STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115327	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads of Flowery Branch of Journey Llc, The	4595 Cantrell Road Flowery Branch, GA 30542

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21792 Based on staff interviews, record review, and review of the facility's policy titled Documentation in Medical Record, the facility failed to ensure accurate documentation was completed regarding a change of condition for one resident (R) (R1) out of six sampled residents reviewed for notification of change. Findings Include: Review of the undated facility's policy titled, Documentation in Medical Record under Policy revealed, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Under the section titled Policy Explanation and Compliance Guidelines revealed, 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Review of R1's medical records revealed diagnoses that included, hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, end stage renal disease, major, unspecified dementia, anemia in chronic kidney disease, dysphagia, dependence on renal dialysis. Review of R1's Annual Minimum Data Set assessment dated [DATE] for Section C (Cognitive Patterns) revealed the Brief Interview of Mental status was not conducted related to the resident was rarely/never understood. Review of R1's Hospital ED (Emergency Department) provider Note dated 7/18/2024 at 9:04 am under Medical Decision Making revealed, R1 presented with altered mental status (AMS). Under ED Diagnosis revealed final diagnoses that included, hypernatremia, dehydration, acute respiratory failure, sepsis, pneumonia of both lungs, and fever. Under the Hospital Problems section, the Assessment & Plan that included Septic shock revealed, R1 was presented with fever 104.7, altered mental status, elevated lactic acid 2.2, and leukocytosis. Most likely source in resp (respiratory) nature based on imaging. Initially LP (lumbar punctures) was completed based on high fever as well as AMS but CSF (cerebrospinal fluid) with high glucose and only minimally elevated protein. (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
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's 24-hour report dated 7/18/2024 revealed there was no documentation related to R1's change of condition. Review of R1's nurses notes, and Situation, Background, Assessment, and Recommendation (SBAR) report revealed there was no documentation related to R1's change of condition. Review of R1's Progress Notes dated 7/22/2024 at 1:51 pm revealed late entries for a Nurses Note, Physician Note, and SBAR communication was completed after the surveyor had questioned staff regarding the change of condition that resulted with the resident being sent to the ED. Interview on 7/22/2024 at 10:05 am with Nurse Practitioner (NP) CC revealed that she came in on Friday morning and was told by the nurse that R1 was transitioning but did not know how long she had been in that condition. She revealed that she did an assessment that found that R1 was difficult to arouse with rapid breaths. She revealed vital signs were checked and 911 was notified. She revealed that R1 was transported out by EMS wearing an O2 (oxygen) mask. Interview on 7/22/2024 at 11:40 am with the Administrator revealed that an interview was conducted with the nurse who stated that she and NP CC assessed the resident for her change in condition, but she forgot to chart the information. She revealed that further investigation revealed no evidence of documentation of R1's change of condition in R1's medical record, nurses notes, 24-hour report, or SBAR report. She revealed that NP CC revealed that she only wrote an order to send R1 out for evaluation, but not why. She revealed that the Licensed Practical Nurse (LPN) FF and the NP CC have had documentation training and have written late entry notes for the change of condition for the resident. Interview on 7/22/2024 at 1:30 pm with LPN FF revealed that it was change of shift and she thought she had charted everything down. She confirmed she did not see the information in the chart She revealed that she sent all the transfer information with the Emergency Medical Services (EMS) but did not chart information on the SBAR form. Interview on 7/22/2024 at 2:14 pm with CNA HH revealed that he provided care to R1 throughout the night. He revealed that there was something different in the resident's behavior throughout the night. He revealed that when he provided incontinent care to the resident throughout the night, she would fight with him; however, on that night she would fight but not as hard as you usually did. He revealed that the resident was checked on every two hours. He revealed that on his last rounds the resident looked like she was declining. He revealed that he reported it to the nurse, she came and checked on the resident, vital signs were done, sent resident out to ER (emergency room). Interview on 7/22/2024 at 2:45 pm with the Assistant Director of Nursing (ADON) JJ revealed that she checked the 24-hr report book and there was no information written about the change of condition for R1. She confirmed that there was no documentation in the nurses' notes. She reported that all staff had been trained on the documentation policy.