

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Crossroads of Flowery Branch of Journey Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on resident and staff interviews, record review, and review of facility policy, the facility failed to report allegations of staff-to-resident abuse to facility administration and/or within two hours to the State Survey Agency (SSA) for two of three residents (Resident (R) 1 and R2) reviewed for abuse out of a total sample of 12. The deficient practice had the potential to place residents at continued risk of abuse. Findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 3/5/2024, revealed reporting of all alleged violations . shall be immediate but no later than 2 hours after the allegation is made .</p> <p>1. Review of R1's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the with diagnoses that included but not limited to dementia, anxiety, protein-calorie malnutrition, and muscle weakness. R1 was admitted to hospice care on 07/30/24. Review of R1's Care Plan, dated 11/5/2024 and located under the Care Plan tab of the EMR, revealed a focus of .</p> <p>Fragile Skin: Resident has fragile skin related to the aging process and is at risk for bruising easily and skin tears . Interventions were to notify the physician and responsible party of any changes. Review of R1's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 4/23/2025 and located under the MDS tab of the EMR, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident could not complete the cognition interview. During an interview on 7/1/2025 at 1:54 PM, the Social Service Worker (SSW) 1, affiliated with the hospice service, stated R1 reported to her on 11/19/2024 that she had been hurt by staff, causing bruising and wounds. SSW1 stated she reported the allegation to the Administrator and the facility Social Service Director (SSD) and filed a report with the Hospice agency. SSW1 stated R1 reported to her again on 3/5/2025 that someone hurt her. SSW1 stated she observed bruising on the resident's left ankle and reported the bruising to the Administrator and to the facility SSD. During an interview on 7/1/2025 at 4:55 PM, the Director of Nursing (DON) stated there were no facility reports or investigation for the allegation reported on 11/19/2024. The DON stated she was aware of the abuse allegation R1 that was reported on 3/5/2025 by the hospice Social Worker regarding R1. The DON stated she had determined the bruise to be related to a fall the resident had on 2/8/2025. The DON could not produce any evidence that the allegation had been reported to the SSA or investigated. During an interview on 7/1/2025 at 5:25 PM, the Administrator stated he was not the Administrator in November 2024. He confirmed that no report of the 11/19/2024 allegation could be located. The Administrator stated they felt the reports from SSW1 were retaliatory and that is why they were not investigated or reported and agreed they should have been reported and investigated. During an interview on 7/2/2025 at 10:20 AM, the SSD stated she thought she remembered a conversation about the allegation from R1 on 11/19/2024 but did not report or have any documentation of the incident. The SSD stated she was aware of the allegation reported to the facility on 3/5/2025. The SSD stated she did not report or do an investigation of the allegation because they had determined the bruise looked like an old injury. The SSD could not produce any documentation of the allegation. 2. Review of R2's admission Record, located under the Profile tab of the EMR, revealed she was admitted with diagnoses that included but not limited to heart failure, kidney failure, depression, hypertension, and muscle weakness. R2 was admitted to hospice care on 8/9/2024. Review of R2's quarterly MDS with an ARD 6/5/2025 and located under the MDS tab of the EMR, revealed R2 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. During an interview on 7/2/2025 at 12:05 PM, R2 stated that she was treated very roughly. R2 stated she had a very sore body and felt like the staff did not care if they hurt her. During an interview on 7/2/2025 at 12:12, Family Member (F) 1 stated that R2 has complained about rough treatment from staff, and he had concerns that staff was unconsciously mistreating R2. During an interview on 7/2/2025 at 3:17 PM, the SSD stated that on 2/28/2025, a Certified Nurse Aide (CNA) had reported to her that R2 had alleged a staff member had held her hand too hard and hurt her. The SSD stated she had documented the allegation in her daily planner but did not report or investigate the allegation. The SSD stated she did not remember who the reporting CNA was. The SSD confirmed she should have reported and investigated the allegation. During an interview on 7/3/2025 at 9:05 AM, the Administrator stated he was not aware that these issues were not reported or thoroughly investigated. The Administrator stated he was concerned that the allegations were not investigated appropriately and agreed that all injuries of unknown origin should be taken seriously and investigated thoroughly.</p>		

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)		

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Based on staff interviews, record review, and review of facility policy, the facility failed to identify and/or investigate allegations of staff-to-resident abuse for two of three residents (Resident (R) 1 and R2) reviewed for abuse out of a total sample of 12. The deficient practice had the potential to allow abuse to continue. Findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation, dated 3/5/2024, revealed, . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . 1. Review of R1's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed she was admitted with diagnoses that included but not limited to dementia, anxiety, protein-calorie malnutrition, and muscle weakness. R1 was admitted to hospice care on 7/30/2024. Review of R1's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 4/23/2025 and located under the MDS tab of the EMR, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident could not complete the cognition interview. Review of R1's Care Plan, located under the Care Plan tab of the EMR and dated 11/5/2024, revealed a focus of, . Fragile Skin: Resident has fragile skin related to the aging process and is at risk for bruising easily and skin tears . Interventions were to notify physician and responsible party of any changes. Review R1's Change of Condition Evaluation, dated 2/8/2025 and located under the Assessment tab of the EMR, revealed R1 had a fall. It was recorded R1 did not sustain an injury, and there were no changes observed on the skin evaluation. Review of R1's Weekly Skin Assessment, dated 2/12/2025 and located under the Assessment tab of the EMR, revealed R1 did not have any bruises, and her skin was intact. Review of R1's Weekly Skin Assessment tab of the EMR, revealed R1 did not have any bruises, and her skin was intact. During an interview on 7/1/2025 at 1:54 PM, the Social Service Worker (SSW)1, affiliated with the hospice service, stated R1 reported to her on 11/19/2024 that she had been hurt by staff, causing bruising and wounds. SSW1 stated she reported the incident to the Administrator and the facility Social Service Director (SSD) and filed a report with the Hospice agency. SSW1 stated R1 reported to her again on 3/5/2024 that someone had hurt her. SSW1 stated she observed bruising on R1's left ankle and reported the bruising to the Administrator and to the facility SSD. During an interview on 7/1/2025 at 4:55 PM, the Director of Nursing (DON) stated there were no investigations into the allegation of abuse for R1 reported on 11/19/2024. The DON could not produce any evidence that the allegation had been investigated. During an interview on 7/1/2025 at 5:25 PM, the Administrator stated no report of the allegation for R1 could be located. The Administrator confirmed the allegations should have been investigated. 2. Review of R2's admission Record, located in in the EMR under the Profile tab, revealed R2 was admitted to the facility with diagnoses that included but not limited to heart failure, kidney failure, depression, hypertension, and muscle weakness. Review of R2's quarterly MDS, with an ARD of 6/5/2025 and located under the MDS tab of the EMR, revealed a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. A review of the facility incident report, dated 11/13/2024 and provided by the facility, revealed that a family friend of R2 noted bruising on R2 on 11/10/2024 but did not report it to staff until 11/13/2024. The report indicated the Administrator was notified on 11/13/2024 by staff. The report indicated the bruising was reported to the appropriate agencies and the investigation was started immediately by the Administrator. Further review of the investigation revealed that staff were interviewed about the bruising; however, there was no documented evidence that R2 was interviewed about the bruising. There was no documented evidence that other residents were interviewed. There was no documented evidence that the event was analyzed to determine how the bruising occurred and how to prevent further incidents. There was no documented evidence that staff had been trained or in-serviced on the reporting or investigating injuries of unknown origin. There was no documented evidence on how to protect the resident and any risk factors they might need to address to prevent further incidents. The follow-up report was submitted within the five-day timeframe; however, there was no documented evidence that any follow-up by social services or any measures that were taken to verify any corrective actions were implemented. During an interview on 07/03/25 at 9:05 AM, the Administrator stated he was not aware that these allegations were not thoroughly investigated. The Administrator stated he was concerned that the allegations were not investigated appropriately and agreed that all injuries of unknown origin should be taken seriously and investigated thoroughly.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded to reflect a significant weight loss for two of 12 residents (Resident (R) 8 and R5) reviewed. The deficient practice had the potential to result in unmet care needs. Findings include: Review of the facility's policy titled, Conducting an Accurate Resident Assessment, dated 3/20/2025, revealed, . Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status . The physical, mental, and psychosocial condition of the resident determines the appropriate level of involvement of physicians, nurses . dietitians, and other professionals .1. Review of R8's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R8 was re-admitted to the facility on [DATE] following a hospital stay, which started 3/6/2025. She had diagnoses that included dysphagia (difficulty swallowing). Review of R8's Weight Summary, located under the Wts/Vitals tab of the EMR, revealed R8's weight on 3/22/2025 was 126.0 lbs. R8 weighed 112 pounds (lbs) on 4/4/2025 and weighed 115 lbs on 4/20/2025, representing a significant weight loss of 8.73% (11 lbs). Review of R8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/23/2025 and located under the MDS tab of the EMR, revealed R8 scored four out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R8 was severely cognitively impaired. It was recorded that R8 weighed 115 lbs but failed to record a significant weight loss. Review of R8's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, [Resident] has a potential risk for weight loss related to dysphagia and disease process revised on 10/3/2022. It did not document the significant weight loss. During an observation on 7/2/2025 at 12:38 PM, R8 was observed eating her meal independently. When asked how her meal was, R8 repeated several times that she was skinny and touched her abdomen. 2. Review of R5's admission Record, located under the Profile tab of the EMR, revealed R5 was re-admitted to the facility on [DATE] following a hospital stay which began on 4/19/2024. R5 had diagnoses that included Parkinson's disease and other disorders of the brain. R5 was discharged from the facility to the hospital on 9/22/2024 and did not return. Review of R5's Weight Summary, located under the Wts/Vitals tab of the EMR, revealed R5's weight on 4/23/2024 was 149.2 lbs and on 4/30/2024 was 153 lbs. R5's next weight was 129 lbs on 5/28/2024, representing a 13.54% weight loss (20.2 lbs) in one month. Review of R5's Progress Note, dated 6/4/2024, written by the Nurse Practitioner (NP), and located under the Progress Notes, tab revealed Remeron was ordered for appetite stimulation due to weight loss. Review of R5's Progress Note, dated 7/10/2024 and located under the Progress Notes tab of the EMR, revealed R5 was assisted with all meals, family brought snacks, and the Registered Dietician (RD) was following R5. Review of R5's quarterly MDS, with an ARD of 7/11/2024 and located under the MDS tab of the EMR, revealed R5 scored 14 out of 15 on the BIMS, which indicated R8 was cognitively intact. It was recorded that R5 weighed 122 lbs, but failed to code weight loss. Review of R5's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, The resident is at risk for alteration in nutrition/hydration secondary to: poor po [oral] intake. 4/24/2024 hospital return-weight gain trend; 8/6/2024 quarterly review-SWL [significant weight loss] with revision date of 8/6/2024. During an interview on 7/2/2025 at 4:20 PM, the RD reported she assisted with the MDS assessments. During an interview on 7/2/2025 at 5:10 PM, the RD confirmed R8's and R5's MDS assessments did not reflect that the residents had a significant weight loss. She stated there was significant weight loss which someone failed to document. During an interview on 7/2/2025 at 6:44 PM, the Director of Nursing (DON) reported she expected the MDS to reflect significant weight loss.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to update care plans to reflect a significant weight loss with current intervention for two of 12 residents (Resident (R) 8 and R5) reviewed. The deficient practice had the potential to result in unmet care needs regarding nutrition. Findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 3/20/2025, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment .1. Review of R8's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R8 was re-admitted to the facility on [DATE] following a hospital stay, which started 3/6/2025. She had diagnoses that included dysphagia (difficulty swallowing). Review of R8's Weight Summary, located under the Wts/Vitals tab of the EMR, revealed R8's weight on 3/22/2025 was 126.0 pounds (lbs). R8 weighed 112 lbs on 4/4/2025, representing a significant weight loss. Review of R8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/23/2025 and located under the MDS tab of the EMR, revealed R8 scored four out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R8 was severely cognitively impaired. It was recorded that R8 weighed 115 lbs but failed to record a significant weight loss.Review of a 5/24/2025 Weight Change Note, completed by the Registered Dietician (RD) and located in the Progress Notes tab of the EMR, revealed significant weight loss at one and three months and revealed R8 refused the supplement due to dislike of the milky base. The RD recorded she spoke with the nurse practitioner about changing her appetite stimulant to Remeron. The RD recommended replacing the two cal supplement with Ensure Clear three times a day and adding a Magic Cup (fortified frozen dessert) with lunch and dinner.Review of the Order Recap from 3/22/2025 to 7/2/2025 revealed R8 started Remeron on 3/22/2025, and it was increased in dosage on 3/25/2025. R8 continued on the two cal supplement and had no orders for Ensure Clear or Magic Cup. There were no orders for routine weights.Review of R8's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, [Resident] has a potential risk for weight loss related to dysphagia and disease process, revised on 10/3/2022. Goals, revised on 6/14/2025, included, . nutrition and hydration needs will be met through the next review date . risk of weight loss will be minimized . Interventions included, Administer medications as ordered, revised on 12/27/2016, Invite me to activities that promote additional intake., revised 5/11/2021, Monitor/document/report [as needed] any signs/symptoms of dysphagia, revised 12/27/2016, Obtain and monitor lab/diagnostic work as ordered, revised 5/11/2021, Provide and serve diet as ordered, revised 12/27/2016, RD to evaluate and make diet change recommendations as needed, revised 12/27/1206, and Supplements as ordered, revised 6/16/2021. No new interventions were documented since 6/16/2021.During an observation on 7/2/2025 at 12:38 PM, R8 was observed eating her meal independently. There was no Magic Cup on the tray. When asked how her meal was, R8 repeated several times that she was skinny and touched her abdomen. When asked if she liked or received ice cream or a frozen dessert, she reported she liked it, but it comes and goes.During an interview on 7/2/2025 at 3:40 PM, Certified Nurse Aide (CNA)1 reported R8 fed herself and had a fair appetite but was not much of a breakfast eater. CNA1 was not aware of any weight loss interventions for R8 but stated that Magic Cups were available as other residents received them on their trays.During an interview on 7/2/2025 at 3:41 PM, CNA2 stated that R8 fed herself. When asked about weight loss interventions, CNA2 said R8's diet changed to mechanical soft when she had an issue with her jaw. The diet remained the same over the last several months.2. Review of R5's admission Record, located under the Profile tab of the EMR, revealed R5 was re-admitted to the facility on [DATE] following a hospital stay which began on 4/19/2024. R5 had diagnoses that included but limited to Parkinson's disease and other disorders of the brain. R5 was discharged from the facility to the hospital on 9/22/2024 and did not return.Review of a Nutrition/Dietary Note dated 5/21/2024, located in the Progress Notes tab of the EMR, revealed R5 had a fair appetite, was assisted with meals, and saw speech therapy for dysphagia. R5 triggered MDS for a significant weight gain with weights of 143 lbs on 3/29/2024 and 153 lbs on 4/30/2024 Review of R5's Weight Summary, located under the Wts/Vitals tab of the EMR, revealed R5's</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to identify a severe weight loss, re-assess nutritional needs, and implement interventions in a timely manner to aid in the prevention of weight loss for two of 12 residents (Resident (R) 8 and R5) reviewed. R8 had a recorded weight loss of 18.65% (percent) in less than three months. R5 had a recorded weight loss of 19.57% in five months. Findings include: Review of the undated facility policy titled, Weight Management Policy and Procedure revealed a weight report which reflected significant weight changes was generated monthly (by the 10th of the month) and reviewed by the dietary manager, Registered Dietician (RD), and Director of Nursing (DON). A significant weight change was defined as 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. Weekly weights were completed for residents exhibiting significant weight changes. 1. Review of R8's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R8 was re-admitted to the facility on [DATE] following a hospital stay, which started 3/6/2025. She had diagnoses that included dysphagia (difficulty swallowing). Review of a Nutrition Note, dated 3/5/2025 (prior to the resident's hospitalization) and located in the Progress Notes tab of the EMR, revealed that she was at risk for inadequate oral intake related to chewing difficulty. She was changed to a mechanical soft diet. R8's supplement (two cal) was increased to 90 milliliters (mL) four times a day. Review of R8's Weight Summary, located under the Wts/Vitals tab of the EMR, revealed R8's weight on 3/22/2025 was 126.0 pounds (lbs). R8 weighed 112 lbs on 4/4/2025, representing an 11.11% weight loss, and weighed 115 lbs on 4/20/2025, representing an 8.73% weight loss in one month. R8 continued to lose weight and weighed 102.5 lbs on 6/9/2025, which was her last recorded weight as of 7/1/2025. This represented an 18.65% (23.5 lbs) significant weight loss in three months. Review of R8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/23/2025 and located under the MDS tab of the EMR, revealed R8 scored four out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R8 was severely cognitively impaired. It was recorded that R8 weighed 115 lbs but failed to record a significant weight loss. Review of the Progress Notes and Evaluations tabs of the EMR revealed no documentation of weight loss until a 5/24/2025 Weight Change Note was completed by the RD. The note documented significant weight loss at one and three months and revealed R8 was refusing the supplement due to dislike of the milky base. The RD recorded she spoke with the nurse practitioner about changing R8's appetite stimulant to Remeron. The RD recommended replacing the two cal supplement with Ensure Clear three times a day and adding a Magic Cup (fortified frozen dessert) with lunch and dinner. Review of the Order Recap from 3/22/2025 to 7/2/2025 revealed R8 started Remeron on 3/22/2025, and it was increased in dosage on 3/25/2025. R8 continued on the two cal supplement and had no orders for Ensure Clear or Magic Cup. There were no orders for routine weights. Review of R8's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, [Resident] has a potential risk for weight loss related to dysphagia and disease process revised on 10/3/2022. Goals, revised on 6/14/2025, included, nutrition and hydration needs will be met through the next review date and risk of weight loss will be minimized. Interventions were last revised in the year 2021. Observations of R8 in her room on 7/1/2025 at 12:30 PM and 12:50 PM revealed R8 seated in her wheelchair with her plate, cover in place, by her on a table. During an observation on 7/2/2025 at 12:28 PM, R8's meal tray was delivered to her room and set up in front of her as she sat in her wheelchair. Staff left to deliver more room trays. At 12:38 PM, R8 was observed eating her meal independently. There was no Magic Cup on the tray. When asked how her meal was, R8 repeated several times that she was skinny and touched her abdomen. When asked if she liked or received ice cream or a frozen dessert, she reported she liked it, but it comes and goes. During an interview on 7/2/2025 at 3:40 PM, Certified Nurse Aide (CNA) 1 reported the restorative aide (RA) weighed the residents. CNA1 reported R8 fed herself and had a fair appetite but was not much of a breakfast eater. CNA1 was not aware of any weight loss interventions for R8 but stated that Magic Cups were available as other residents received them on their trays. During an interview on 7/2/2025 at 3:50 PM, the RA reported he weighed residents weekly when they had a weight loss. The RA wrote down the weights and gave them to the DON to record in the EMR. The RD and DON determined who was weighed weekly, and the RD spoke to him about residents with weight changes. He was unable to recall if R8 was weighed weekly and stated he had to check his binder. He thought she may have refused, and he did not want to upset her, so he did not continue them. He was unable to recall the RD</p>		