

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER Cambridge Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2020 McGee Road Snellville, GA 30078	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled Resident Rights, the facility failed treat one of 9 sampled residents (R) (R9) in a dignified manner. Findings included: During an observation on 2/4/2026 at 1:15 pm, R9 was observed at the nurses' station in her self propelling in her wheelchair. The resident was verbalizing that she had to use the bathroom. As R9 proceeded to self-propel her wheelchair towards the A Hall, Certified Nursing Assistant (CNA) AA approached R9 from behind her wheelchair, stopping the wheelchair and requesting to help move R9 in another direction. At that time, R9 pointed down the hall and stated, No. I am going that way. CNA AA told R9, No, you don't need to go down there. R9's tone elevated, and she began to hit the arm of her wheelchair, stating, No, no, no, no. I want to go that way, pointing towards A Hall. Staff AA grabbed the handles of R9's wheelchair and backed her up against the wall across from the nurses' station and locked the wheels on R9's wheelchair. A review of R9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of five, which indicates R1 has a severe cognitive impairment. A review of the care plan dated 10/27/2025 indicated that R9 presented with diagnosis of Alzheimer's Disease and goals included, but were not limited to, maintaining the resident's dignity and autonomy at the highest level through the next review date. Interventions included, but were not limited to, assessing R9 for coping strategies, respecting her wishes, and working with nursing staff to provide maximum comfort for the resident. During an interview on 2/4/2026 at 1:26 pm, CNA AA stated that she put R9 up against the wall so she would not go down the hall and go into other residents' rooms. During an interview on 2/4/2026 at 1:34 pm, the Director of Nursing (DON) confirmed that it is against the residents' rights and choices to restrict movement throughout the facility. She revealed the resident should be allowed to self-propel down the hall. During an interview on 2/5/2026 at 10:20 am, the Administrator revealed that residents have the right to wander anywhere in the building and that the residents are kept lined up in front of the nurses' station for more supervision. A review of the policy titled Resident Rights, dated July 2025, noted that each resident has the right to be treated with dignity and respect. When providing care services, each staff member respects each resident's individuality, as well as honors and values their input.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 115771	Facility ID: 115771 If continuation sheet Page 1 of 1