STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115368	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Crossing of Journey LLC	2327 North Highway 27 Carrollton, GA 30117

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled Abuse, Neglect and Exploitation, the facility failed to protect one of three sampled residents' (R) (R1) rights to be free from physical and verbal abuse by a staff member when Certified Nursing Assistant (CNA) NN struck R1 while providing care. Findings include:Review of the facility's policy titled Abuse, Neglect, and Exploitation, revised 03/05/2024, included, It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Further review revealed the Definitions section included Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.Review of the Facility Incident Report, dated 05/21/2026, revealed that the facility reported an allegation of physical/verbal abuse by CNA NN against R1 to the State Survey Agency (SSA).Review of the [Name] County Sheriff's Office Incident Report, dated 05/21/2026 at 5:00 AM, revealed the officer spoke with a family member of R1 and viewed video footage captured by a camera in R1's room. The report documented that the office witnessed CNA NN striking R1 in the face with the backside of his hand. The report documented that there were no injuries observed on R1's face at the time of the report. Review of the facility-provided Separation Notice revealed that CNA NN was terminated on 5/21/2026. The Reason for Separation section documented Abuse/Resident Rights. Review of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, metabolic encephalopathy, type 2 diabetes mellitus, bipolar disorder, major depressive disorder, anxiety disorder, atherosclerotic heart disease, chronic kidney disease, hypertension, hypothyroidism, chronic pain, insomnia, and generalized muscle weakness.Review of R1's quarterly Minimum Data Set (MDS) assessment, dated 03/04/2026, revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Section GG (Functional Abilities and Goals) revealed R1 required substantial to maximal assistance with activities of daily living (ADLs). Review of the care plan revealed a Focus initiated on 05/21/2026, of the resident had experienced abuse. The Goal was for the resident to have no indicators of psychosocial well-being problems. Interventions included assessing the resident for nonverbal signs of abuse, behavior monitoring, building relationships and trust with the resident, providing emotional support services as needed, and reporting any concerns the resident voices about care.Interview on 06/04/2026 at 11:00 AM with R1 revealed that CNA NN had slapped her and stated the incident occurred one time. R1 stated she felt alright now and felt safe in the facility. R1 stated she did not report the incident to facility staff at the time it occurred and instead called her son. R1 stated that her son observed the incident through a camera located in her room. Review of the Progress Notes for R1 revealed an entry dated 05/21/2026 at 12:24 PM that (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented that a full assessment was conducted by the unit Manager, Registered Nurse (RN), and direct caregiver, Licensed Practical Nurse (LPN), Unit Nurse. No major injuries or acute distress were noted during the assessment. Review of the Progress Notes for R1 revealed an entry dated 05/22/2026 by the Nurse Practitioner (NP) that documented the chief complaint was for an evaluation following a reported incident of physical abuse by a facility care partner. The note documented that the resident reported no acute concerns, there was no obvious bruising or signs of trauma noted, and the resident was calm, and affect was appropriate. Review of the Progress Notes for R1 revealed an entry dated 05/22/2026 for a psychiatric evaluation. The assessment documented the resident reported being struck once in the face by a male staff member in her room. The follow-up recommendations were for staff to notify psychiatry services if the resident begins to exhibit signs of worsening mood, anxiety, confusion, or behaviors between visits. Interview on 06/04/2026 at 11:57 AM with the Director of Nursing (DON) revealed that R1's son presented the facility administration with video footage of the incident between 11:00 AM and 12:00 PM on 05/21/2026. After reviewing the video, facility leadership determined the allegation was reportable and initiated an abuse investigation. Interview on 06/04/2026 at 12:53 PM with the Administrator revealed that on 05/21/2026 at around 11:45 AM, R1's son and daughter-in-law arrived at the facility requesting a meeting. During the meeting, video footage was presented from a camera placed in R1's room. The video reportedly captured CNA NN providing care to R1 at around 5:00 AM on 05/21/2026. The Administrator stated that while the video did not clearly show physical contact, it captured CNA NN speaking to R1, and stating, turn, I do not like liars, followed by a visible flinch by the resident. Immediately afterward, R1 was heard stating, You better not ever hit me again, leading facility leadership to believe that CNA NN had physically struck the resident. The facility implemented the following corrective actions after becoming aware of the allegation on 05/21/2026:1. On 05/21/2026, the facility submitted an incident report to the State Survey Agency (SSA) and reported to the State CNA Registry.2. On 05/21/2026, CNA NN was removed from resident care duties pending investigation.3. On 05/21/2026, the facility notified local law enforcement. A police report was completed on 05/21/2026 at 3:00 PM. Case Number: 202605004835.4. On 05/21/2026, CNA NN was terminated from employment. 5. On 05/21/2026, a skin assessment was completed for R1, and no injuries were identified. 6. On 5/21/2026, the facility completed full head-to-toe skin assessments for all residents with a BIMS score below 10. No findings indicative of abuse, neglect, or unexplained injury were identified.7. On 5/21/2026, the facility conducted structured abuse screening interviews for all interviewable residents with BIMS scores above 10. No findings indicative of abuse, neglect, or unexplained injury were identified.8. On 05/22/2026, R1 received a psychiatric evaluation. 9. From 05/21/2026 through 06/02/2026, the facility provided abuse prevention education to all staff.10. On 05/21/2026, the facility conducted a Quality Assurance and Performance Improvement (QAPI) meeting to address the incident. The attendees included the Medical Director, Administrator, and DON.