STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115354	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lagrange Trails of Journey LLC	2111 West Point Road Lagrange, GA 30240

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, record reviews, and review of the facility's policies titled, Medication Administration, Insulin Pen, and the package insert TRESIBA (insulin degludec) injection, for subcutaneous use, the facility failed to ensure the accurate administration of medications for four of 40 medication opportunities observed, resulting in a medication error rate of 10 percent for two residents(R) (R4 and R3) during medication administration. This deficient practice had the potential to negatively impact residents' clinical conditions and lead to complications in their current health statusFindings include:Observation on 05/12/2026 at 10:08 AM on Hall 300 (East Wing) with Licensed Practical Nurse (LPN) AA revealed R4 had a physician order for Calcium 600 (calcium carbonate), give 600 milligrams(mg) one time a day. During medication administration, the nurse administered Calcium 600 + D 10 micrograms(mcg), which did not match the physician's order. Observation on 05/12/2026 at 11:02 AM on Hall 300 (East Wing) with LPN AA revealed R3 had physician orders for Amlodipine Besylate 5 mg daily and Losartan Potassium 50 mg daily for hypertension. During medication administration, the nurse obtained the resident's blood pressure of 125/63 and heart rate of 101, then withheld both antihypertensive medications, stating the resident's blood pressure was too low for administration despite no physician-ordered hold parameters.During the same observation, R3 also had an order for Degludec (Tresiba) 100 unit/milliliters(ml) solution, inject 30 units subcutaneously daily for DM (diabetes mellitus). LPN AA dialed the ordered dose but failed to prime the insulin pen prior to administration. The insulin pen was removed approximately two seconds after the final click, and medication leakage was observed at the injection site, right upper arm. The nurse wiped the leakage with the resident's shirt sleeve.Interview on 05/12/2026 at 11:58 AM with LPN AA stated that she believed dialing the prescribed dose constituted priming the pen. When questioned regarding post-injection dwell time, the nurse provided inconsistent responses, 30 seconds to 15 seconds, regarding how long the pen remained in place following administration. Follow-up interview with LPN AA on 05/13/2026 at 1:44 PM revealed it was her understanding that R3's blood pressure was typically low at baseline. The nurse stated she withheld the antihypertensive medications based on nursing judgment rather than physician-ordered parameters due to the resident's diastolic blood pressure of 63. Interview on 05/13/2026 at 2:17 PM with the Director of Nursing (DON) revealed that nursing staff were expected to administer medications according to active physician orders, including following all ordered parameters for medications such as insulin and antihypertensives. The DON stated that nurses were expected to verify orders, obtain required vital signs and blood glucose readings, and clarify missing parameters with the provider prior to withholding medications. She also revealed that education may be needed when nurses were unclear when to administer medications such as antihypertensives when vitals were within normal limits. Medication discrepancies or errors are expected to be promptly addressed through provider notification, responsible party notification, and required facility documentation. The DON further stated that insulin administration should include proper insulin pen technique, including priming the pen with 2 units and holding the injection in place for three seconds after administration. She confirmed that all medications administered must match active physician orders.Review of the facility policy titled, Medication Administration revised February 14, 2024, revealed item 8. When applicable, hold medication for those vital signs outside the (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
	115354	A. Building B. Wing	05/13/2026

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's prescribed parameters. Further review of item 11. Compare medication source (bubble pack, vial, etc.) with medication administration record(MAR) to verify resident name, medication name, form, dose, route, and time Item 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR.Review of the facility policy titled, Insulin Pen implemented April 4, 2025, revealed item 11 . Procedure: h. Prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. Further review of item j. Fully depress the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin.Review of package insert titled, TRESIBA (insulin degludec) injection, for subcutaneous use revised July 2022 revealed under section Instruction for Use .step 7. Priming your TRESIBA FlexTouch Pen: Turn the dose selector to select 2 units, step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. Further review of step 13: Press and hold down the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. You may then hear or feel a click. Keep the needle in your skin after the dose counter has returned to 0 and slowly count to 6. When the dose counter returns to 0, you will not get your full dose until 6 seconds later. If the needle is removed before you count to 6, you may see a stream of insulin coming from the needle tip. If you see a stream of insulin coming from the needle tip you will not get your full dose. If this happens you should check your blood sugar levels more often because you may need more insulin.

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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 - Many	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and review of the facility policy titled, Glucometer Disinfection, the facility failed to ensure staff followed appropriate disinfection procedures for blood glucose monitoring devices. Specifically, staff failed to properly disinfect the glucometer between resident use during blood glucose monitoring observations for three of three sampled Residents (R) (R4, R2 and R3). This deficient practice placed residents at increased risk for infection transmission and cross-contamination. Findings Include:Observation on 05/12/2026 at 10:08 AM on Hall 300 (East Wing) with Licensed Practical Nurse (LPN) AA revealed R4 received a blood glucose check using a shared glucometer. Following use, the nurse cleaned only the strip insertion area of the glucometer with an alcohol swab rather than disinfecting the entire device according to facility policy.Observation on 05/12/2026 at 10:39 AM on Hall 300 (East Wing) with LPN AA revealed R2 received a blood glucose check using the same shared glucometer. Following use, the nurse cleaned only the strip insertion area with an alcohol swab rather than disinfecting the entire device.Observation on 05/12/2026 at 11:02 AM on Hall 300 (East Wing) with LPN AA revealed R3 received a blood glucose check using the same shared glucometer. Following use, the nurse cleaned only the strip insertion area with an alcohol swab rather than disinfecting the entire device according to facility policy.Interview on 05/12/2026 at 11:58 AM with LPN AA regarding glucometer use and infection control practices revealed there was one shared glucometer available for resident use. The nurse stated proper protocol required disinfecting the glucometer with approved sanitizing wipes between each resident use and allowing appropriate drying/contact time. LPN AA reported checking the medication room and medication carts but was unable to locate disinfecting wipes. She further stated she had not been informed that alcohol wipes could be used in place of approved disinfecting wipes.Interview on 05/13/2026 at 2:17 PM with the Director of Nursing (DON) revealed glucometers were expected to be disinfected between resident use with approved sanitizing wipes and allowed to air dry according to facility protocol. The DON stated alcohol wipes were not considered appropriate for glucometer disinfection and confirmed staff education had been initiated regarding proper disinfection technique. The DON further confirmed sanitizing wipes were available in the facility.Review of facility policy titled, Glucometer Disinfection revised February 1, 2024, revealed item 3. The glucometers will be disinfected with a wipe pre-saturated with an EPA (Environmental Protection Agency) registered healthcare disinfectant that is effective against HIV (human immunodeficiency), Hepatitis C and Hepatitis B virus. Further review of item 4. Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use.