STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115324	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bainbridge Landing of Journey LLC	1155 West College Street Bainbridge, GA 39819

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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, Controlled Substance Administration and Accountability and Medication Administration, the facility failed to ensure the Controlled Substances Proof of Use form was signed after narcotic administration for one of 41 sampled residents (R) R8 during review of one of two medication carts. This deficient practice had the potential to cause incorrect narcotic counts, missed or overdose of narcotic medication for R8.Findings include: Review of the facility's policy titled, Controlled Substance Medication Accountability reviewed 02/14/2024 documented Policy: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. Policy Explanation and Compliance Guidelines:1. General Protocols:. f. All controlled substances (Schedule II, III, IV, V) are accounted for in one of the following ways:. ii. All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. iii. All specially compounded or non stock Schedule II controlled substances dispensed from the pharmacy for a specific patient are recorded on the Controlled Drug Record supplied with the medication or other designated form as per facility policy. g. In all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record. h. The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration. i. The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy.Review of the facility's policy titled Medication Administration reviewed 02/14/2024 documented Policy Explanation and Compliance Guidelines: .18. If medication is a controlled substance, sign narcotic book.Review of the electronic medical records (EMR) revealed R8 was admitted to the facility on [DATE] with diagnosis included but not limited to chronic pain syndrome.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview for Mental Status (BIMS) score of 15 which indicated R8 had intact cognition, Section J (Health Conditions) R8 received as needed (PRN) pain medications, had pain over the last five days, Section N (Medications) R8 takes opioid.Review of care plan dated 08/26/2025 documented R8 is receiving an opioid medication and is at risk for or has reported actual side effects related to chronic pain. Goal: side effects will be monitored through next pain evaluation. Intervention: Monitor for Increased sensitivity to pain, monitor for symptoms of withdrawal if medication is stopped or dose held.Review of the Physician's Orders dated 03/24/2026 documented included but not limited to Acetaminophen Oral Tablet 5-325 milligram (mg) (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain related to chronic pain syndrome.Observation and interview on 03/31/2026 at 11:58 AM during review of the 100 Hall medication cart revealed the narcotics and (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	narcotic book were checked and one signature was missing from the Controlled Substances Proof of Use form. Further observation revealed the Controlled Substances Proof of Use form documented Hydrocodone - Acet 5-325 mg tablet for R8 had 14 tablets remaining and the blister pack had 13 tablets. Licensed Practical Nurse (LPN) DD was present during the review, and she confirmed the Controlled Substances Proof of Use form documented Hydrocodone - Acet 5-325 mg tablet for R8 had 14 tablets remaining and the blister pack had 13 tablets. She stated she administered the narcotic tablet and did not sign that it was administered. She stated she always signed immediately after administration of narcotics but she was distracted by a relative of another resident, and she forgot to sign. She stated that during the mediation pass this morning she signed right after administering narcotics and she stated that during this review of all the narcotics in the 100-hall cart, only the one narcotic was found to not be signed for. LPN DD further stated she should have signed that she administered the Hydrocodone - Acet 5-325 mg tablet for R8 and since she did not sign that it was administered, there would be a discrepancy with the narcotic count, and it could seem as if she took the medications. She further stated that another nurse could give the medication to the resident and not know that it was already given and the resident could get an overdose.Interview on 03/31/2026 at 4:03 PM with the Director of Nursing (DON) revealed she stated her expectations were for the nurses to sign the narcotics they administered at the same time right after they administered it after removal. She stated the controlled sheets protect from diversion or misappropriation. The DON stated that medically, a negative outcome for the resident could be that when the nurse does not sign immediately that she administered the narcotic it could lead to possible misappropriation. If it was not signed out at the time it was given and it was signed one hour later, when the resident needed pain medication again the medication administration record (MAR) would say that it was too soon to be administered. The opposite would also happen if it were signed out before the medication was given, the MAR would say it cannot be given sooner and if it is given sooner it could lead to overdose of the medication. The DON stated if it was given too late depending on what the medication was, the resident's condition may worsen.Interview on 04/01/2026 at 4:00 PM with LPN HH revealed she stated the nurse should sign in the computer and the narcotic book whenever a narcotic medication was administered. She further stated the narcotic book should be signed immediately after administering the narcotic because persons could go back and look to see when it was last administered and it also would be accounted for. If it was not signed out it would be a medication error and the nurse could forget to go back and another nurse would give another dose of the medication to the resident which would cause overdose.Interview on 04/01/2026 at 4:03 PM with LPN II revealed that the narcotic book should be signed immediately after administering the narcotic because if it was not signed for at the time it was given, and the nurse remembered an hour afterwards and documented it, the EMR system would record it one hour later and the next dose would be too early if the other nurse gave it to the resident, not knowing that the resident already received it and this would overmedicate the resident and cause the resident distress.

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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. Based on observations, staff interviews and review of the facility's policy titled, Medication Storage, the facility failed to place open dates on two vials of blood glucose strips in one of two carts (100 hall cart) reviewed. This deficient practice had the potential to cause inaccurate blood sugar readings for the residents.Findings include:Review of the facility's policy titled, Medication Storage revised 02/14/2024 documented Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations.Observation and interview on 03/31/2026 at 11:52 AM during review of the 100 Hall medication cart revealed two blood glucose vials were in the top right drawer of the medication cart had no open dates. Licensed Practical Nurse (LPN) DD was present during the review, and she confirmed there were two blood glucose vials with no open dates in the top right drawer of the medication cart. LPN DD stated there should be open dates on the blood glucose strips because after the bottle was opened there was a depreciation of the strips and no one would know when the strips were opened if there was no open date. She stated if the strips were used on residents there would be inaccurate blood sugar readings.Interview on 03/31/2026 at 04:16 PM with the Director of Nursing (DON) revealed she stated her expectations were for the medications to have open dates. She stated that there were medications which would have a shortened shelf life and blood glucose strips would fall under that category so it should have an open date. The DON further stated if the blood glucose strips were used on the residents, there would be inaccurate blood sugar readings, medication errors and the residents could be over medicated or under medicated.Interview on 04/01/2026 at 04:00 PM with LPN HH revealed she stated blood glucose strips should have open dates. She stated that whenever the vials were opened, the strips would be exposed to air which can degrade the strip and lead to false blood sugar readings.Interview on 04/01/2026 at 04:02 PM with LPN II revealed she stated blood glucose strips should have open dates when they first opened because there was a certain time after the vial was opened for the strips to be no longer be good. She further stated if the strips were used on residents, they would get false readings such as false high blood sugar readings when they were not high or false low blood sugar readings when they were not low. The residents would be treated for the false blood sugar reading, and the residents could pass away.

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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 Infection Prevention and Control Program, the facility failed to practice infection control protocol by staff not practicing proper glove use and hand hygiene between glove change during wound care for one of six sampled residents (R) R2 with wounds, and during Foley catheter care for one of five sampled R's with Foley catheter, R42. This deficient practice had the potential to cause infection to the residents.Findings include:Review of the facility's policy titled Hand Hygiene revised 02/01/2024 documented Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). 6. Additional considerations: a. 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 Infection Prevention and Control Program dated 03/20/2025 documented Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.1. Review of the facility's electronic medical records (EMR) revealed R2 was re-admitted to the facility on [DATE] with diagnosis included but not limited to open wound, right hip. Review of the Medicare Part A Minimum Data Set (MDS) dated [DATE] documented Section, C (Cognition) Brief Interview for Mental Status (BIMS) of 09 which indicated R2 had moderately impaired cognition, Section M (Skin Conditions) R2 had unhealed pressure ulcers and had 2 stage 4 pressure ulcers present on admission.Review of care plan reviewed 03/09/2026 documented R2 on Enhanced Barrier Precautions Infection Prevention related to (r/t) pressure ulcer wounds with interventions for appropriate precautions will be taken.Review of the Physician's Orders dated 03/27/2026 documented included but not limited to Clean right lateral thigh with Vashe, pat dry and apply Silver Sulfadiazine to areas, cover with border gauze and change x 3 weekly and as needed (PRN) if soiled or displaced one time a day every Monday, Wednesday, Friday and as needed.2. Review of the facility's EMR revealed R42 was admitted to the facility on [DATE] with diagnosis included but not limited to neuromuscular dysfunction of the bladder.Review of the Quarterly MDS dated [DATE] documented Section C (Cognition) BIMS score of 15 which indicated R42 had intact cognition, Section H (Bladder and Bowel) R42 had external catheter.Review of care plan reviewed 01/03/2023 documented R42 was at risk for urinary tract infection (uti)/moisture associated skin damage (MASD) and/or other complications related to supra-pubic catheter for neurogenic bladder. Goal: Complications will be minimized daily through [sic] next review date. Interventions: catheter (cath) care every (q) shift.Review of the Physician's Orders dated 11/20/2024 included but not limited to Cleanse around insertion site of supra pubic catheter with normal saline or wound care cleanser pat dry, apply Sure prep to surrounding skin and cover with dry dressing.Observation on 03/31/2026 at 10:25 AM during R8's wound care with the Wound Care Nurse (WCN)/Infection Preventionist (IP) BB revealed she placed gloves in her pocket, removed the gloves from her pocket and put on the gloves to use during wound care. Observation further revealed WCN BB removed used gloves and donned a new pair of gloves without sanitizing or washing her hands. She cleaned the wound, removed the gloves and put on another pair of gloves without sanitizing her hands.Observation on 03/31/2026 at 10:49 AM during R42's Foley catheter care with WCN/IP BB revealed she removed the old dressing from the suprapubic catheter site, disposed of the dressing in a garbage bag, removed gloves from her pocket and put on the new pair of gloves. WCN/IP BB did not sanitize her hands between glove change.Observation on 03/31/2026 at 11:17 AM revealed Licensed Practical (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse (LPN) CC came out of a resident's room on the 300 hall while removing her gloves, walked with the gloves rolled up in her left hand to the nurses' station, disposed of the gloves in the garbage bin on the medication cart at the nurses' station, then donned a new pair of gloves and cleaned the a blood sugar machine on the medication cart. LPN CC did not hand sanitize between glove change.Interview on 03/31/2026 at 11:02 AM with the WCN/IP BB revealed and confirmed she removed gloves from her pocket and used them during wound care and catheter care. She also confirmed that she changed gloves without sanitizing her hands. She stated she washed her hands after removing her gloves however she did not wash nor sanitize her hands each time she removed her gloves. She stated that whenever gloves were worn, hands were to be sanitized when gloves were removed to prevent spread of germs/bacteria and to prevent spread of infection. WCN/IP stated if hands were not sanitized, the residents would get infections. The WCN/IP further stated that pockets were not ok to place gloves in for use, gloves were to come directly from a box or placed on a barrier to be used. She stated germs from pockets would cause infection to the residents.Interview on 03/31/2026 at 11:20 AM with LPN CC revealed and confirmed she did not hand sanitize between glove change. She stated she should have sanitized her hands when she removed her gloves and before putting on a new pair of gloves. LPN CC stated that when she did not hand sanitize between glove change, it could cause cross contamination because germs or whatever was on the used gloves could get on her hands when she removed them, so if she did not hand sanitize before putting on a new pair of gloves, the resident could get sick.Interview on 03/31/2026 at 04:16 PM with the Director of Nursing (DON) revealed her expectations were for hands to be cleaned prior to putting on and after removing gloves. She stated that a negative outcome for the residents would be that the residents would be at risk for infection. The DON further stated that gloves must not be kept in pockets for use by the staff, it was an infection control concern, and the residents could get infections.Interview on 04/01/2026 at 04:00 PM with LPN GG revealed hands should be sanitized before and after glove use. She stated it was an infection control issue, and germs could be passed on to the resident if hands were not sanitized or washed between glove change.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the policy titled, Safe and Homelike Environment Policy and Procedure, the facility failed to maintain a clean and safe environment by ensuring that air filters in resident rooms were free from excessive dust in two of 37 sampled rooms (rooms [ROOM NUMBERS]). This deficient practice had the potential to create an unsafe and unclean homelike environment for residents.Findings include:Review of the facility's policy titled Safe and Homelike Environment Policy and Procedure, revised on 02/01/2024, documented Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Definitions:.Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living. Policy Explanation and Compliance Guidelines: .3.Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.Observation on 03/30/2026 at 11:59 AM of room [ROOM NUMBER] revealed that the airˆfilter unit located under the window was heavily coated with dust. A second observation on 03/31/2026 at 10:15 AM of room [ROOM NUMBER] confirmed that the air filter remained heavily coated with dust. A third observation on 04/01/2026 at 9:08 AM of room [ROOM NUMBER] revealed continued accumulation of dust on the air filter.Observation on 03/30/2026 at 11:36 AM of room [ROOM NUMBER] revealed that the airˆfilter unit located under the window was heavily coated with dust. A second observation on 03/31/2026 at 10:22 AM of room [ROOM NUMBER] confirmed that the air filter remained heavily coated with dust. A third observation on 04/01/2026 at 9:02 AM of room [ROOM NUMBER] revealed continued accumulation of dust on the air filter.Interview and concurrent observation on 04/01/2026 at 10:47 AM with the Maintenance Director confirmed that the air filters in rooms [ROOM NUMBERS] were excessively dusty, should not have been in that condition, and required cleaning. The Maintenance Director stated that air filters were cleaned monthly on the first of each month; however, no complete documentation was provided to verify that the cleaning had been performed as scheduled.Interview on 04/01/2026 at 10:52 AM with the Infection Preventionist stated that the Maintenance Director was responsible for ensuring that air filters were maintained in a clean condition.