STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115298	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairburn Heights of Journey LLC	178 West Campbellton Street Fairburn, GA 30213

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. Based on observations, staff interviews, and review of the facility policy titled, Food Storage: Cold Foods, the facility failed to properly store opened, unopened and sealed food items in the walk-in freezer. The deficient practice had the potential to affect 87 residents receiving an oral diet from the kitchen. Findings include:Review of the facility policy titled Food Storage: Cold Foods, states under Policy Statement: All Time/Temperature Control for Safety in accordance with guidelines of the FDA food Code. All food items will be stored, wrapped or in covered containers, labeled and dated and arranged items should be covered, sealed, labeled, and dated appropriately.Observation on 02/10/2026 at 9:35 AM of the cold storage area in the walk-in freezer revealed an opened freezer burned bag of eggs that was not securely closed, without a labeled open date or an expiration date, observation also revealed an opened expired pimento cheese spread container with best by date 02/05/2026.During an interview on 02/10/2026 at 9:37 AM, the Certified Dietary Manager (CDM) confirmed the walk-in freezer contained an opened freezer burned bag of eggs and the bag was not securely closed, it also was without a labeled open date or an expiration date, as well as an opened expired canister of pimento cheese spread best by date, dated 02/05/2026. The CDM revealed he expected dietary staff to routinely perform routine inventory in the walk-in freezer also to document the food products received dates upon delivery, and to perform routine inventory of the walk-in freezer documenting product open and expiration dates to ensure proper handling and safe food storage.Observation on 02/10/2026 at 9:45 AM of the walk-in freezer revealed two unopened five-pound bags of dry noodles without a labeled open date or an expiration date, the dates of 12/22/2026, and 01/06/2026 were written on the two bags of noodles, observation also revealed a bag of unopened rotten potatoes with an expiration date of 01/12/2026.During an interview on 02/10/2026 at 9:47 AM, the CDM confirmed the two unopened five-pound bag of dry noodles were without a labeled open date or an expiration date, he also confirmed the dates of 12/22/2026, and 1/6/2026 that were written on the two unopened bags of the noodles, he confirmed he was not able to confirm whether the dates listed on the two unopened bags of noodles were the received or expiration dates. While in the walk-in freezer the CDM confirmed a bag of unopened rotten bag of potatoes was expired with an expiration date of 01/12/2026. The CDM revealed he expected dietary staff to date opened food items before storage and expected dietary staff to routinely perform routine inventory in the walk-in freezer to ensure all received, opened and expiration dates are in accordance with the regulation and policy procedures.Observation on 02/10/2026 at 9:55 AM of the walk-in freezer revealed an opened expired bag of improperly stored bag of green onion with an expiration date of 01/30/2026 and a bag of unopened rotted green onion with an expiration date of 01/19/2026, observation of the walk-in freezer also revealed a bag of unopened rotted green celery with an expiration date of 01/16/2026.During an interview on 02/10/2026 at 10:02 AM, with the CDM the CDM confirmed there was an opened expired bag of improperly stored green onion with an expiration date of 01/30/2026 and a bag of unopened rotted green onion with an expiration date of 01/19/2026, as well as a bag of unopened rotted green celery with an expiration date of 01/16/2026 was in fact in the walk-in freezer. The CDM revealed he expected dietary staff to date opened food items before (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	storage and expected dietary staff to routinely perform routine inventory in the walk-in freezer to ensure all received, opened and expiration dates are in accordance with the regulation and policy procedures.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility policy titled, Routine Cleaning and Disinfection, the facility failed to ensure that Packaged Terminal Air Conditioning (PTAC) Units were free of dust and debris preventing proper filtration for heat and air in five of 15 resident (R) (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) rooms, and failed to ensure nails protruding from the wall were removed to prevent accident hazards.Findings include: The facility policy for Cleaning Packaged Terminal Air Conditioning Units was requested but not provided.Review of the facility policy titled Routine Cleaning and Disinfection revised date of February 2025 revealed under Policy: To ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.During the initial facility tour on 02/10/2026 at 11:32 AM, a heavy accumulation of dust was observed on the filter for the PTAC unit in room [ROOM NUMBER]. Also, the toilet tissue dispenser in the bathroom was rusted and the toilet tissue was propped on top of holder and could not be secured on the holder. Observation on 02/10/2026 at 11:54 AM in room [ROOM NUMBER] revealed a heavy accumulation of dust on the filter for the PTAC unit.Observation on 02/10/2026 at 12:05 PM in room [ROOM NUMBER] revealed a heavy accumulation of dust on the filter for the PTAC unit.Observation on 02/10/2026 at 12:03 PM in room [ROOM NUMBER] revealed a heavy accumulation of dust on the filter for the PTAC unit.Observation on 02/10/2026 at 12:19 PM in room [ROOM NUMBER] revealed a heavy accumulation of dust on the filter for the PTAC unit. The PTAC unit had debris resembling food crumbs on top of the PTAC unit and on the unit control panel. Multiple nails were observed protruding from the wall. Observation on 02/10/2026 at 12:33 PM revealed a heavy accumulation of dust on the filter for the PTAC unit in room [ROOM NUMBER]. Observation on 02/12/2026 at 9:14 AM in room [ROOM NUMBER] revealed a heavy accumulation of dust on the filter for the PTAC unit. Observation on 02/12/2026 at 9:14 AM in room [ROOM NUMBER] revealed a heavy accumulation of dust on the filter for the PTAC.Interview and observation on 02/12/2026 at 11:03 AM with two Surveyors, the facility Administrator and Maintenance Director revealed a heavy accumulation of dust on the PTAC unit filters in resident rooms 210, 211, 212, 213, and 214. The Administrator and Maintenance Director confirmed observations of dirty filters for the PTAC units, bathroom baseboard and other general plant matters. The Maintenance Director reported he would clean all PTAC units on the unit that same afternoon, including those not identified during the environmental tour. The Administrator acknowledging all the PTAC units on the Unit were in the same condition and that she had seen enough. She expressed her expectations for all PTAC units to be cleaned in accordance with the Preventative Maintenance Schedule in the TELS system and going forward, every three months; to include Maintenance retaining logs validating that the PTAC units were cleaned. Filter cleaning, coil cleaning and inside the PTAC will be the responsibility of the Maintenance Team.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 observations, resident and staff interviews, record review, and review of the facility's policies titled, MDS 3.0 Completion, the facility failed to correctly assess and identify intravenous (IV) access ordered and inserted the day after admission for one of 46 sampled residents (R) (R127). This deficient practice had the potential to confound care and monitoring of IV access, as well as the timely change of IV access.Findings include:Review of the facility's policy titled MDS 3.0 Completion, revised 12/23/2023, section d. ii. Revealed: Based on the CAA (Care Area Assessment) review, key findings regarding a resident's status are documented, including the nature of the condition, complications and risk factors that affect the care planning decision, factors that must be considered in developing care plan interventions, and the need for referrals or evaluation by appropriate health professionals. The assessment must be accurate and correct. Section 3. A. iii. Revealed: The PPS (prospective payment system) assessment authorizes payment for the entire PPS stay, so the initial assessment needs to be correct and accurate.Review of the electronic medical record (EMR) revealed R127 was admitted to the facility with pertinent diagnoses including but was not limited to; metabolic encephalopathy, staphylococcal arthritis of the left knee, atherosclerosis of native arteries of the extremities with intermittent claudication in the right leg, kidney disease stage 2, chronic embolism, thrombosis of deep veins of the left lower extremity, and sacral pressure ulcer.Review of R127's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated R127 had moderate cognitive impairment. Section GG, Functional Status, revealed R127's admission performance- requires supervision for eating, oral hygiene, is dependent for toileting hygiene, dependent for shower/bath, dependent for dressing upper and lower body, and dependent for putting on and taking off footwear. She is dependent for bed mobility and positioning to the sitting position. Section H, Bowel and Bladder, R127 is always incontinent of bowel and bladder. Section M, Skin Conditions, Resident has a stage 3 pressure ulcer and 3 venous/arterial ulcers, all present on admission. Section O, Special Treatments, Procedures and Treatments, documented IV access as a midline catheter for antibiotic therapy. Review of R127's care plan dated 02/3/2026 indicated a problem of IV medications related to left septic knee. Enhanced barrier precautions (EBP) related to wounds and midline IV access in the left upper arm. IV antibiotic therapy for staphylococcal arthritis to the left knee, stop date 3/7/2026Review of the hospital records in the EMR revealed an order from the infectious disease physician for a peripheral percutaneous inserted central line catheter (PICC) line IV access to be placed for antibiotic therapy with weekly dressing changes and care of vascular access.Review of the Physician's Orders for R127 included but were not limited to: Wound care to sacral the vascular wound every Monday, Wednesday, and Friday. Vancomycin 1000mg (milligrams)/250ml (milliliters) daily IV. Ceftriaxone sodium solution 2 g (gram) two times daily IV. PICC (peripherally inserted central catheter) line placement order. PICC line care.Review of the Progress note from admission revealed: Effective Date: 2/3/2026 at 21:24 (09:24 PM), by Unit Manager Registered Nurse (RN) FF. Resident arrived to facility via ambulance on stretcher. Alert and orientated x (times) 3, periods of confusion noted. Pain 10/10 in the L (left) knee with any touch or movement. Vs stable and wnl. Skin on les tight and scaly, extremely dry. wounds noted to R (right) ankle and l buttock. Buttock wound unable to stage due to large loose brown slough being present. Incontinent of urine and bm (bowel movement). Loose brown bm, upon arrival, urine clear yellow with no odor. Abd (abdomen) soft nontender bs (bowel sounds) x 4. Lungs diminished, denies any dyspnea or cough. L knee swollen and tender. Currently to receive IV antibiotics but no IV access noted. Notified MD (medical doctor) on call Dr and orders received for PICC line placement. Called name of IV company and spoke with RN and nurse will be out to place line in the morning. New orders for Tramadol received for pain. Resident educated on bed controls and call light. Denies any questions. No emergency contact listed.Observation and interview on 02/10/2026 at 11:32 AM with (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R127 revealed the resident had an IV access with a gauze under a clear dressing with no date on the dressing. The access dressing was clean, dry, and intact. She stated she thought they changed it yesterday or something. She was confused as to the situation; she stated she was in the hospital.Interview on 02/11/2026 at 03:45 PM with the MDS (Minimum Data Set) coordinator revealed that R127 came in with no IV access, and the nurse on the floor called the pharmacy to have the IV access team come and insert an IV access for R127. The last company we used would only place midline IV access. She stated that she just assumed that that was what the resident had. She confirmed the PICC line order by the physician.Interview on 02/11/2026 at 04:15 PM with the MDS Coordinator revealed that the documentation had not been uploaded into the system yet, and she brought a copy of the PICC line insertion done on 02/4/2026 at 06:35 PM from name of IV company. Interview on 02/12/2026 at 11:23 AM with the Director of Nursing (DON) revealed that her expectations for the admission assessment were that the assessment be correct and accurate and that PICC and midline dressings be dated at time of change. Interview on 02/12/2026 at 03:25 PM with the Administrator confirmed that her expectations were that the nursing assessments be correct and accurate before they were sent to Medicare.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility policy titled, Resident Assessment-Coordination with PASRR (Preadmission Screening and Resident Review) program, the facility failed to ensure that one of 46 sampled residents (R) (R7) was assessed for level two PASRR to the appropriate state-designated authority for evaluation and determination of specialized services (PASRR), if warranted. The deficient practice had the potential for R7's needs and services to go unmet.Findings include:Review of the facility's policy titled, Resident Assessment- Coordination with PASARR program date 02/10/2024 revealed under Policy: This facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Under Policy Explanation and Compliance Guidelines revealed: The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.Review of R7's electronic medical record (EMR) revealed that she was admitted to the facility with diagnoses including but not limited to paraplegia, cognitive communication deficit, other schizophrenia, bipolar disorder, major depressive disorder.Review of the quarterly Minimum Data Set (MDS) dated [DATE] documented R7 with a Brief Interview of Mental Status (BIMS) score of 15, indicating R7 cognitively intact.Review of the Care Plans for R7 revealed care plan dated 06/18/2025 revealed resident has a mood problem r/t (related to) diagnosis of bipolar disorder, major depressive disorder, schizophrenia. She should be observed for s/s (signs/symptoms) of worsening mood such as alterations in sleeping pattern, appetite changes, sudden mood swings. Goal revealed the resident will have improved or stabilized mood state through the review date. Interventions revealed monitor/document/report PRN (as needed) any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Monitor/record mood to determine if problems seem to be related to external causes, i.e. medications, treatments, concern over diagnosis. Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills. Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behaviour monitoring protocols. Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. Observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity.Review of the Preadmission Screening/Resident Review (PASRR) Level two list dated 02/07/2026 revealed R7 was not listed.Review of the PASRR Level one dated 06/05/2026 revealed approved with physician signature. PASRR Level two dated 02/12/2026 revealed pending.Interview conducted on 02/12/2026, at 12:50 PM with the Assistant Director of Nursing (ADON) disclosed that she was neither responsible for nor involved in the PASRR process for the residents. It was noted that the resident's PASRR had been finalized by the Administrator and the Social Worker.Interview on 02/12/2026 at 01:34 PM with the Administrator confirmed that the Social Worker Director recently finalized an audit in which R7 was possibly overlooked. Administrator confirmed that R7 should have (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been included due to her diagnoses. The Administrator further confirmed that the PASSR will be submitted immediately.Interview on 02/12/2026 at 2:45 PM with the Social Service Director (SSD) disclosed that her responsibilities included processing the PASRR. The SSD indicated that the facility conducted PASRR level one upon admission and subsequently, the admission Coordinator provides her with names for further assessment to submit for a PASRR level two. The SSD mentioned that she conducted an audit two to three weeks ago for residents with issues related to schizophrenia, depression, and bipolar disorder, but she was unable to locate the submission for R7.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, staff and interviews, record review, and review of the facility's policies titled, Comprehensive Care Plans, the facility failed to follow the interventions of the comprehensive care plan for one of 46 residents sampled residents (R) (R12). This deficient practice could increase the risk of injury during a fall.Findings include:Review of the facility's policy titled Comprehensive Care Plans revised 01/01/2025, revealed under Policy Explanation and Compliance Guidelines: .3. a. The comprehensive care plan should describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Review of R12's care plan dated 02/07/2026 indicated a problem of Risk for falls. Interventions included, but were not limited to, Fall [NAME] on the floor on the right side of the bed when the resident is in bed. The resident is with Hospice and is a Full Code. R12 has a condition or chronic disease that may result in a life expectancy of less than six months.Review of the Physician's Orders for R12 included, but was not limited to: wound care to sacral wound, EBP (enhanced barrier precautions), tramadol HCL (hydrochloride) 50mg (milligrams) four times a day routine, lorazepam 1 mg every four hours prn (as needed), morphine 20mg/ml (milligram per milliliter) give 0.25ml every 2 hours for severe pain, Scopolamine transdermal patch 1mg, change every 3 days, place behind the ear for secretions. Carbidopa-Levodopa 10-100mg four times a day.Observation on 02/10/2026 at 12:34 PM with R12 revealed the resident lying on her back, half side rails in place, the bed was in the lowest position, R12's eyes were closed, and there was no fall mat on either right or left side of her bed as per her care plan.Observation made on 02/11/2026 at 3:50 PM of R12 revealed R12 lying in bed on her back, half side rails in place, there was no fall mat present on the right or left side of her bed on the floor.Observation made on 02/12/2026 at 9:43 AM of R12 revealed R12 lying in bed, head of bed elevated 45 degrees, and the resident was leaning to the right side. Her eyes were closed, and half rails were in place. No fall mats were on the floor as care planned.An interview on 02/12/2026 at 9:46 AM with Licensed Practical Nurse (LPN) HH revealed she did not recall having a fall mat on the floor beside R12's bed.An interview on 02/12/2026 at 10:58 AM with Registered Nurse (RN) FF revealed that she was the RN supervisor on the evening that R12 fell out of bed. She stated she went into R12's room after the CNA told her about the fall. She stated that she found the resident sitting on the floor beside the right side of the bed; no fall mat was present at the time. An interview on 02/12/2026 at 2:43 PM with the Director of Nursing (DON) confirmed that there were no fall mats in place on R12's floor. She states that her expectation for following the care plan was that it be followed. An interview on 02/12/2026 at 3:02 PM with the Administrator revealed that he expected whatever the policy stated to be done.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, staff interviews, and record review, the facility failed to ensure physician orders were followed and documented for routine suprapubic catheter changes for one of four sampled residents (R) (R5). This deficient practice had the potential risk of infection and complications associated with prolonged indwelling catheter use when routine catheter changes were not completed and documented as ordered.Findings include:Review of the electronic medical record (EMR) for R5 revealed admission to the facility with diagnoses of but not limited to obstructive and reflux uropathy, benign prostate hyperplasia with lower urinary tract symptoms, personal history of malignant neoplasm of prostate.Review of physician orders dated 11/10/2025 directed that R5's suprapubic catheter (20 French, 10 mL (milliliter) balloon) be changed monthly and as needed.Review of the care plan for R5 identified catheter-related interventions on 10/14/2025 (catheter dislodgement and replacement) and on 01/08/2026 (catheter change and irrigation); however, no documentation was identified verifying that the resident's suprapubic catheter was changed between 10/24/2025 and 01/08/2026.Observation on 02/11/2026 at approximately 11:00 AM revealed R5 with a suprapubic catheter in place draining to a bedside collection bag. The resident was alert and responsive urine was flowing well at the time of observation.Interview on 02/12/2026, Licensed Practical Nurses GG and HH acknowledged they were unable to locate documentation in the EMR verifying a suprapubic catheter change during the period of 10/24/2025 through 01/08/2026 and stated the physician order required routine catheter changes every 30-39 days.Interview on 01/12/2026 with the Assistant Director of Nursing confirmed there was no documented evidence of a catheter change during this timeframe and stated facility expectations were for staff to follow physician orders and document care provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Oxygen Administration, the facility failed to ensure proper maintenance of an oxygen (O2) concentrator (machine that produces O2) and failed to secure an O2 tank for one of 23 residents (R) (R58) receiving oxygen. This practice had the potential to cause respiratory distress, increased risk of respiratory complications, and injury Findings include:Review of the facility policy titled Oxygen Administration revised [DATE], under the section titled Policy Explanation and Compliance Guidelines, number 2 documented, Personnel authorized to initiate oxygen therapy include physicians, RNs (Registered Nurses), LPNs (Licensed Practical Nurses), and respiratory therapists (RTs).A review of the electronic medical records (EMR) revealed R58 was admitted to the facility with diagnoses including, but were not limited to, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, and shortness of breath.Review of R58's physician orders revealed an order dated [DATE] for oxygen at night during sleep, 2L (liters)/min (minute) via nasal cannula every night shift.Review of R58's physician orders revealed an order dated [DATE] . oxygen at night during sleep, 4L/min via nasal cannula every night shift.Observation on [DATE] at 1:45 PM revealed R58 was receiving oxygen via O2 concentrator. The O2 concentrator emitted a continuous beeping throughout the observation.Observation on [DATE] at 5:10 PM revealed R58's O2 concentrator filter to be heavily soiled with visible dust and debris accumulation. Further observation revealed the O2 concentrator covered in dirt and the service tag was expired by five years. Also observed was an O2 tank standing upright, unsecured and unsupervised while in the R58's room. The O2 concentrator was constantly beeping during the observation.Observation on [DATE] at 12:15 PM revealed R58's O2 concentrator was covered in dirt and the O2 concentrator filter to be heavily soiled with visible dust and debris accumulation and the service tag was expired by five years. An unsecured oxygen tank was standing upright and unsupervised while in the residents' room, with the O2 concentrator alarm consistently beeping. Interview on [DATE] at 12:40 PM with R58, she revealed there was a loud and distracting beeping noise coming from the O2 concentrator. She mentioned she had been complaining for months to the Director of Nursing (DON); however, no one responded to her concerns. Interview on [DATE] at 1:15 PM with the DON revealed she was not aware of any issues related to R58's O2 concentrator nor was she aware there was an O2 tank standing upright and unsecured, without use, in a residents' room. She also mentioned that the Assistant Director of Nursing (ADON) was responsible for the monitoring of the O2 concentrators and or any respiratory equipment.Interview on [DATE] at 1:35 PM with the ADON revealed the 02 concentrators were cleaned on a routine basis. She also mentioned that O2 concentrators were the Unit Managers responsibility, however due to the Unit Managers overwhelming case load, she wanted to assist by assuming the responsibility but was not aware of an issue with R58's O2 concentrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115298	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairburn Heights of Journey LLC	178 West Campbellton Street Fairburn, GA 30213

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 - Few	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. Based on record review, staff interviews and review of facility's policy titled, Emergency Staffing, the facility failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for six days, 04/05/2025, 04/06/2025, 05/03/2025, 05/24/2025, 05/25/2025, and 05/26/2025. This failure had the potential to affect all residents residing in the facility. The facility census was 110.Findings Include:Review of facility's policy titled Emergency Staffing Policy reviewed on 02/16/2024 revealed under section titled, Policy Explanation and Compliance Guidelines: The number of staff required for meeting resident needs on a daily basis are determined through the facility assessment. Schedules shall reflect sufficient staff with minimum use of scheduled overtime. In an emergency, the Administrator and key staff (as designated by the facility's Incident Command System) shall meet for briefing on staffing needs and develop an action plan. Staffing needs will be fulfilled in a step-wise fashion:a. On-duty staff and scheduled staff.b. Off-duty staff and on-call staff, including department managers.c. Staff from sister facilities (i.e., owned by same company), and non-medical volunteers who are already on file with the facility.d. Staff from other facilities with which the facility has a Memorandum of Understanding on file to provide staff in the event of an emergency or disaster.e. Staff from receiving facilities who intend to stay and assist with providing care.f. Volunteers from Medical Reserve Corps (or similar agency available to facility) in which credentialing has been pre-verified.g. Healthcare professional volunteers who present to the facility to provide assistance.The staffing schedule and timecard punches were requested of the DON on 2/10/2025 for the following dates 04/06/2025, 05/03/2025, 05/24/2025, 05/25/2025, and 05/26/2025. Due to salaried status of the Registered Nurses, no extra evidence was available to verify physical presence in the facility on the identified dates.Review of timecard punches/payroll revealed:04/06/2025 (Sunday): Payroll reflected RN TT as salaried; however, no supporting documentation was provided to verify RN TT's presence.05/03/2025 (Saturday): Payroll reflected RN SS as salaried; however, no supporting documentation was provided to verify RN SS's presence.05/24/2025 (Saturday), 05/25/2025 (Sunday), and 05/26/2025 (Monday): Payroll reflected RN SS as salaried; however, no documentation was provided to verify RN SS's presence for at least eight consecutive hours.Record review of staffing schedule revealed:04/06/2025 (Sunday): Staffing sheet reflected zero RN hours, and no documentation was provided to verify RN presence.05/03/2025 (Saturday): Staffing sheet reflected zero RN hours, and no documentation was provided to verify RN presence.05/24/2025 (Saturday), 05/25/2025 (Sunday), and 05/26/2025 (Monday): Staffing sheet reflected zero RN hours, and no documentation was provided to verify RN presence.Interview on 02/12/2026 at 2:43 PM with the Director of Nursing (DON) revealed all RNs were salaried so they did not clock in or out. She stated the facility's process regarding having RN coverage was that an RN was here Monday through Friday. She stated if she was off, then the ADON was here. She stated on weekends, if there was no scheduled RN coverage, then she would take a day or the ADON would take a day. She stated they always have to have eight hours of coverage and would get an RN to work to ensure coverage. She further stated they could not find supporting documentation that an RN was in the building for the additional identified dates 04/06/2025, 05/03/2025, 05/24/2025, 05/25/2025, and 05/26/2025. She stated her expectation as DON was that the DON or ADON would be present Monday through Friday, and on weekends the supervisor would be present, and if not, between the ADON or DON, one of them would be in the facility. When asked about potential negative outcomes of not having RN coverage, she stated the assessment component could be affected, stating that LPNs can assess, but sometimes an RN could be more clinical than an LPN. She stated if a patient codes (stops breathing and heart stops), an RN would be required to pronounce death, as LPNs cannot pronounce. She stated that much of the RN role was management and clinical oversight.Interview on 02/12/2026 at 3:59 PM with the Administrator revealed the facility's process was that you always have RN (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coverage. She stated the expectation is that they ensure they always have nurse coverage and that they have been doing a whole lot better. She confirmed they could not provide evidence that there was an RN present on 04/06/2025, 05/03/2025, 05/24/2025, 05/25/2025, and 05/26/2025, and she acknowledged documentation was not available to verify RN presence. She stated the expectation was to ensure nurse coverage daily. She stated a potential negative outcome from not having RN coverage was clinical is not covered and there would be a lack of clinical leadership in the building.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policies titled, Hand Hygiene and Enhanced Barrier Precautions, the facility failed to use proper hand hygiene during wound care for one of 46 sampled residents (R) ( ) and failed to provide signage and PPE protocols for two of 46 sampled R's (R127 and R88). The deficient practice had the potential to cause the spread of infection to other residents and staff.Findings include:Review of the facility's policy titled Hand Hygiene revised 02/01/2024, under section 6. a. revealed that the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.Review of the facility's policy titled Enhanced Barrier Precautions revised 03/20/2025, under section 2b states, An order for enhanced barrier precautions (EBP) will be obtained for residents with any of the following: i. Wounds (e.g. Chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wound, and chronic venous stasis ulcers) and or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, peripheral inserted central catheter (PICC) lines, midline catheters) even if the resident is not known to be infected or colonized with a multi drug resistant organism (MDRO). (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP. Section 3. a, b, c, d read: Implementation of Enhanced Barrier Precautions includes a. Make gowns and gloves available immediately near or outside of the resident's room. Personal Protective equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned before entering the resident's room. C. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). D. Position a trash can inside the resident room and near the exit for discarding PPE after removal, before exit of room, or before providing care for another resident in the same room.Review of the electronic medical record (EMR) revealed resident R127 was admitted to the facility with pertinent diagnoses, including but not limited to metabolic encephalopathy, staphylococcal arthritis of the left knee, atherosclerosis of native arteries of the extremities with intermittent claudication in the right leg, kidney disease stage 2, chronic embolism and thrombosis of deep veins of the left lower extremity.Review of R127's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating R127 had moderate cognitive impairment. Section GG (Functional Abilities and Goals) revealed, admission performance- requires supervision for eating, oral hygiene, is dependent for toileting hygiene, dependent for shower/bath, dependent for dressing upper and lower body, and dependent for putting on and taking off footwear. She is dependent on bed mobility and positioning to the sitting position. Review of R127 Care Plan dated 02/03/2026 revealed IV antibiotic therapy for staphylococcal arthritis to the left knee, stop date 3/7/2026, R127 is on IV Medications r/t (related to) left septic knee. Enhanced barrier precautions r/t wounds and midline IV access. Review of the hospital records in the electronic medical record (EMR) revealed that R127 had an order for a PICC line for intravenous antibiotic therapy.An observation on 02/10/2026 at 11:32 AM with R127 revealed R127 has a vascular access PICC line with no date on the dressing. The resident states she thought it was changed yesterday. The resident in A bed, R88, was on a low air mattress with no sheet. R88 explained that she has a wound on her bottom and that the mattress should ot have a sheet on it to work the best at pressure relief. Bags of linen were seen in the sink area, and R88 explained that it was clean linen that they use throughout the day to change their beds. There was no signage noted outside indicating that residents R127 or R88 were on EBP. There was no PPE available, and no trash can to remove PPE in the room.Observation on 02/11/2026 at 8:10 AM revealed R127 and R88 were both in room [ROOM NUMBER], and both were care planned for EBP, but there were no PPE supplies available or signage outside the room. Licensed Practical Nurse (LPN) DD and Certified Nursing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant (CNA) AA donned (put on) gloves to reposition R127 in C bed, but no gown was donned.An observation on 02/11/2026 at 8:17 AM revealed LPN DD and LPN KK Unit Manager enter room [ROOM NUMBER] and reposition C bed (R127), who has orders for EBP. There is no PPE or signage available on the door. They donned gloves. An observation on 02/11/2026 at 8:20 AM, a CAN was observed delivering a breakfast tray to room [ROOM NUMBER] B without hand hygiene upon entrance or exiting room.An observation on 02/11/2026 at 9:20 AM, LPN DD and CNA RR entered R127's room to turn and perform personal care without PPE other than gloves.An observation and interview on 02/11/2026 at 9:24 AM with LPN DD revealed that 311-bed A also had a wound according to her orders, it was a stage IV, and she was also care planned for enhanced barrier precautions; there was no signage or PPE available. An observation on 02/11/2026 at 9:30 AM, LPN DD went into room [ROOM NUMBER] and assisted the residents with hygiene and positioning. She did not wear PPE or gloves at this time. An interview with LPN DD on 02/11/2026 at 9:33 AM revealed LPN DD confirmed that residents R127 and R88, both in room [ROOM NUMBER] A and C, were supposed to be on EBP, and there was no sign on the door or PPE available. She said there should have been a sign because of R88, even before R127 was admitted . She also confirmed that the staff had not been wearing PPE during the care of these residents. An observation of wound care on 02/11/2026 at 9:58 AM revealed Wound Care, LPN EE donned PPE gown and gloves, and performed hand hygiene. Instructed R127 on the procedure and left the room to collect supplies. 02/11/2026 at 10:02 AM, LPN EE collected supplies including normal saline, calcium alginate with silver, and foam protective dressing. She performed hand hygiene and donned her gown and gloves. She has already dated and put her initials on the foam dressing. R127 was assisted to roll on her left side, and LPN EE removed the old dressing and disposed of it in a red bag. She then removed her dirty gloves and donned clean gloves without hand hygiene. She cleaned with normal saline and 4x4 gauze, removed her dirty gloves, donned clean gloves without performing hand hygiene, and applied calcium alginate with silver and applied a foam dressing. An interview on 02/11/2026 at 11:30 AM with LPN EE confirmed that she did not use hand sanitizer between glove changing but she was told not to bring hand sanitizer into the room. An interview on 02/11/2026 at 01:46 with the Director of Nursing (DON) confirmed that she expected wound care to be done in an aseptic manner. She denied telling the wound care nurse not to bring the alcohol in the room and would sort out a way to have the nurse perform hand hygiene in between glove changes when doing wound care.