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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115368	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policy titled, Food Safety Requirements, the facility failed to store, handle, and serve food in a safe and sanitary manner by failing to: ensure expired food items were discarded; ensure food items were properly labeled and dated; properly store raw meat to prevent cross-contamination; maintain food storage areas in a clean condition; properly store food off the floor; ensure equipment and surfaces were maintained in a sanitary condition; and ensure meal tray carts were covered during transport. This deficient practice had the potential to affect all 94 residents who receive food orally by placing them at increased risk for foodborne illness, contamination, and infection.Findings included:A review of the facility's policy titled, Food Safety Requirements, revealed the policy, dated revised 1/4/2024, to read in part:Regarding food labeling, dating, and storage: Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded.Regarding raw meat storage and cross-contamination: Separating raw foods (e.g., beef, fish, lamb, pork, and poultry) from each other and storing raw meats on shelves below fruits, vegetables or other ready-to-eat foods so that meat juices do not drip onto these foods.Regarding food storage conditions: Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. and Dry food storage - keep foods/beverages in a clean, dry area off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents.Regarding ice machine sanitation: Cleaning and sanitizing the internal components of the ice machine according to the manufacturer's guidelines.Regarding food transport: Covering all foods when traveling a distance (i.e., down a hallway, to a different unit or floor).Regarding equipment sanitation: All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination.An initial brief kitchen tour was conducted on 4/7/2026 at 8:57 AM with the Dietary Kitchen Manager (DKM). The following concerns were identified:Dry Storage/Pantry:Observation conducted on 4/7/2026 at 9:00 AM of the dry storage/pantry revealed four (4) [NAME] Ready Care Thickened Orange Juice items with an expiration date of 2/2/2026, making them expired at the time of observation. Floor surfaces in the pantry were observed with heavy accumulation of food debris, dried food residue, and soiling beneath and around shelving units, indicating a lack of routine cleaning and sanitation of the area. Observation conducted on 4/7/2026 at 9:31 AM revealed an open bag of white bread that was not labeled with an open date or expiration date.Cooler:Observation of the cooler conducted on 4/7/2026 at 9:19 AM revealed six rolls of [NAME] Choice Ground Beef 77% Lean/23% Fat stored directly on top of a cardboard box without a leak-proof container to contain meat drippings during thawing. Additionally, a cardboard box containing additional ground beef that was thawing was observed with dark brown staining and dried liquid residue covering a large portion of the box exterior, also without a leak-proof container to contain meat drippings. Additionally, three onions were observed stored directly on the floor of the cooler without being placed on a shelf or in an appropriate container at the required minimum of six inches off the floor. The onions appeared partially peeled and deteriorated, with outer layers coming off. The cooler floor beneath and around the onions was (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	completing their cleaning responsibilities. She stated her expectation is that all areas are kept clean at all times. She stated that a potential negative outcome is that bugs are attracted by food debris and that wet nesting grows bacteria, both of which are harmful to residents.Regarding the ice machine, she stated that the machine is cleaned monthly by the maintenance department and that she would be transitioning to a cleaning frequency of every two weeks. She identified the presence of the black substance as an oversight. She stated her expectation is that the machine be cleaned properly and that a potential negative outcome is sickness to residents.Regarding wet nesting of dishware, she stated that items are supposed to be fully dry before being stored. She acknowledged that wet nesting occurs when two items are stacked on top of each other while still wet and that this practice can grow bacteria. She stated her expectation is that all items are dry prior to being put away and that a potential negative outcome is harm to residents from bacterial growth.Regarding meal tray transport, she stated that tray carts should be covered when leaving the kitchen, that covers help keep food hot, and that covering serves as an extra layer of infection control. She attributed the uncovered tray carts to herself and stated that when she inherited the building, the standard for this practice was low. She stated she is responsible for ensuring tray carts are covered and that a potential negative outcome is an infection control risk during transport.Regarding staff personal food stored in the resident cooler, she stated the facility's policy does not permit staff food to be stored in resident refrigerators or storage areas. She acknowledged that a designated section for staff food had been historically maintained in the resident cooler. She stated her expectation going forward is that no personal food or beverages be stored in the resident's cooler and that staff food will be kept in the break room. She stated that a potential negative outcome is that staff may bring in food from unknown environments, which could contaminate resident food.An interview conducted on 4/9/2026 at 10:45 AM with the Administrator revealed the following. Regarding food labeling and dating, she stated that the DKM is responsible for ensuring all food items are labeled, dated, and rotated. She stated she believed items found out of compliance were taken out of their original packaging without being labeled, and that staff were not being adequately monitored. She stated that a potential negative outcome is that residents could become sick.Regarding cross-contamination and raw meat storage, she stated all kitchen staff are responsible for ensuring raw meats are stored and thawed appropriately. She stated her expectation is that raw meat be properly stored with a drip pan beneath it to prevent contamination of other foods. She attributed the observed deficiency to a dietary error in which staff did not consider the need for proper containment. She stated that a potential negative outcome is that residents could become sick.Regarding food storage conditions, she stated that all kitchen staff are responsible for maintaining proper food storage. She stated her expectation is that staff follow the proper cleaning schedule and that food is stored appropriately at all times. She stated the issue occurred because staff had been avoiding addressing ongoing problems. She stated that a potential negative outcome is that residents could become ill from unclean storage conditions.Regarding ice machine sanitation, she stated maintenance is on a rotating cleaning schedule and that the machine is cleaned every two weeks. She stated her expectation that the schedule be followed and that the machine be kept clean. She attributed the black substance observed to an oversight by maintenance. She stated that a potential negative outcome is that if mold gets into the ice, it will be distributed to residents and could make them sick.Regarding wet nesting of dishware, she stated that dietary staff are responsible for ensuring dishware is properly cleaned, dried, and stored. She stated her expectation is that staff follow the cleaning schedule and that no water be left standing, as it can cause waterborne illness to residents. She attributed the observation to carelessness by staff. She stated that a potential negative outcome is that residents could become sick.Regarding meal tray transport, she stated DKM is responsible for ensuring tray carts are covered during transport. She stated her expectation is that carts are fully covered at all times. She stated that a potential negative outcome is cross-contamination and infection control risk.Regarding staff food storage, she stated DKM is responsible for ensuring staff food is stored separately from resident (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	food. She stated her expectation is that staff use the designated break room refrigerators. She attributed the staff food observed in the resident cooler to convenience and easy access. She stated that a potential negative outcome is failure to follow proper procedures, which could place residents at risk.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and a review of the facility policy titled Routine Cleaning and Disinfection, the facility failed to maintain a safe, clean, and comfortable home-like environment related to dusty grayish buildup on packaged terminal air conditioner (PTAC) units in one of four halls (300 Hall).Findings included:During an observation on the 300 Hall on 4/7/2026 from 10:40 am until 11:40 am and on 4/8/2026 at 8:55 am, two rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) were observed with an excessive amount of dusty grayish buildup on PTAC units. During an interview on 4/8/2026 at 11:38 am, the Maintenance Director (MD) confirmed that the maintenance department services the PTAC units. He stated that he has one maintenance assistant tasked with cleaning the PTAC units throughout the facility, and cleaning the units should occur monthly. The MD verified that he does not implement any procedures in the electronic maintenance system. He utilizes a paper log.During an interview and observation conducted on 4/8/2026 at 11:41 am, Maintenance Assistant PP confirmed that room [ROOM NUMBER] and room [ROOM NUMBER] had a buildup of gray-like dust in the PTAC units. The MD confirmed the concerns and stated that cleaning will be done immediately. A review of facility documentation titled Maintenance Log (PTAC 2026) dated 1/7/2026 through 3/23/2026, the room number column and problem/concern column were blank; the maintenance signature was provided by Maintenance Assistant PP. A review of the policy titled Routine Cleaning and Disinfection dated 2/1/2024, revealed that routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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 policies titled Consulting Physician/Practitioner Orders and Provision of Quality of Care, the facility failed to provide treatment and care in accordance with professional standards of practice for two of 48 sampled resdients (R) (R2 and R48) related to ensuring that physician orders were in place to provide standard of care concerning: 1) catheter care, in that a physician order was not in place for indwelling Foley catheter and catheter care for R2 resulting in approximately 85 days of catheter care provided without a corresponding physician order; and 2) documentation and assessment of bowel movements and risk for bowel impaction for R48 resulting in the resident to be hospitalized for a 24-hour period for nausea and vomiting that was caused by a bowel impaction. These deficient practices had the potential to place residents at increased risk for catheter-associated urinary tract infection (UTI), catheter-related complications, undetected changes in bowel status, and adverse outcomes related to bowel impaction. Findings included: 1. During a review of the electronic medical record (EMR) revealed that resident R48 was admitted to the facility on [DATE], and pertinent diagnoses, including but not limited to cerebral vascular accident ischemic, atherosclerotic heart disease, type 2 diabeties, kidney disease, heart failure, anxiety, constipation, multiple sclerosis, vascular dementia, and major depressive disorder.During a review of R48's annual Minimum Data Set (MDS) assessment, a Brief Interview for Mental Status (BIMS) score of 13 was obtained, indicating R48 was cognitively intact in the 13-15 range. Section GG, functional status, revealed R48 was dependent for all activities of daily living (ADLs) except eating; she required set-up assistance. Section H-She was incontinent of bowel and bladder function. During the review of the care plan, it was revealed that there is no care planning for constipation. Medical records from the recent hospitalization have been requested. Review of the Physician's Orders for R48 included, but was not limited to, Macrobid cap 100mg one time daily, Cymbalta 60mg daily, Colace 100mg daily, Metformin 500mg twice daily, Senna tabs 8.6mg 2 tablets daily, Plavix 75mg daily, Polyethylene Glycol 3350 oral powder, 17 GM scoop, mix in water, given twice daily, starting on 4/4/2026, ordered during the hospital stay.During a review of the facility's policy titled Provisions of Quality of Care, revised 2/1/2024, section 1 revealed that each resident will be provided care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being.An observation and interview on 4/7/2026 at 11:31 am with R48 revealed that she had returned from the hospital on 4/1/2026. She went for nausea and vomiting, but it was because she had not had a bowel movement in 3 weeks. She stated that they gave her an enema in the hospital, and she had a bowel movement, and her nausea improved. The resident was lying in bed, and the roommate was very vocal about R48 care. The resident responded to questions appropriately. She was dressed in street clothes and stated that she occasionally got out of bed with a mechanical lift. During an interview with R48 on 4/8/2026 at 2:51 pm, she revealed that she had an enema in the hospital and had a bowel movement, but she has not had a bowel movement since coming back to the facility. She states that her usual bowel movement routine is once a week. She denies abdominal pain; she says she has not had any abdominal pain in a long time. During an interview with the Director of Nursing (DON) on 4/9/2026 at 10:50 am, she revealed that she confirms that R48's hospitalization could have been prevented if the assessment had been more complete. She also attempted to review the CNA documentation, but the EMR system would not allow her to. She was unable to see when the residents' bowel movements were documented prior to her going to the hospital. The DON was able to pull up the week's documentation, and it was documented that the resident had several bowel movements since coming from the hospital. She states they gave her IV fluids, but ultimately the resident requested to go to the hospital.2. A review of the facility's policy titled Consulting Physician/Practitioner Orders revealed the policy, dated revised 2/14/2024, to read in part: The attending physician shall authenticate orders for the care and treatment of assigned (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents.A record review of R2's electronic health record (EHR) revealed R2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. R2 had diagnoses including, but not limited to, cerebral infarction unspecified, Alzheimer's disease unspecified, encephalopathy unspecified, altered mental status unspecified, acute kidney failure unspecified, and chronic kidney disease stage 3A.A record review of R2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the following: Section C (Cognitive Patterns) documented that R2 was rarely or never understood. Section GG (Functional Abilities and Goals) documented functional limitations in the range of motion (ROM) with impairment on one side of the upper extremities and impairment on both sides of the lower extremities. Section GG further documented that R2 was dependent on eating, oral hygiene, toileting, showering and bathing, upper body dressing, lower body dressing, and putting on and taking off footwear, and required substantial to maximal assistance with personal hygiene. Section H (Bladder and Bowel) documented R2 had an indwelling urinary catheter, with urinary continence recorded as not rated, and bowel continence recorded as always continent. Section M (Skin Conditions) documented R2 had unhealed pressure ulcers, including two stage 3 pressure ulcers and one stage 4 pressure ulcer, and was receiving pressure ulcer and injury care with a pressure-reducing device for the bed. Section O (Special Treatments, Procedures, and Programs) documented that R2 was receiving hospice care.A record review of R2's care plan revealed an indwelling Foley catheter was initiated on 12/30/2025, with the documented reason being pressure ulcer and skin breakdown. The care plan identified goals for R2 to remain free from catheter-related trauma and to show no signs or symptoms of urinary tract infection (UTI) through the review date of 04/20/2026. Documented interventions included emptying the Foley catheter every shift and as needed, maintaining the Foley catheter strap in place at all times, providing Foley catheter care every shift, observing and documenting for pain or discomfort due to the catheter, and observing, recording, and reporting to the physician any signs or symptoms of urinary tract infection (UTI) including pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, urinary frequency, foul-smelling urine, fever, chills, altered mental status or behavior, and change in eating patterns.A record review of R2's Order Summary Report dated 4/7/2026 revealed the following active physician orders related to the indwelling Foley catheter, all with an order date and start date of 3/25/2026: Foley Catheter: Catheter care every shift and as needed (PRN) every shift, Foley Catheter: Foley Catheter 16 French (Fr) with 10 milliliter (ML) balloon to bedside bag, and Foley Catheter: May change Foley and as needed ((PRN) every shift. The Order Summary Report revealed an active physician order with an order date and start date of 12/30/2025, which stated: For Your Information (FYI) Enhanced Barrier Precautions related to Indwelling Foley Catheter: Wear gown and gloves during high contact activities every shift for Indwelling Foley Catheter. No physician orders for catheter placement or catheter care were identified in the Order Summary Report before 3/25/2026, confirming that formal facility physician orders for catheter care were absent for approximately 85 days following the care plan initiation date of 12/30/2025.A record review of R2's Medication Administration Record (MAR) for the period of 12/29/2025 through 3/24/2026 revealed no physician orders for catheter placement or catheter care during that period. Record review of R2's MAR for the period of 3/01/2026 through 3/31/2026 revealed that the Foley catheter care every shift and as needed order reflected an entry of X, indicating not administered or not applicable, for days 1 through 24 of March 2026, with documentation of catheter care beginning on 3/25/2026 and continuing through 3/31/2026. The Foley catheter may change as needed order reflected the same pattern, with entries of X for days 1 through 24 and documentation beginning on 3/25/2026. Record review of the Enhanced Barrier Precautions order related to the indwelling Foley catheter revealed staff sign-offs every shift from 12/30/2025 through 3/31/2026, confirming that catheter care activities were being performed by staff throughout the entire period in which no corresponding facility physician order for catheter placement or catheter care existedA record review of the Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report dated 1/2/2026 revealed that the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospice plan of care, effective 1/1/2026, included an order for the hospice nurse to maintain the indwelling catheter 16 French (Fr)/10 cubic centimeter (cc) balloon and to change the catheter every four weeks or as needed, confirming the catheter was in place at the time of hospice admission on [DATE]. Record review of the Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated 2/27/2026 revealed the Medical Social Worker (MSW) narrative stated R2 receives nourishment via feeding tube and has a catheter, confirming the catheter remained in place through at least 2/27/2026.A record review of a communication note dated 3/26/2026 at 5:26 PM revealed the following documentation: Resident daughter [NAME] notified of order placed by hospice Medical Doctor (MD) for foley catheter placement. Resident daughter verbalized understanding and has no concerns or questions at this time. This communication note confirmed that a formal order for catheter placement was entered on 3/25/2026.Interview conducted on 4/8/2026 at 1:19 PM with the Certified Nursing Assistant (CNA) GG revealed that she has been employed at the facility for approximately six months and is typically assigned to the 400 Hall, describing herself as familiar with R2. CAN GG revealed that when R2 first returned from the hospital around December 2025, that was when she first began providing catheter care to R2, and confirmed that to her knowledge, R2 has had a Foley catheter in place continuously since that time. CNA GG revealed that when documenting care in the facility's electronic health record (EHR) system, she selects the incontinence documentation option and records R2 as incontinence not rated due to indwelling catheter, confirming her ongoing awareness and consistent documentation of the catheter's presence throughout her time caring for R2.Interview conducted on 4/08/2026 at 1:24 PM with the Unit Manager Registered Nurse (RN) FF revealed that she has been employed at the facility since 03/22/2026 and confirmed that she is aware that R2 has an indwelling Foley catheter. After reviewing R2's physician orders, RN FF confirmed that R2's indwelling Foley catheter has been in place continuously since 12/30/2025 and that there was no physician order for catheter placement or catheter care until 03/25/2026. RN FF confirmed that she personally reviewed the discontinued orders to determine whether any prior catheter orders had been entered and subsequently discontinued, finding none. RN FF revealed that she was unable to provide an explanation as to why no formal physician order had been in place during those 85 days and confirmed that it was the Director of Nursing (DON) who identified the missing order and entered it into the system on 03/25/2026. The Unit Manager Registered Nurse (RN) revealed that based on her professional expertise as a RN, it was her clinical judgment that a physician order should have been in place in order for catheter placement and care to be provided, and she acknowledged that the absence of such an order during that period posed potential negative outcomes for R2, including but not limited to an increased risk for infection and other catheter-associated complications.An interview conducted on 4/8/2026 at 1:28 pm with the Director of Nursing (DON) revealed that she has been in the role for approximately 30 days and confirmed that R2 has an indwelling Foley catheter that was first placed when R2 returned from the hospital in December 2025. DON revealed that when asked about the absence of a formal facility physician order for catheter care on the Medication Administration Record (MAR) before 3/25/2026, representing approximately 85 days of catheter care provided without a physician order, she confirmed that she was the individual who identified the missing order and subsequently entered it into the system. DON revealed that during the time of R2's admission or readmission, the facility was utilizing agency nursing staff who did not capture all orders at that time, and that in her role as Assistant Director of Nursing (ADON) at that point, she was not conducting admission or readmission evaluations, which contributed to the order being missed during that process. DON revealed that she discovered the missing order while conducting a routine order review and that upon recognizing R2 had an indwelling Foley catheter with no corresponding physician order in the system, she entered the order on 03/25/2026. DON revealed that when asked about potential negative outcomes associated with a catheter being in place without a formal physician order, she acknowledged that R2 could have been at increased risk for a urinary tract infection (UTI) and other catheter-associated complications as a (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result of the missing order and the absence of a formal order-driven monitoring protocol during that period.An interview conducted on 04/09/2026 at 11:13 AM with the Administrator revealed that she stated R2 should have had a physician order and that when R2 returned from the hospital, that order should have been put in at that time. The Administrator stated it was a lack of informing the physician of the order, and stated that a lot of the time they have agency nurses and that they also have processes in place for orders, but was not sure how that was missed. The Administrator stated her expectation is that upon any resident's return from the hospital, they have orders for catheter care and for the catheter itself. The Administrator stated that potential negative outcomes associated with a catheter being in place without a formal physician order could cause re-infection and sepsis.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and the facility policy titled Restorative Nursing Program, the facility failed to provide restorative services for one of three sampled residents (R) (R86) related to splinting and range of motion (ROM) services.Findings included:During an observation on 4/7/2026 at 8:30 am, R86 was observed resting in bed with her left hand resting on her stomach. Her hand was closed and appeared to be contracted. No splint was observed.During an observation on 4/8/2026 at 10:30 am, R86 was observed in a reclining chair near the nursing station. Her left hand was contracted, and she was holding it on her lap. No splint was observed.During an observation on 4/9/2026 at 2:00 pm, R86 was observed in a reclining chair. Her left hand was in her lap. The left hand was closed in toward her palm, her fingernails were pressing into skin, and her wrist was turned inward. No splint was observed. A review of the electronic medical record (EMR) revealed that R86 was admitted to the facility on [DATE] with diagnoses including, but not limited to, neurocognitive disorder with Lewy bodies, a history of falls, and osteoarthritis.A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R86 had no limited ROM of the upper extremities and was not receiving skilled therapy or restorative services.A review of the admission Nursing Evaluation dated 9/3/2025 revealed that R86 had no contractures on admission to the facility.A review of the Joint Range of Motion Screen dated 3/2/2026 revealed R86 had full ROM in the upper wrist and fingers on the right and left side.A review of the care plan dated 1/23/2026 revealed that R86 had no plan of care related to contracture prevention/management or restorative ROM services.During an observation on 4/9/2026 at 3:15 pm, the Director of Nursing (DON), Regional Registered Nurse CC, and Regional Registered Nurse DD all confirmed that R86's left wrist was contracted. During this observation, the resident had no splint, hand roll, or contracture management devices in place.During a telephone interview on 4/9/2026 at 2:30 pm, the Physician for R86 revealed that if the resident had contractures, he had no recall of being notified. He stated the facility should have restorative nursing and skilled therapy to guide him on recommendations. He stated that if a resident had contractures, he would have documented those findings in his physical exam notes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate safety interventions were implemented and followed for one of 48 sampled residents (R) (R11) by failure to ensure the resident wore a smoking apron while smoking. This deficient practice placed the resident at risk for burns and other accident hazards related to smoking injuries.Findings included:A review of facility policy titled Protocol: Smoking, undated, revealed in the designated smoking area section, fire extinguishers/smoking blanket will be available in designated smoking areas. Smoke-Free Facility -Grandfathered in Policy Acknowledgement provided dating 4/9/2026.A review of R11's electronic medical record (EMR) revealed the resident was initially admitted to the facility on [DATE] with diagnoses of intracapsular fracture of the right femur, chronic obstructive pulmonary disease, dementia, major depressive disorder, acute respiratory failure, and contracture of the right ankle.A review of R11's EMR titled Smoker Screen, dated 8/4/2025, indicated the resident requires a protective assistive device while smoking (i.e., smoking jacket or apron).A review of R11's Minimum Data Set (MDS) assessment revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, which revealed the resident was cognitively intact.A review of the care plan R11 smokes and is at risk for burns and other injuries. Interventions: Advise her & family not to keep cigarettes or lighters in her room & all smoking supplies are to be kept at the nurses' station. Assist her to & from the smoking area during assigned times as/if needed. Assure that she will always be supervised during smoking times. Inform the family when she is low on cigarettes. Inform her of smoking location & times. Monitor skin & clothing for burn areas. Smoking assessments to be completed quarterly as long as she continues to smoke. Weekly room safety checks for smoking supplies.An observation on 4/7/2026 at 10:02 AM revealed R11 going outside to the designated smoking area with the Activities Assistant with Certified Medication Aide (CMA)2. R11 did not have on a smoking apron. Signage posted with smoke break times of 10:00 am, 1:00 pm, 4:00 pm, and 6:00 pm.An observation on 4/7/2026 at 10:00 am revealed R11 smoking in the designated area without a smoking apron, with a staff member supervising.An observation on 4/8/2026 at 10:00 am revealed R11 smoking in the designated area without a smoking apron, with a staff member supervisingAn observation on 4/9/2026 at 10:01 am revealed the resident being escorted via wheelchair to the designated smoking area by Activities Assistant MM. She applied a smoking apron to the resident, provided a cigarette, and lit it for her. Two fire extinguishers were observed in the smoking area.An interview with Activities Assistant NN on 4/8/2026 at 2:02 pm revealed that R11 has not worn a smoking vest due to the facility not having one. Activities Assistant NN, a few months ago (August 2025, September 2025), observed ashes fall on the resident's clothes, burn a hole, but it was not reported nor was it documented. Later stated she didn't see the ashes fall on the pants, but noticed a burn hole on her pants and assumed it was from smoking.An interview with Activities Assistant MM on 4/9/2026 at 10:01 am revealed her taking R11 out for her smoke break. Activities Assistant MM stated that cigarettes are retrieved from a locked nurses' cart for Hall A. Today was the first day that R11 was observed and required to wear a smoking apron. She stated that she was not aware that a smoking vest was required (nor did the facility have one) and confirmed that she lights the cigarette for the resident. Activities Assistant MM states she had not received any education on smoking since she was hired in 2021.An interview with the Director of Nursing (DON) on 4/8/2026 at 12:05 pm revealed the facility is designated as a non-smoking environment, except for one resident who has been grandfathered in for smoking privileges. The DON stated that staff are expected to supervise residents during smoking and assist with lighting cigarettes. Residents are required to extinguish cigarettes in the ashtray. Additionally, the DON indicated that the facility's smoking policy and procedures will be reevaluated. Regional Registered Nurse (RN) CC and Regional RN DD were also present during the interview.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility policies titled Oxygen Administration and Oxygen Concentrator, the facility failed to ensure that three of 11 sampled residents (R) (R45, R104, and R56) received respiratory care as ordered related to oxygen therapy and a Bilevel Positive Airway Pressure (BIPAP) machine.Findings included:1. During an observation on 4/7/2026 at 11:41 am and on 4/8/2026 at 8:55 am, R45 was observed receiving oxygen therapy via a nasal canula at the flow rate of between 3.0 and 3.5 liters (L). In addition, the oxygen concentrator filter was observed to have a gray-like dust build-up. During an observation and interview on 4/8/2026, at 9:52 am, Registered Nurse (RN) BB confirmed the concentrator filter had a considerable accumulation of dust-like particles. RN BB stated that R45 has been diagnosed with chronic obstructive pulmonary disease (COPD), which includes symptoms of shortness of breath and hypoxia. She stated that the concentrator filters should not contain dust, but she will verify the flow rate and provide further information. RN BB mentioned the nurses on the night shift are supposed to check and clean the oxygen equipment, and that unclean filters could cause respiratory distress. At 10:11 am, RN BB clarified that the Maintenance Director and third-party providers are to clean the respiratory equipment. A review of the electronic medical record (EMR) revealed that R45 was admitted to the facility on [DATE] with diagnoses including, but not limited to, chronic respiratory failure with hypoxia, paroxysmal atrial fibrillation, gastro-esophageal reflux disease without esophagitis, and COPD. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that R45 presented with a Brief Interview for Mental Status (BIMS) score of eight, indicating that R45 presents with moderate cognitive impairment. The assessment further revealed that R45 was receiving oxygen therapy. A review of the physician's revision order dated 8/18/2025 for R45 revealed oxygen 2L per minute via a nasal cannula continuously with exertion and sleep. A review of the care plan initiated 3/28/2025 revealed that R45 was receiving oxygen therapy with interventions including, but not limited to, monitoring and documenting side effects and effectiveness, and providing oxygen therapy at 2L via the nasal canula as ordered by the physician. 2. During an observation and interview on 4/7/2026 at 12:41 pm, R104's BiPAP (Bilevel Positive Airway Pressure) machine didn't have a filter. During an interview, R104 stated that the mask was never sanitized. RN FF was the manager of the unit, and she stated that a third-party provider was expected to configure the machine settings. However, the third-party provider only delivered several machines, and she was uncertain about specific residents assigned to each machine. She confirmed that the BIPAP machine does not contain a filter and that there are no filters available in stock for weekly replacements, as necessary. A review of the EMR revealed that R104 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, acute and chronic respiratory failure, chronic obstructive pulmonary disease, type 2 diabetes, anxiety, polyneuropathy, atherosclerotic heart disease, opioid dependence, chronic pain syndrome, and fracture of the first thoracic vertebra. A review of the MDS assessment dated [DATE] revealed that R104 presented with a BIMS score of 14, indicating that the resident was cognitively intact. A review of the care plan dated 3/9/2026 revealed that R104 was diagnosed with COPD and was using my BIPAP machine. It was noted that the BIPAP should be used as ordered, listing parameters; assess and document respiratory rate, heart rate, oxygen requirements, and lungs sounds as needed; clean mask and tubing per manufacturers guidelines; connect the filter and tubing to the device and the mask as needed (usually used at night for 8 to 10 hours; and plug device into a power source or use the detachable battery as needed. A review of the physicians' orders revealed that R104 was ordered to require BiPap at night, to start at the hour of sleep following setting parameters; place oxygen tubing and nebulizer in a bag when not in use; and change bag, oxygen tubing, nebulizer mask, water, and date weekly. A review of the progress note dated 4/8/2026 documented, resident's oxygen concentrator (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	filter was heavily soiled with dust, and the oxygen flow rate was set at 3.5L/min. The RN entered the resident's room to assess the patient, reviewed the current oxygen order in the MAR (Medication Administration Record), and adjusted the oxygen flow rate to the prescribed 2L/min. The oxygen concentrator was replaced with a clean, properly functioning unit. During an interview on 4/8/2026 at 2:07 pm, R104 stated that the settings, the mask, and tubing had not been changed for his BiPAP machine. He confirmed that the oxygen tubing and mask were not stored in bags when not in use. He stated that the mask has never been replaced or cleaned. An observation revealed that the BiPAP machine still did not have a filter. During an interview on 4/9/2026 at 10:50 am, the Director of Nursing (DON) stated that she expected that the residents using BiPAP machines would have the necessary filters and supplies. During an observation on 4/9/2026 at 11:56 am, R104's BiPAP machine still did not have a filter. 3. A review of the EMR for R56 revealed he was admitted to the facility on [DATE] with a diagnosis that included, but was not limited to, centrilobular emphysema. A review of the most recent MDS assessment, dated 1/8/2026, documented that R56 had a BIMS score of 12, indicating that the resident had intact cognition and was receiving oxygen therapy. A review of the care plan for R56 revealed a care plan dated 4/18/2024 that documented the resident required oxygen as ordered/needed related to the disease process, with interventions that include giving oxygen therapy as ordered by the physician. A review of the physician order dated 7/25/2024 revealed an order for oxygen at 2L via nasal cannula to keep peripheral capillary oxygen saturation (Sp02) above 92% every morning and at bedtime; place the oxygen tubing in a bag when not in use; and change and date the oxygen tubing and water bottle every night shift, every Wednesday. An observation on 4/7/2026 at 10:07 am revealed R56's oxygen concentrator had gray fuzzy material covering the back filter of the machine, and the oxygen level on the concentrator was set to 3.5L. An observation on 4/8/2026 at 9:00 am revealed R56's concentrator set at 3.5L of oxygen and grey fuzzy material covering the vent. An observation on 4/9/2026 at 9:30 am revealed R56 was not in the room, and the oxygen tubing was lying on the bed, not in a bag. An observation on 4/9/2026 at 9:53 am with the RN FF confirmed that the concentrator had grey material covering the back, and she stated that it needed to be cleaned. She revealed that she was not sure who was responsible for cleaning the machine. She confirmed the oxygen setting to be 3.5L. An interview on 4/9/2026 at 9:15 am with Licensed Practical Nurse (LPN) JJ revealed that it is the nurse's responsibility to check the oxygen tubing and rate. When the resident returns to the room if they are out, the nurse would be the one to reset the oxygen. She stated that when you turn the concentrator off, the rate should remain the same as it was prior to turning it off. An interview on 4/9/2026 at 10:03 am with the Unit Manager/RN FF revealed that oxygen is always checked by a nurse. She stated the nurse will set the rate and make changes per the physician's orders.

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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 observation, record review, and staff interviews, the facility failed to ensure the medication rate was less than 5 percent (%) related to four errors with thirty-two opportunities. The medication error rate was 12.5%.Findings included:During an observation on 4/8/2026 at 7:50 am, Registered Nurse (RN) FF was observed administering R2 scheduled 9:00 am medications through her gastrostomy tube (G-tube). RN FF prepared two medications; three were scheduled at this time. The 325 milligrams (mg) aspirin enteric coated (EC) could not be crushed, and a non-EC aspirin was not available. RN FF confirmed that she did notify the Director of Nursing (DON), and that a new order was obtained for a chewable aspirin that was given late.During an observation on 4/8/2026 at 8:23 am, Licensed Practical Nurse (LPN) AA was in 300 Hall. LPN AA was observed obtaining medication for R23. Three medications for R23 were unavailable: Bumex (diuretic), metoprolol (blood pressure), and citalopram (antidepressant). LPN AA stated that it looks like the medications had been ordered prior. Overflow medications were checked. R23's blood pressure was obtained (131/82). LPN AA reported to the Unit Manager that these medications were unavailable. Two of the medications (Bumex, citalopram) were pulled from the Pyxis (an automated medication dispensing cabinet) at 3:25 pm, which were due at 9:00 am.During an observation on 4/8/2026 at 8:00 am, LPN QQ was delivering medication to R23; the medication had already been obtained, and the nurse was in the resident's room. The medications that were missing from the medication pass yesterday at 9:00 am were also missing during this observation. The nurse reported this to the Unit Manager, and she obtained the medications from the Pyxis this am promptly. Residents Blood Pressure was 152/60, and pulse was 88.During an interview on 4/9/2026 at 10:09 am, LPN HH revealed that if she were missing medications for one of her residents, she would first re-order them through the computer. She would then check the overflow, and if the medication was not there, she would pull from the Pyxis. She would not wait until her med pass was finished; she would go immediately and try to obtain.During an interview on 4/9/2026 at 8:20 am, the Unit Manager/Registered Nurse (RN) BB revealed that when medications are missing, it should be brought to her attention, and she or the nurse would call the pharmacy, check the overflow, or obtain from the Pyxis. She stated that she pulled R23's medication from the pyxis, and they were given. Receipt shows pulled from Pixis at 3:24 pm (medication was due at 9:00 am) and Bumex, one of the medications missing, was ordered to be given twice a day. Metoprolol was not given on 4/7/2026.During an interview on 4/9/2026 at 10:23 am, the Administrator revealed that she expects that if any medications are missing from the med-pass, it should be reported to the DON, and they should be ordered and pulled from the Pyxis for timely delivery. She stated pharmacy should also be called. If unavailable, obtain the medication, and the physician should be called.A review of the facility policy titled Unavailable Medications, dated 2/14/2024, revealed that the facility shall use uniform guidelines for unavailable medications and that a STAT supply of commonly used medications is maintained in-house for the timely initiation of medications. It was noted that the facility staff would notify the physician of the inability to obtain medication upon notification or awareness that medication is not available.

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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 and resident interviews, record review, and review of the facility's policies titled Hand Hygiene, the facility failed to perform hand hygiene when performing resident care, including Foley catheter care and wound care, for one of 48 sampled residents (R) (R2). This deficient practice had the potential to cause the spread of infection to other areas of the residents' bodies and infection to staff.Findings included:During a review of the electronic medical record (EMR), it was revealed that resident R2 was admitted to the facility on [DATE], and pertinent diagnoses, including but not limited to Cerebral infarction, type 2 diabetes, chronic kidney disease, atherosclerotic heart disease, depression, bipolar disorder, and schizoaffective disorder.During a review of R2's quarterly Minimum Data Set (MDS) assessment, it was revealed that a Brief Interview for Mental Status (BIMS) score was not attempted, which indicated R2 was severely cognitively impaired; that R2 is dependent on staff for all activities of daily living (ADL) care; that R2 has a Foley catheter; and that R2 is incontinent of bowel.During a review of R2's care plan, it was indicated that there was a risk of skin breakdown; has an indwelling catheter, pressure ulcer, and skin breakdown.A review of the current Physician's Orders for R2 included, but was not limited to: Foley catheter care every shift and PRN; Wound care to the sacrum: cleanse with NS, pat dry, apply a collagen sheet and calcium alginate to the wound bed, and cover with an island gauze dressing daily. An observation and interview on 4/8/2026 at 10:27 am with Licensed Practical Nurse (LPN) KK performing wound care on R2 revealed LPN KK donned a gown, washed her hands with soap and water, and collected the dressing supplies. She reentered the room with the wound care supplies, placed them on R2's bedside table, and then washed her hands with soap and water. She donned clean gloves, set up a clean field on the resident's bedside table, and arranged the wound care supplies. She then removed her gloves and donned clean gloves. (no hand hygiene) She removed the resident's brief, removed the old dressing and packing material, cleaned the sacral wound with sterile normal saline-damp gauze, removed her dirty gloves, donned clean gloves (no hand hygiene), and cleaned the wound again with normal saline-damp gauze. She then opened a calcium alginate dressing, stopped, removed her dirty gloves, and donned clean gloves (no hand hygiene performed). She then placed a 2x2 square of collagen and covered that with calcium alginate, but the calcium alginate fell to the bed, so she removed her dirty gloves (no hand hygiene), went to the treatment cart, and obtained more calcium alginate. She then washed her hands with soap and water, donned clean gloves, opened the dressing material, and placed the wound, covering it with a bordered dressing. The LPN did not bring in a biohazard bag; she used the small resident trash bag, gathered it, and took it out to the large receptacle. LPNKK stated she felt she had done everything correctly, but when breaks in hand hygiene were pointed out, she realized the mistake and stated she was nervous.An observation made on 4/8/2026 at 10:40 am of Certified Nursing Assistant (CNA) GG performing Foley catheter care on R2 revealed that the CNA GG washed her hands with soap and water in the resident's bathroom and then donned her gown and gloves. While the resident was on her left side, the CNA, using disposable wipes, cleaned the resident's rectal area, which had a small amount of bowel movement present. The CNA then took a clean disposable wipe and went as far up as she could, wiping the catheter tubing downward from the meatus. (She did not perform hand hygiene and changed her gloves before doing this.) The foley tubing is lying behind the resident rather than over a leg and is not secured with a securement device. There is no privacy cover on the urine bag. The CNA then rolls the resident on her back and, using a clean disposable wipe, wipes the resident's labia 3 times from front to back. (She did not perform hand hygiene and did not don clean gloves) The CNA then removed her dirty gloves and washed her hands with soap and water. She disposed of the wipes and gown in the appropriate receptacle. The CNA required prompting to turn the resident and perform care from the resident's front. CNA GG stated that she was nervous and could not remember how to properly perform Foley catheter care.During a (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility's policy titled Hand Hygiene revised 2/1/2024, section, Policy explanation and compliance guidelines #2 revealed Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the hand hygiene table. #6a states: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene before donning them and immediately after removing them. The hand hygiene table in the hand hygiene section includes the following: Hand hygiene should be performed when handling contaminated objects, before applying personal protective equipment (PPE), and after removing PPE, including gloves. Before and after handling clean or soiled dressings, linens, and during resident care, moving from a contaminated body site to a clean body site. During an interview with the Registered Nurse RN FF unit manager for the 400 wing on 4/8/2026 at 11:13 am, it was revealed /confirmed that she has been here for 3 weeks, but she expects that cath care should be performed every time the resident is cleaned and should start at the meatus and extend down the tubing. The labia area should be cleaned from front to back using a clean part of the cloth each wipe. She confirmed that she is aware that many of the staff require education on infection control.During an interview with the DON (who has been in this position for one month) on 4/8/2026 at 12:43 pm, it was revealed/confirmed that the DON expects to perform Foley care properly. And do wound care properly. She confirms that the staff needs education and plans to conduct a skills check-off in the coming months.During a review of the facility's policy titled Catheter Care dated 11/5/2025, further review of sections: Female #8 and #10; revealed #8 Gently separate the labia to expose the urinary meatus, and #10 use a new part of the cloth or a different cloth for each side.