STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115404	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woods at Lumber City of Journey Llc, The	93 GA- 19 Lumber City, GA 31549

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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 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. Based on observations, staff interviews, record review, and review of the facility's policy titled, Ice Machines and Portable Ice Carts, the facility failed to ensure that one of one ice machines was clean and sanitized. This had the potential to affect 54 out of 59 residents receiving an oral diet from the kitchen.Findings include:Review of the facility's policy titled, Ice Machines and Portable Ice Carts, with revised date of 4/25/2025, Under the Policy statement revealed, It is the policy of this facility to ensure that ice machines/carts are working in proper order, cleaned, and maintained as per Federal, State, local, or facility guidance, according to manufacturer's instructions and current standards of practice. Under Policy Explanation: revealed, 1. Ice machines can be prone to microbial contamination due to improper handling or storage of ice, poor cleaning or maintenance of equipment, or through ice handling equipment. Proper cleaning, maintenance, and infection control in relation to ice machines is important to decrease the risk of illness to residents, staff and visitors. Under Compliance Guidelines revealed, 1. Ice machines will be cleaned at a frequency specified by the manufacturer or, if manufacturer specifications absent, at a frequency necessary to preclude accumulation of soil or mold.Observation on 8/12/2025 at 10:18 am revealed, a black substance on the inside of the ice machine where the door opens, in the corners/crevices, on both the left and right side.Observation and interview on 8/12/2025 at 10:18 am with the Dietary Kitchen Manager (DKM), confirmed that the ice machine had a black substance when wiped with a white paper towel. She revealed that the ice machine had been cleaned, and she didn't know why that black substance was in the ice machine. The DKM stated that the Maintenance Director was responsible for cleaning the ice machine.Interview on 8/13/2025 at 1:41 pm with the Maintenance Director revealed that he had a schedule that he followed to clean the ice machine and provided the surveyor a copy of the Work History Report schedule.Review of the Work History Report schedule revealed that the Ice Machines/Ice Bins was marked as done on-time on 5/30/2025, 2/27/2025, 11/1/2024 and 8/6/2024. There was no further indication that the Ice Machines/Ice Bins had been serviced since 5/30/2025.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on resident and staff interviews, record review, and review of the facility's policy titled Advance Directive, the facility failed to provide residents and/or representatives written information regarding the right to accept or refuse medical or surgical treatment for two out of three Residents (R) (R9 and R33). The deficient practice had the potential to affect the resident's highest practical physical, mental, and psychosocial well-being.Finding include: Review of the facility's policy titled Advanced Directive Policy dated 3/5/2025 under the Policy statement revealed, It is the policy of this facility to support and facilitate a resident's right to request, refuse and /or discontinue medical or surgical treatment and formulate advanced directives. Under Policy Explanation and Compliance Guidelines revealed, .2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive.1. Review of the clinical records revealed that R33 was admitted with diagnoses that included but not limited to dementia and acute kidney failure.Review of clinical records for R33 revealed, there was no documentation that the facility provided the resident and/or representative with written information regarding the right to accept or refuse medical or surgical treatment.2. Review of the clinical records revealed that R9 was admitted with a diagnoses that included but not limited to type 2 diabetes and sequelae of cerebral infarction.Review of clinical records for R9 revealed, there was no documentation that the facility provided the resident and/or representative with written information regarding the right to accept or refuse medical or surgical treatment.Interview on 8/12/2025 at 1:30 pm with the Social Worker (SW) revealed that she was not aware of any language in the admission packet where a resident accepts or denies medical or surgical treatment. During the interview, the SW printed the admission packet for R33 and R9. During a review of the admission packets for R33 and R9 with the SW, she confirmed that the paperwork did not include a consent for the residents and/or representatives to accept or deny medical or surgical treatment. Interview on 8/13/2025 at 2:00 pm with the Corporate Nurse confirmed that they did not have an advanced directive with verbiage of a consent for the resident and/or representative to accept or deny medical or surgical treatment in R33's or R9's clinical records.

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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 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 observation, staff interviews, and review of the facility's policy titled Safe and Homelike Environment, the facility failed to ensure that it maintained a safe, comfortable, and homelike environment for two out of 15 rooms located on the 100 hall. Specifically, the toilet lid was the wrong size in the bathroom of room [ROOM NUMBER]-1 and the paint was peeling from the wall in room [ROOM NUMBER]-2.Findings include: Review of the facility's policy titled Safe and home-like environment dated 4/23/2025 under the Policy statement revealed, In accordance with resident rights, the facility will provide a safe, clean, comfortable home-like environment, allowing the residents to use his or her personal belongings to the extent possible. This includes. Be sure that the resident can receive care and services safely and that the physical layout of the facility maximizes residence independence and does not pose a safety risk. Under Policy Explanation and Compliance Guidelines revealed, 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.Observation on 8/12/2025 of rooms [ROOM NUMBERS]-2 revealed that room [ROOM NUMBER]-1's toilet lid did not fit and was wrong size. Further observation revealed that in room [ROOM NUMBER]-2, the paint was peeling from the wall.A walk-through observation on 8/14/2025 at 2:30 pm with the Maintenance director confirmed that the toilet in the bathroom of room [ROOM NUMBER] had the wrong size toilet lid, which did not fit. The Maintenance Director acknowledged that this could lead to possible harm. The Maintenance Director confirmed that the paint was peeling from the wall in room [ROOM NUMBER]-2 needed to be repainted. He explained that he would order a new toilet lid and repaint the resident's wall.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, staff interviews, and review of the facility's policy titled Abuse, Neglect and Exploitation, the facility failed to report resident-to-staff abuse immediately, but no later than 2-hours of the allegation to the State Agency for one out of 32 sampled Residents (R) (R68).Finding include:Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 3/25/2025 Under the Policy statement revealed, It is the policy of the facility to provide protections 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. Under the Reporting/Response section revealed, A. The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies within specified timeframes: a. Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the event that causes the allegation does not involve abuse and does not result in serious bodily injury. 5. Taking all necessary actions as a result of the investigation, which may include, but are not limited to the following: a. Analyzing the occurrence (s) to determine why abuse, neglect, misappropriation of resident property, or exploitation occurred, and what changes are needed to prevent further occurrences: b. Defining how care provision will be changed and /or improved to protect residents receiving services; Defining how care provision will be changed and /or improved to protect residents receiving services; C. Training staff on changes and administering staff competency after implementation; d. Identification of staff responsible for the implementation of corrective actions: e. The expected date for implementation, and identification of staff responsible for the implementation of corrective actions. The expected date for implementation is to be confirmed, along with the identification of staff responsible for monitoring the plan's implementation. Review of R68's clinical record revealed an admission date of diagnosis, including, but not limited to, schizoaffective disorder, bipolar disorder, and dementia.Review of the Quarterly Minimum Data Set (MDS) for R68, dated 9/24/2024 revealed, for Section C (Cognitive Patterns) revealed, a Brief Interview for Mental Status (BIMS) score of 00 which indicated cognitive impairment.Review of a social worker (SW) progress note dated 9/24/2024 revealed that the SW had been actively looking for an alternate placement for R68, a resident with aggressive behaviors. All of the many facilities that I have contacted deny her. Today, 9/24/2024, the resident snatched the housekeeper's broom from her and threatened to hit her and many other staff members. The resident stated that she wanted the phone to call her guardian, but when I attempted to give her the phone, she threatened to hit me with the broom. The Nurse Practitioner signed a 1013 to have the resident sent to the emergency room Service for an evaluation. The resident has become increasingly aggressive toward staff and other residents. Review of the Incident Summary revealed that on 9/24/2024, at approximately 8:15 am, R68 suddenly got agitated. She threw her breakfast at her (Certified Nursing Assistant) CNA. She pulled off her colostomy bag and smeared feces on the floor. She grabbed a wheelchair and started hitting the door with it. She snatched the broom from the housekeeper and started swaying it at the staff. She threatened to hurt someone. She threatened to kill someone. The social worker attempted to calm her down and get the broom from her. The resident refused to return the broom. The resident would not give staff the broom. The staff notified me. I attempted to talk to R68. She almost hit the Administrator with the broom. I instructed staff to call the police, and the police arrived. The staff got the broom from R68. A 1013 was issued. Police stayed and helped calm R68 down as he waited for transport. R68 was discharged to the hospital. Review of the Facility Reported Incident Report Form dated 9/25/2024 revealed that the verbal and physical abuse towards staff happened on 9/24/2024 however it was not reported to the state until 9/25/2024 which resulted in the facility's failure to follow the required 2-hour reporting regulation for abuse.Interview on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/13/2025 at 10:25 am with the Administrator revealed that the reason she submitted the facility incident report to the state the next day about the abuse was because it was witnessed. However, she confirmed that it should have been reported immediately or no later than two hours.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on staff interviews, record review, and review of the facility's policy titled Discharge Planning Process, the facility failed to ensure one out of four Residents (R) (R68) reviewed for discharges was not inappropriately transferred and discharged against the resident and/or representative wishes. As a result, R68 stayed at the hospital longer than expected until placement could be found at another facility.Findings include:Review of the facility's policy titled Discharge Planning Process dated 4/1/2025 under the Policy statement revealed, It is the policy of the facility to develop and implement an effective discharge planning process that focuses on the residence. Discharge goals, the preparation of residence. To be active partners and effectively transition them to post-discharge care and the reduction of factors leading to preventable readmissions. Under the Procedure section revealed, 10. The facility will assist residents and their resident representatives to choosing an appropriate post-acute care provider (another SNF, HHR, IRF, or LTCH) that will meet the resident's needs, goals, and preferences. (a.) This Social Services Director, or designee, shall compile available data on other post-acute care options to present to the resident, including, but not limited to: i. Data on providers within the residence desire geographic. Area, where available. ii. All the measure data, based on standardized. Patient assessments data, publicly available on CMS Care Compare website. iii. Data on resource use. To the extent the data is available, such as number of residents/patients. Are discharged to the community, and rates of potential preventable hospital rating readmissions. (b.) The facility will ensure that the data used to relevant in applicable to the resident's goal of care and treatment preferences. (c.) The Facility will present provider information to the resident and resident representatives, if applicable, in an accessible and understanding. Format and will answer any questions to assist in the resident/representative's understanding.12. The results of the evaluation in the final discharge plan will be discussed with the resident or resident representative. All relevant information will be provided in the discharge summary to avoid unnecessary delays and the residents discharge or transfer, and to assist the residents in adjustment to his or her new living environment.Review of R68's clinical record revealed diagnoses, that included but not limited to, schizoaffective disorder, bipolar disorder, and dementia.Review of the Quarterly Minimum Data Set (MDS) for R68, dated 9/24/2024 revealed, for Section C (Cognitive Patterns) revealed, a Brief Interview for Mental Status (BIMS) score of 00 which indicated cognitive impairment.Review of the Incident Summary revealed that on 9/24/2024, at approximately 8:15 am, R68 suddenly got agitated. She threw her breakfast at her (Certified Nursing Assistant) CNA. She pulled off her colostomy bag and smeared feces on the floor. She grabbed a wheelchair and started hitting the door with it. She snatched the broom from the housekeeper and started swaying it at the staff. She threatened to hurt someone. She threatened to kill someone. The social worker attempted to calm her down and get the broom from her. The resident refused to return the broom. The resident would not give staff the broom. The staff notified me. I attempted to talk to R68. She almost hit the Administrator with the broom. I instructed staff to call the police, and the police arrived. The staff got the broom from R68. A 1013 was issued. Police stayed and helped calm R68 down as he waited for transport. Review of the FORM 1013-Certificate Authorizing Transport to Emergency Receiving Facility & Report of Transportation (Mental Health) dated 9/24/2024 revealed, it was incomplete and missing the location, referring staff, receiving staff, and telephone number.Review of a progress note dated 9/24/2024 revealed that R68 was discharged to the Behavioral Health Unit on 9/24/2024. There was no documentation of prior arrangements found in the medical records nor was there notification that R68's guardian was made aware of the transfer. Further review of records revealed that no 30-day notice was given to R68 and/or a representative. The facility never received approval for admittance to the Behavioral Health Unit.Interview on 8/12/2025 at 10:30 am with the Social Worker (SW) revealed that R68 had shown many behavior issues in the past, but on 9/24/2024, she was chasing (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff and residents with a broom, and she threw her tray at staff and she would not give the broom back to the staff then 911 was called. Further interview revealed that the police took her to the Behavioral Health Unit. The SW admitted that she did not have approval, nor had prior arrangements been made, and she was not sure who gave the verbal instruction to take her there. The SW further revealed the police ended up taking her to the hospital after denial. She confirmed that the 1013 form was incomplete and stated that the interim Administrator gave verbal instructions on where to take R68. The SW also confirmed that she should not have been discharged to the Behavioral Health Facility and that no discharge planning was conducted to ensure a successful discharge. The SW began to explain that after she was taken to the hospital, the resident was denied coming back and was never given a bed hold or a 30-day notice. In a further interview the SW revealed, R68 was a ward of the state, and that she had spoken with a representative, who was distraught because she wanted her to return to the facility until they found a behavioral health unit that would approve R68.Interview on 8/12/2025 at 11:00 am with the Administrator, revealed that she was at the building when R68 was chasing staff with a broom, and she threw her tray at staff and hit them. R68 was also smearing feces on the floor and yelling and cursing at the staff. The Administrator called 911, and the police came to assist and transported her to the Behavioral Health Facility, where she was admitted . However, R68 was not accepted there because she did not have approval to be admitted . The Administrator explained that the police took the residents there without instruction from the facility. After the Administrator was shown the incomplete form for 1013, she admitted that the form did not give instructions on where to take the resident. No prior documentation was found of arrangements being made for transfer. The Administrator stated that she could not have done anything different and that R68's behavior was a danger to herself, residents, and other staff. The Administrator confirmed that R68 was not allowed to return to the facility, even after receiving 1013 services from the hospital.An interview on 8/12/2025 at 11:15 am with the Corporate Nurse revealed that the facility could have done several things differently for R68 such as providing R68 with a bed hold and allowing the resident to return after receiving services from the hospital. The clinical team could have implemented behavioral interventions until they found a behavioral health unit and conducted a proper discharge.A phone interview on 8/13/2025 at 11:34 am with the Director of Behavioral Health of Georgia (DBHG) revealed that R68 was a ward of the State of Georgia. The (DBHG) revealed that the resident was not allowed to come back to the facility and was in the hospital longer than expected due to the facility's decision not to accept her back.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interviews, record review, and review of the facility's policy titled Discharge Planning Process, the facility failed to develop and implement an effective discharge plan to ensure a successful discharge for one out of four Residents (R) (R68) reviewed for discharges. Specifically, R68 was not accepted back to the facility after hospital discharge and did not have a discharge transfer to another facility in place.Findings include: Review of the facility's policy titled Discharge Planning Process dated 4/1/2025 under the Policy statement revealed, It is the policy of the facility to develop and implement an effective discharge planning process that focuses on the residence. Discharge goals, the preparation of residence. To be active partners and effectively transition them to post-discharge care and the reduction of factors leading to preventable readmissions. Under the Procedure section revealed, 10. The facility will assist residents and their resident representatives to choosing an appropriate post-acute care provider (another SNF, HHR, IRF, or LTCH) that will meet the resident's needs, goals, and preferences. (a.) This Social Services Director, or designee, shall compile available data on other post-acute care options to present to the resident, including, but not limited to: i. Data on providers within the residence desire geographic. Area, where available. ii. All the measure data, based on standardized. Patient assessments data, publicly available on CMS Care Compare website. iii. Data on resource use. To the extent the data is available, such as number of residents/patients. Are discharged to the community, and rates of potential preventable hospital rating readmissions. (b.) The facility will ensure that the data used to relevant in applicable to the resident's goal of care and treatment preferences. (c.) The Facility will present provider information to the resident and resident representatives, if applicable, in an accessible and understanding. Format and will answer any questions to assist in the resident/representative's understanding.12. The results of the evaluation in the final discharge plan will be discussed with the resident or resident representative. All relevant information will be provided in the discharge summary to avoid unnecessary delays and the residents discharge or transfer, and to assist the residents in adjustment to his or her new living environment.Review of R68's clinical record revealed diagnoses, including, but not limited to, schizoaffective disorder, bipolar disorder, and dementia.Review of the Quarterly Minimum Data Set (MDS) for R68, dated 9/24/2024 revealed, for Section C (Cognitive Patterns) revealed, a Brief Interview for Mental Status (BIMS) score of 00 which indicated cognitive impairment.Review of a progress note dated 9/24/2024 revealed that R68 was discharged to the Behavioral Health Unit on 9/24/2024. There was no documentation of prior arrangements found in the medical records nor was there notification that R68's guardian was made aware of the transfer. Review of the FORM 1013-Certificate Authorizing Transport to Emergency Receiving Facility & Report of Transportation (Mental Health) dated 9/24/2024 revealed, on 9/24/2024 at 0900 R68 appeared to be a mentally ill person requiring involuntary treatment in that he/she appears to be mentally ill. The form was missing the location, referring staff, receiving staff, and telephone number. Further review of medical records revealed that no bed hold notice was given to R68 nor a representative and that the facility never received approval for admittance to [Name of Facility] Behavioral Health Unit.Interview on 8/12/2025 at 10:30 am with the Social Worker (SW) revealed that R68 had shown many behavior issues in the past, but on 9/24/2024, she was chasing staff and residents with a broom, and she threw her tray at staff and she would not give the broom back to the staff then 911 was called. Further interview revealed that the police took her to the Behavioral Health Unit. The SW admitted that she did not have approval, nor had prior arrangements been made, and she was not sure who gave the verbal instruction to take her there. The SW further revealed the police ended up taking her to the hospital after denial. She confirmed that the 1013 form was incomplete and stated that the interim Administrator gave verbal instructions on where to take R68. The SW also confirmed that she should not have been discharged to the Behavioral Health Facility and that no discharge planning was (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted to ensure a successful discharge. The SW began to explain that after she was taken to the hospital, the resident was denied coming back and was never given a bed hold or a 30-day notice. In a further interview the SW revealed, R68 was a ward of the state, and that she had spoken with a representative, who was distraught because she wanted her to return to the facility until they found a behavioral health unit that would approve R68. Interview on 8/12/2025 at 11:00 am with the Administrator verified she was in the building when R68 chased staff with a broom and threw her tray at them. R68 was also seen smearing feces on the floor, yelling, and cursing at the staff. The Administrator stated she called 911, and the police came to assist and transported her to the Behavioral Health Facility however, R68 was not accepted there because she did not have approval to be admitted . The Administrator explained that the police took the residents there without instruction from the facility. After the Administrator was shown the incomplete 1013 form, she admitted that the form did not give instructions on where to take the resident. There were no prior documentation was found of arrangements being made for transfer. The Administrator stated that she could not have done anything different because R68's behavior was a danger to herself, residents, and other staff.An interview on 8/12/2025 at 11:15 am with the Corporate Nurse revealed that the facility could have done several things differently for R68 such as providing R68 with a bed hold and allowing the resident to return after receiving services from the hospital. The clinical team could have implemented behavioral interventions until they found a behavioral health unit and conducted a proper discharge.A phone interview on 8/13/2025 at 11:34 am with the Director of Behavioral Health of Georgia (DBHG) revealed that R68 was a ward of the State of Georgia. The (DBHG) revealed that the resident was not allowed to come back to the facility and was in the hospital longer than expected due to the facility's decision not to accept her back.A bed hold policy was requested but was not provided.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, staff interviews, and record review, the facility failed to ensure that the menu was followed to assure the appropriate nutrition was received for residents on a puree diet. This had the potential to affect five out of five residents who received a puree diet at the facility.Findings include: Observation and interview on 8/13/2025 at 10:30 am revealed, Dietary [NAME] (DC) II preparing a meal for the five residents who received a pureed diet. The Dietary Kitchen Manager (DKM) was present and provided a copy of menu and the recipe for Philly steak filet, dinner roll, mashed potatoes, and vegetable juice. Further observation revealed the preparation of the puree meal that included the Philly Steak Filet which consisted of seven scoops of Philly Steak, and four scoops of gravy placed in the food processor, pureed and then checked for consistency. Once the consistency was reached, the processor was emptied, cleaned, and air dried; the station was sanitized; and the processor was prepared for the next item. The Philly Steak was then placed in a 6 serving pan, covered, and placed in the oven for warmth. During the observation, an interview was conducted with DC II that revealed, although the facility had five pureed residents, the kitchen prepares for seven, so that a resident could get an extra serving if they wanted more. DC II then washed her hands and changed gloves, then she added seven rolls and one cup of water and placed them in the food processor, pureed, and checked for consistency. Another 1/3 cup of water was added, then pureed again. Once the consistency had been reached, the rolls were placed in a 5 serving pan and placed in the refrigerator. Once completed the processor was cleaned, air dried, and the station was sanitized. Review of the facility provided Steak Filet 2-ounce (OZ) conv (PHILLY) PU recipe menu revealed, the preparations of ingredients for serving sizes in the amount of 10, 50, 75, 100, and 150; For the serving size of 10 revealed, 10- 3oz steak fillet, 2 Tablespoons-1 1/2 teaspoon of food thickener bulk and 1 1/4 cup of stock bee/soup base conv. The recipe menu did not provide the preparation of ingredients to be used to prepare a puree diet for seven residents and it also specified for thickener to be added to the recipe. Review of the facility provided Dinner Roll (DOUGH) PU recipe menu revealed, the preparations of ingredients for serving sizes in the amount of 10, 50, 75, 100, and 150; For the serving size of 10 revealed, one each, 2 Tablespoons-1 1/2 teaspoon of food thickener bulk, and 1 1/4 cup of water or juice. The recipe menu did not provide the preparation of ingredients to be used to prepare a puree diet for seven residents and it also specified for thickener to be added to the recipe. An interview on 8/13/2025 at 10:50 am with DKM confirmed that the kitchen staff did not follow the menus during the puree process. The menus call for a serving size of 10; however, they only make enough for seven residents. She stated that they reduce the number of servings to have the serving size to equal seven residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115404	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woods at Lumber City of Journey Llc, The	93 GA- 19 Lumber City, GA 31549

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	Provide and implement an infection prevention and control program. Based on observations, staff interviews and review of the facility's policies titled, Infection Prevention and Control Program and Medication Administration, the facility failed to ensure infection control practices was maintained during one of two wound care observations and one of one perineal care observations conducted with staff Registered Nurse (RN) RN BB, Licensed Practical Nurse (LPN) LPN CC, Certified Nursing Assistant (CNA) CNA GG, and CNA HH). The deficient practice had the potential to spread infection to other residents and staff.Findings include:Review of the facility's policy titled, Infection Prevention and Control Program, last date revised 5/19/2025, under the Policy statement revealed, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Under Policy Explanation and Compliance Guidelines revealed, .4. Standard Precautions, a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. B. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. C. All staff shall use personal protective equipment (PPE) according to established facility policy governing use of PPE. Review of facility's policy titled, Medication Administration dated 4/1/2025 under the Policy statement revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Under Policy Explanation and Compliance Guidelines revealed,. 14. Remove medication from source, taking care not to touch medication with bare hand.1. Observation on 8/13/2025 at 9:40 am of wound care conducted with RN BB and LPN CC revealed, they both entered R4's room with a plastic container filled with wound care supplies in hand. RN BB removed personal items on the bedside table belonging to R4 and placed the wound supply container on the bedside table without sanitizing the surface. LPN CC assisted with the removal of the soiled wound dressing. LPN CC used the soiled gloved hands to assist in opening sterile pack of abdominal (ABD) pad dressing on the bedside table, picking up the tube of Medihoney and squeezing the gel onto the ABD sponge. RN BB applied the ABD sponge with Medihoney gel on to the wound bed and held it in place while LPN CC prepared a second and third ABD sponge with Medihoney and handed it to RN BB to apply to the wound. LPN opened a silicone foam dressing with the same soiled gloved hands and passed it to RN BB to apply over the wound site.2. Observation on 8/14/2025 at 10:45 am of perineal care for R3 was conducted with CNA GG, CNA EE, CNA FF and Staff Coordinator/CNA HH revealed, all staff entered the room, sanitized hands, and donned gown and gloves. CNA GG provided the perineal care using wipes, while the other staff held R3 in position. CNA GG she did not stop to wash her hands or use hand sanitizer and apply clean gloves during the perineal care or with transferring the resident to the mobile chair with use of the Hoyer lift. Staff coordinator/CNA HH was observed removing an outer layer of gloves after the perineal care for R3 was complete and prior to transferring her to the mobile chair.Interview on 8/14/2025 at 11:00 am with Staff Coordinator/CNA HH revealed that she received training on infection prevention and control which included proper us of Personal Protective Equipment (PPE), proper hand hygiene and utilizing disinfecting products. CNA HH acknowledged that she wore double gloves during the perineal care procedure as that would keep her from having to walk away to change gloves. CNA HH confirmed that double gloving was not an acceptable practice. During an interview on 8/14/2025 at 11:15 am with CNA GG, the procedure she followed during the perineal care was reviewed. CNA GG confirmed that she did not stop to wash her hands or use hand sanitizer and apply clean gloves during the perineal care or with transferring the resident to the mobile chair with use of the Hoyer lift.Interview on 8/14/2025 at 12:30 pm with the Director of Nursing (DON) confirmed that her expectations when the nurse performs a procedure that they are to wash their hands with soap (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and water before, between and after each treatments. The DON revealed that during perineal care, her expectations are for staff to adhere to enhanced barrier precaution standards which include use of gowns and gloves when giving direct patient care explaining that when in the room, they are to wash hands, don gown and gloves to complete perineal care. After perineal care is complete, they are to remove soiled gloves, sanitize hands and don clean gloves to proceed with assisting the resident with transferring. The DON confirmed that double gloving was not an acceptable practice when rendering resident care.