed for 8/22/2024, 8/23/2024, lunch and dinner on 8/24/2024 and 8/25/2024. A document in the book used to write sanitizer levels titled, Test for Chlorine Sanitizer revealed the sanitizer should have been 50 PPM. (continued on next page)

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 08/28/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/25/2024 at 7:57 pm, the Dietary Manager (DM) stated she shook the sanitizer container and then primed it, and she got it to 100 PPM. She was informed it was zero PPM and verified it should have been at 50 PPM and if it was not, the staff should not have been using the dishwasher.