STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115670	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockdale Healthcare Center	1510 Reniassance Drive Conyers, GA 30012

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on staff interviews, record review, and review of the facility's policy titled Advance Directives, the facility failed to ensure the Advance Directive status was consistently documented in the clinical record for one of 45 sampled residents (R) (R71). This deficient practice had the potential to place R71 at risk of not receiving life-sustaining treatment in accordance with the resident's wishes. Findings include:Review of the facility's policy titled Advance Directives dated 7/2025 documented Policy: A resident's choice about Advance Directives will be respected. Policy Interpretation and Implementation: 3b; Do Not Resuscitate-Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health-care proxy, or representative have directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods are to be used.Review of the admission Record for R71 revealed R71 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, acute chronic systolic congestive heart failure, and hypertensive heart and chronic kidney disease with heart failure. The Advanced Directive section documented the resident's code status was Do Not Resuscitate (DNR).Review of the Annual Minimum Data Set (MDS) for R71, dated [DATE], documented Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) of 10, which indicated R71 had moderately impaired cognition.Review of the care plan for R71 revealed a focus area of the resident/family desires a DNR status. The goal was for the resident's desires to be met through next review date. The interventions included following the facility protocol for DNR status, and that the resident is DNR-will not be resuscitated per resident/family request. Review of the Clinical Physician's Orders for R71 revealed an order dated [DATE] and discontinued [DATE] of Code Status: Full Code. Further review revealed an order dated [DATE] of Code Status: DO NOT RESUSCITATE.Review of R71's electronic medical record (EMR) header documented Code Status: (Advance Directives) CODE STATUS: DO NOT RESUSCITATE.Review of a Physician's Orders for Life-Sustaining Treatment (POLST) for R71, dated [DATE], documented DNR Allow Natural Death (AND) - Do Not Attempt Resuscitation. The document was signed by a physician and a concurring physician. Review of a POLST for R71, dated [DATE], documented Full code: Attempt Resuscitation (CPR). The document was signed by a physician and the resident.In an interview on [DATE] at 2:59 pm, the Social Services Assistant (SSA) AA confirmed there was a DNR order in the EMR and a DNR status in the header of the EMR. She further confirmed that a Full Code Advance Directive was signed on [DATE] by the resident and would have rendered the previous Advance Directive of DNR, signed on [DATE], null and void. The SSA AA stated that the current Advance Directive should have been updated in the EMR, but it was not. She further stated that she did not have a chance to update it in the EMR, and that a negative outcome, if it was not updated, would be that the residents' wishes would not be fulfilled based on what he signed to be put in place. The SSA AA further stated that when (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
	115670	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockdale Healthcare Center	1510 Reniassance Drive Conyers, GA 30012

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the staff sees the DNR order, they would not resuscitate the resident during an emergency; therefore, the staff would go against the resident's wishes.In an interview on [DATE] at 3:26 pm, the Interim Director of Nursing confirmed the Advance Directive in the EMR for R71 was a DNR order, and the DNR was the status in the header of the EMR. She further confirmed that a current Full Code Advance Directive, signed on [DATE], was on file in the EMR for the resident. She stated that she placed the DNR order in the EMR and that it was a human error. She stated she inadvertently discontinued the wrong Advance Directive, and she should have placed the Full Code Advance Directive in the EMR instead. She stated that in an emergency, the staff would first look at the orders and the dashboard/header in the EMR for the resident's Advance Directive, and if the incorrect Advance Directive of DNR was in the orders and on the EMR dashboard, a negative outcome could be that the staff would not commence resuscitation for the resident.In an interview on [DATE] at 3:32 pm, the Unit Manager (UM) of the 200 Hall stated that the staff would first look in the EMR system for a resident's Advance Directive, and the staff would look for the order in the banner/dashboard. The UM stated that the staff would see a DNR order and a DNR Advance Directive status in the banner in the EMR for R71. She stated that if R71 had a DNR order and DNR banner/header in the EMR when R71's current Advance Directive status was Full Code, a negative outcome would be that in an emergency, the staff would not attempt to resuscitate R71.