STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115424	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reserve at Appling of Journey Llc, The	6698 Washington Road Appling, GA 30802

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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, and review of the facility's policy titled Ice Machines and Portable Ice Carts, the facility failed to ensure the dietary ice machine was free from buildup. This deficient practice had the potential to place the 76 residents receiving nutrition or hydration from the kitchen at risk of foodborne illness. Findings include: Review of facility policy titled Ice Machines and Portable Ice Carts, revised April 2025, revealed the Policy section stated, It is the policy of this facility to ensure that ice machine 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. The Compliance Guidelines section included, 1. Ice machines will be cleaned at a frequency specified by the manufacturer or, if manufacturer specifications are absent, at a frequency necessary to preclude accumulation of soil or mold. 3. The maintenance director or other designee is responsible for cleaning and maintaining the ice machine at the facility. Observation and interview on 8/25/2025 10:09 am in the kitchen area with the Dietary Manager (DM) revealed that the interior of the ice machine contained dark brown and black buildup. The DM confirmed the dark brown and black buildup was inside the ice machine. The DM revealed that she and the kitchen staff had made attempts to remove the dark brown and black buildup, but it would not go away. In an interview on 8/27/2025 at 1:05 pm, the DM revealed that the Maintenance Director was responsible for cleaning the ice machine, and cleaned it monthly. The DM stated that the kitchen staff attempts to clean the ice machine at times. The DM confirmed the ice machine needed to be cleaned due to the dark brown substance found inside the ice machine. In an interview on 8/27/2025 at 1:41 pm, the Maintenance Director revealed he cleaned the ice machine monthly, and confirmed he was responsible for ensuring the ice machine was cleaned. The Maintenance Director confirmed there was dark brown buildup inside the ice machine, and he was unaware of the buildup prior to the interview. In an interview on 8/27/2025 at 1:50 pm, the Administrator confirmed the inside of the ice machine contained dark brown buildup. The Administrator stated she expects the Maintenance Director and kitchen staff to clean the ice machine regularly and thoroughly during each cleaning.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, staff interviews, record review, and review of the facility's policies titled Hand Hygiene and Enhanced Barrier Precautions (EBP), the facility failed to ensure nursing staff performed hand hygiene and used personal protective equipment (PPE) while administering medications via gastrostomy tube (G-Tube [a tube surgically inserted through the abdominal wall into the stomach to provide nutrition and medication]), while suctioning the tracheostomy (a surgically created hole in the trachea to provide an airway and facilitate breathing), and during perineal care for one of 18 residents (R) (R23) on EBP. The deficient practice had the potential to place R23 at increased risk of unmet needs and medical complications and to increase the spread of infection due to cross-contamination for the 80 residents residing in the facility.Findings include:Review of the facility's policy titled Hand Hygiene, revised 4/1/2025, revealed the Policy Explanation and Compliance Guidelines section included, . 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to the attached hand hygiene table.6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The Hand Hygiene Table listed conditions when hand hygiene should be performed either with soap and water or with either soap and water or alcohol based hand rub (ABHR is preferred). The list included: Before preparing or handling medications. Before and after handling clean or soiled dressings, linens, ., when, during resident care, moving from a contaminated body site to a clean body site, after assistance with personal body functions (e.g. (such as), elimination, hair grooming, smoking).Review of the facility's policy titled Enhanced Barrier Precautions, reviewed 4/2/2025, revealed the Policy Explanation and Compliance Guidelines section included, .3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4.High-contact resident care activities include: a. Dressing. b. Bathing. c. Transferring. d. Providing hygiene. e. Changing linens. f. Changing briefs or assisting with toiletin. g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes. h. Wound care: any skin opening requiring a dressing.1. Review of the electronic medical record (EMR) for R23 revealed diagnoses that included, but were not limited to, cerebral infarction, acute respiratory failure, paralysis of vocal cords, tracheostomy status, gastrostomy status, dysphagia, failure to thrive, type 2 diabetes, and dementia.Review of the Quarterly Minimum Data Set (MDS) assessment for R23, dated 8/7/2025, revealed Section K (Swallowing and Nutritional Status) documented the resident had a feeding tube. Section O (Special Treatments, Procedures, and Programs) documented the resident received oxygen, suctioning, and tracheostomy care while a resident. Review of the Order Summary Report for R23 revealed an order dated 3/28/2025 of Resident is on enhanced barrier precautions related to tracheostomy and G-tube every shift.Review of the Medication Administration Record (MAR) for 23, dated August 2025, revealed an entry stating, Resident is on enhanced barrier precautions related to tracheostomy and G-tube every shift and initialed by the nursing staff as completed each shift for the month.Observation on 8/26/2025 at 12:00 pm, during medication administration observation, revealed that LPN AA was observed preparing medications or R23. Observation revealed that she donned (put on) gloves without sanitizing her hands, removed the medications from the medication cart, crushed them, and dissolved them in individual cups of warm water. During the medication preparation, she realized that one medication was missing and needed to retrieve it from another cart. She removed her gloves, did not perform hand hygiene, walked to another cart, returned, and donned a new pair of gloves without sanitizing her hands. After the medications were prepared, LPN AA placed the cups on a tray, entered the resident's room, and placed the tray on the bedside table. She then put on new gloves and did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sanitize or wash her hands. Continued observation revealed that LPN AA did not don a gown. Observation revealed signage on the resident's door indicating that the resident was on EBP, and PPE supplies were readily available in the room. Upon completion of medication administration, she washed her hands and left the room. In an interview on 8/26/2025, after the medication administration, LPN AA stated that her hands were clean since they had been inside gloves, and she did not believe they needed to be sanitized after glove changes. She confirmed that she did not don a gown when providing care to R23, who has a G-Tube and a tracheostomy. She explained that EBP was a new practice in the facility and had only recently been implemented.2. Observation on 8/27/2025 at 3:47 am revealed Certified Nurse Aide (CNA) CC and CNA DD performed peri-care for R23. Observation during the care revealed the CNAs did not don gowns before providing the care and did not perform hand hygiene between glove changes during the care. In a concurrent interview on 8/27/2025, following the observation, CNA CC and CNA DD confirmed they did not don gowns before providing peri-care to R23 and stated they were unaware they should. 3. Observation on 8/27/2025 at 4:12 am, revealed Registered Nurse (RN) BB walked in the hall, heard R23 coughing, and entered R23's room, sanitized her hands, and donned gloves, but did not don additional PPE, despite PPE supplies being readily available upon entry. After completing the procedure and exiting the room, she removed her gloves and sanitized her hands. In an interview immediately following the observation, RN BB acknowledged she should have used PPE but stated she was in a rush to suction the resident.In an interview on 8/26/2025 at 3:35 pm, the Infection Preventionist (IP) stated her expectation was for staff to follow EBP when providing high-contact care and to perform hand hygiene as outlined on the Hand Hygiene Table. She stated staff had received education on EBP and hand hygiene, and skills check offs were conducted. The IP further stated her expectation was for staff to wash or sanitize their hands between glove changes, and that the use of gloves is not a substitute for hand hygiene.In an interview on 8/26/2025 at 4:00 pm, the Director of Nursing (DON) stated that nursing staff were expected to follow infection control practices, including using PPE for high-contact care such as tracheostomy care or tube feeding. She reported that staff were educated on EBP and hand hygiene, emphasizing that gloves do not replace handwashing or sanitizer. She added that staff are expected to gown when providing direct care and that PPE supplies were readily available in resident rooms.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interviews, record review, and review of the facility policies titled Medication Storage and Medication Administration Policy, the facility failed to ensure that medications, biologicals, and supplies were stored following manufacturers' recommendations, or those of the suppliers, in one of four medication carts and two of two medication rooms. This deficient practice has the potential to place residents at risk of receiving medications or biologicals with altered effectiveness. Findings include:Review of the facility policy titled Medication Storage, revised 4/9/2025, included, The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. Review of policy titled Medication Administration, revised 4/9/2025, included, . 13. Identify expiration date. If expired, notify nurse manager.A review of the manufacturer's instructions on the electrolyte bottle revealed that once the electrolyte bottle is open, it is good for 48 hours under refrigerated conditions.A concurrent observation and interview on 8/26/2025 at 11:17 am of one of two medication carts on Hall A, with Certified Medication Assistant (CMA) KK, revealed one insulin pen with an open date of 7/15/2025 and a discard date of 8/11/2025. CMA KK confirmed the insulin pen should have been discarded on 8/11/2025. Continued observation revealed an open, unlabeled container of thickener in the bottom drawer with a date on the container of 6/23. CMA KK stated that the thicker was good for 30 days after opening, and stated she was unsure how long it had been opened or what the date of 6/23 indicated. Further observation revealed two bottles of electrolyte solution in the cart, unrefrigerated, with open dates of 8/20/2025 and 8/25/2025. CMA KK stated she was unaware that the electrolyte solution was only good for 48 hrs and needed to be refrigerated. She stated she had given residents the orange solution on this date with medications. She further stated that the orange electrolyte solution had not been refrigerated, and was unsure when the purple electrolyte solution, dated 8/25/2025, was last used.Concurrent observations and interviews on 8/26/2025 at 11:52 am of the front medication storage room, with the Assistant Director of Nursing (ADON), revealed one saline enema expired 6/2023, one hemorrhoidal ointment expired 5/2025, multi-vite liquid expired 2/2025, and one box of bisacodyl suppositories expired 1/2025. Observations of the back medication storage room revealed one box of bisacodyl suppositories expired 1/2025, one adult liquid acetaminophen expired 7/2025, lubricating jelly expired 2/28/2023, and control solutions for a glucometer expired 8/17/2025. The ADON verified the findings in the medication storage rooms. The ADON stated that expired medications should not be stored in the medication storage rooms. In an interview on 8/26/2025 at 1:11 pm, the Staff Coordinator and Central Supply Clerk stated that she checked supplies on Monday, Wednesday, and Friday. She stated that the supplies were rotated, and she checked constantly for expired items. She verified the expired items. In an interview on 8/27/2025 at 2:33 pm, the Director of Nursing (DON) stated she was surprised that there were expired medications and supplies found. She stated the pharmacy consults with the DON and reviewed medication carts, and she completed random checks of the medication storage rooms and carts.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff and resident interviews, and record review, the facility failed to ensure one of 52 sampled residents (R) (R34) was treated with dignity during dining. This deficient practice had the potential to place R34 at risk of a diminished quality of life or feeling intimidated when staff fed her while standing over her.Findings include: Review of the admission Minimum Data Set (MDS) for R34, dated 6/10/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 00 (indicating severe cognitive impairment). Section I (Active Diagnoses) documented diagnoses, including, but not limited to, Down syndrome, non-Alzheimer's dementia, and a history of transient ischemic attack without deficit. Section GG (Functional Abilities and Goals) documented that R34 required set-up and cleanup assistance with meals.Review of the care plan for R34, dated 6/8/2025, revealed that R34 had activities of daily living (ADL) self-care performance deficit and is at risk for not having her needs met in a timely manner related to her Down Syndrome and muscle weakness. The interventions include providing her with set up with meals/eating, extensive assistance with oral hygiene, toileting, dressing, and personal hygiene. The amount of assistance required could vary from day to day.Observations on 8/25/2025 at 1:06 pm, 1:15 pm, and 1:19 pm revealed Certified Nursing Assistant (CNA) VV standing over R34 while assisting her with lunch meal in the resident's room. In an interview on 8/25/2025 at 1:25 pm, CNA VV confirmed that she stood over R34 while feeding the resident. CNA VV stated that there was no chair in the room to sit in. In an interview on 8/27/2025 at 2:20 pm, the Assistant Director of Nursing (ADON) stated that staff should not stand over the resident when feeding them, and should sit when feeding a resident.In an interview on 8/27/2025 at 2:33 pm, the Director of Nursing (DON) stated that staff should not stand over a resident while feeding them.

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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. Based on observations and staff and resident interviews, the facility failed to maintain a safe, functional, and sanitary environment by not repairing roof leaks in one of two shower rooms (Shower Room A) and the facility's dining room. This deficient practice had the potential to place the 80 residents residing in the facility at risk of living in an unsafe and unsanitary environment. Findings include:The facility's policy on environmental maintenance was requested, but was not provided.Observation on 8/27/2025 at 3:21 am in Shower Room A revealed the ceiling protruding downward with visible brown stains around the light fixture.In an interview on 8/27/2025 at 3:21 am, Certified Nursing Assistant (CNA) SS revealed that the Shower Room A ceiling leaked when it rained and stated the leak caused the ceiling area to protrude down. In a concurrent observation and interview on 8/27/2025 at 11:35 am, observation in the Dining Room revealed brown discolored areas on the dining room ceiling. Kitchen Aide PP stated that the leak in the middle of the dining room had been a known problem for over a year. She further stated that when it rains, staff place trash cans and towels to collect the water as needed.In an interview on 8/27/2025 at 11:40 am, the Maintenance Director stated that the ceiling had leaked for some time. He stated that staff attempted to repair it themselves by applying silicone, which did not help. He further stated that the issue has persisted for over a year and that he had several local companies come to provide estimates, which he provided to the Administrator.In an interview on 8/27/2025 at 11:45 am, the Administrator confirmed that the ceiling in the Dining Room and Shower Room A leaked when it rained, and stated that several companies evaluated the leaks. She reported that the companies advised it was difficult to identify the source of the leaks and recommended replacing the roof. She further stated she had emailed the owner regarding the issue, but could not provide the estimates.During the resident council meeting on 8/27/2025 at 3:00 pm, residents reported ongoing issues with roof leaks in the Dining Room and in Shower Room A.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, staff interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to implement care plan interventions for one of 18 residents (R) (R23) requiring Enhanced Barrier Precautions (EBP). This deficient practice had the potential to place R23 at risk of unmet care needs and a diminished quality of life. Findings include:Review of the facility's policy titled Comprehensive Care Plans, revised 2/5/2025, revealed the Policy Explanation and Compliance Guidelines included, 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality.3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being.6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress.Review of the electronic medical records (EMR) for R23 revealed diagnoses that included, but were not limited to, cerebral infarction, acute respiratory failure, paralysis of vocal cords, tracheostomy status, gastrostomy status, trach/PEG [percutaneous endoscopic gastrostomy tube] dependent, dysphagia, failure to thrive, type 2 diabetes, and dementia.Review of the Quarterly Minimum Data Set (MDS) assessment for R23, dated 8/7/2025, revealed Section K (Swallowing and Nutritional Status) documented the resident had a feeding tube. Section O (Special Treatments, Procedures, and Programs) documented the resident received oxygen, suctioning, and tracheostomy care while a resident. Review of the care plan for R23, revised 2/24/2025, revealed a Focus area of the resident had a tracheostomy (a surgically created hole in the trachea to provide an airway and facilitate breathing). Interventions included the resident being on EBP related to tracheostomy and G-Tube (a tube surgically inserted through the abdominal wall into the stomach to provide nutrition and medication) status. Observation on 8/26/2025 at 12:00 pm revealed Licensed Practical Nurse (LPN) AA did not put on a gown while administering medication to R23 through the G-Tube. In an interview following the observation, LPN AA confirmed she did not wear a gown during medication administration through the G-Tube and stated she did not review the care plans daily. Observation on 8/27/2025 at 3:47 am revealed Certified Nurse Aides (CNAs) CC and DD did not put on gowns during glove changes while providing perineal care for R23. In concurrent interviews following the observation, CNA CC and CNA DD confirmed they did not wear a gown while providing perineal care to R23, and stated they should have reviewed the care plan to refresh themselves on the resident's required care.Observation on 8/27/2025 at 4:12 am revealed Registered Nurse (RN) BB did not put on a gown while suctioning R23's tracheostomy. In an interview following the care, RN BB stated she should have put on a gown before performing the suctioning and further stated she would look in the orders and the care plan to determine whether EBP were required.In an interview on 8/26/2025 at 3:35 pm, the Infection Preventionist (IP) confirmed EBP was on the care plan for R23. She stated the care plan instructed nursing staff how to care for a resident. She emphasized her expectation was for staff to follow care plan interventions, including using EBP for high-contact care.In an interview on 8/26/2025 at 4:00 pm, the Director of Nursing (DON) stated her expectation was for nurses to review care plans routinely, as they are individualized and updated as resident conditions change. She emphasized that nurses must be familiar with resident goals and interventions in order to provide appropriate care, and she expected nursing staff to follow EBP.In an interview on 8/27/2025 at 10:28 am, the MDS Coordinator stated that all nursing staff involved in a resident's care were expected to review the care plan so they know how to provide care according to resident-specific needs.(Cross-reference F880)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled Resident Rights Regarding Treatment and Advance Directives, the facility failed to ensure the comprehensive person-centered care plan was updated for one of 52 sampled residents (R) (R82).Findings include:Review of the facility's policy titled, Resident's Rights Regarding Treatment and Advance Directives dated [DATE] under the section titled Policy Explanation and Compliance Guideline included, . 7. During the care planning process the facility will identify, clarify, and review with the resident or legal representatives whether they desire to make any changes related to any advance directives. 9. Any decision-making regarding the resident's choice will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.Review of the admission Record for R82 revealed admission on [DATE]. The Advanced Directive section documented a DNR (Do Not Resuscitate).Review of the admission Minimal Data Set (MDS) for R82, dated [DATE], revealed that Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 13 (indicating little to no cognitive impairment). Review of the care plan for R82, revised [DATE], revealed a Focus of has a physician's order that includes a status of full code. Goal included that the staff will administer CPR (Cardio-Pulmonary Resuscitation) if the resident had an arrest through the next review date. Interventions included ensuring a Full Code order on the chart, ensuring staff were aware of code status through designated systems, monitoring for changes in the code status and updating as needed, and beginning CPR after the absence of vital signs, calling 911, and notifying the physician and family/responsible party. Review of the Physician Orders for R82 revealed an order dated [DATE] for DNR. Review of the Georgia POLST form for R82 revealed a signed POLST order for a DNR status, signed by the resident on [DATE] and the physician on [DATE].In an interview on [DATE] at 10:50 am, the Admission/Social Worker stated that when a resident was admitted , she provided the POLST form to the resident and/or representative at admission. She stated that after the form was completed by the resident or resident representative, she sent the form to the physician and notified the department heads of the resident's code status. She further stated the resident was considered a full code until a POLST was completely completed and signed by all parties. She stated that the Director of Nursing (DON) changed the resident's code status in the electronic medical system. In an interview on [DATE] at 2:47 pm, the DON stated the MDS Coordinator was responsible for updating the care plan for residents. She further stated she communicated daily with the MDS Coordinator at 2:00 pm during the daily team meeting.In an interview on [DATE] at 11:02 am, the MDS Coordinator revealed that the Social Worker completed the care plans for the advance directive. She stated that care plans should be updated immediately when there is a change in code status. The MDS Coordinator confirmed R82's care plan stated the resident was a full code, and the POLST forms stated the resident was a DNR. She stated she was unaware of the resident's change in code status.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and review of the facility's policy titled Nail Care, the facility failed to provide nail care for three of 52 sampled residents (R) (R66, R50, and R81). This deficient practice had the potential to place R66, R50, and R81 at risk of unmet needs and a diminished quality of life. Findings include: Review of the facility's policy titled Nail Care, reviewed 1/14/2025, revealed the Policy Explanation and Compliance Guidelines section included, . 3. Routine cleaning and inspection of nails will be provided during ADL [Activities of Daily Living] care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule . Nail care will be provided between scheduled occasions as the need arises. Record review of a letter from a podiatrist dated June 9th, 2023 revealed, This letter is to inform you that podiatrist will no longer provide services to your facility. Due to changes at your facility, we are unable to provide podiatric care to our standards for our residents. Please accept this notice effective immediately. 1. Review of the admission Record for R66 revealed admission on [DATE] with diagnoses including, but not limited to, lack of coordination, muscle weakness, and hemiplegia and hemiparesis following cerebral infarction affecting the left side. Review of the Quarterly Minimum Data Set (MDS) assessment for R66, dated 6/15/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 8 (indicating moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident was dependent for all ADLs. In an interview and observation on 8/25/2025 at 1:39 am, R66 stated his fingernails and toenails are awfully long. He stated he had asked a nurse about trimming his nails and was informed that a podiatrist must clip his toenails since he had diabetes. Observation revealed extremely long and jagged fingernails and toenails. In an interview and observation on 8/26/2025 at 1:41 pm, observation revealed the resident's fingernails remained extremely long and jagged. R66 stated that he just wished they would trim his toenails and cut his fingernails. In an interview on 8/27/2025 at 3:35 am, Licensed Practical Nurse (LPN) EE revealed that bath sheets were completed by the Certified Nursing Assistants (CNAs). The bath sheets go to the Wound Care Nurse first, who notes any skin abnormalities, including hand and foot nails. Any nail abnormalities were referred to the podiatrist, especially those of people with diabetes who require special nail care. In an interview on 8/27/2025 at 3:43 am, CNA FF revealed that she would identify the need for nail care on shower day, and if she noted fingernails or toenails that needed trimming, she would trim them. She stated that if the person had diabetes, she would give the bath sheet to the Wound Care nurse and alert her of the need. She stated she wasn't sure what happened after that. In an interview on 8/27/2025 at 7:04 am, LPN GG/Wound Care Nurse stated weekly skin assessments were conducted by the Charge Nurse. LPN GG stated the nurse reported abnormal nail findings and further stated nurse aides aren't allowed to cut diabetic residents' nails. LPN GG stated the facility had trouble finding a podiatrist. In an interview on 8/27/2025 at 7:14 am, the Director of Nursing (DON) stated the facility had not had a podiatrist to provide nail care for residents since at least April 2024. The DON stated that residents who request podiatry services were sent to a podiatrist. In an interview on 8/27/2025 at 7:23 am, the Administrator stated the facility had not had an on-site podiatrist for a while, and when there was a dire need, they schedule residents to go to an outside appointment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115424	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reserve at Appling of Journey Llc, The	6698 Washington Road Appling, GA 30802

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the MDS assessment for R50, dated 7/30/2025, revealed that Section C (Cognitive Patterns) documented a BIMS score of 1 (indicating severe cognitive impairment). Section I (Active Diagnoses) documented diagnoses of, not all-inclusive, Parkinson's disease, dyskinesia, muscle weakness, and need for personal care. Section GG (Functional Abilities and Goals) documented that R50 was dependent on staff for personal care. Review of the care plan for R50, dated 7/5/2025, revealed that R50 had an ADL self-care performance deficit and was at risk for not having her needs met in a timely manner because of her diagnoses, which include Parkinson's, cervical disc disorder, and edema. The interventions included providing her with extensive assistance with personal hygiene, showering, bathing, and dressing. An observation and interview with the Resident Representative (RR) for R50 on 8/25/2025 at 12:58 pm revealed that fingers and toenails were long. RR expressed that they should not have to address the need for nail trimming with the facility because they should be keeping up with nail care. RR stated they had reported to the nurse about the long nails. RR stated that the facility painted nails but did not cut them. RR further stated that her fingernails were so long and dirty that she had to cut them last week. 3. Review of the MDS assessment for R81, dated 7/1/ 2025, revealed that Section C (Cognitive Patterns) documented a BIMS score of 5 (indicating severe cognitive impairment). Section I (Active Diagnoses) documented diagnoses of, not all-inclusive, need for assistance with personal care, generalized muscle weakness, metabolic encephalopathy, chronic obstructive pulmonary disorder, and malignant neoplasm of the prostate. Section GG (Functional Abilities and Goals) documented that R81 required maximal assistance from staff for personal care, including nail grooming. Review of the care plan for R81, dated 4/29/2025, revealed that R81 had an ADL self-care performance deficit and is at risk for bathing, hygiene, dressing, and grooming deficits related to his diagnoses, including but not limited to chronic obstructive pulmonary disorder, hypertension, and prostate cancer. The interventions included providing him assistance and encouraging independence with bathing, grooming, and dressing. R81 has the potential for alteration in skin integrity related to fragile skin due to impaired mobility and incontinence. Interventions include good skin care and podiatry care as ordered. A review of the physician's orders for R81 revealed no order for podiatry. Observation and interview with R81 on 8/25/2025 at 11:45 am revealed the resident with long fingernails and toenails. He stated his fingernails or toenails had not been trimmed in eight months. In an interview on 8/25/2025 at 11:39 am, the RR for R81 stated the resident's fingernails or toenails had not been trimmed since she moved into the facility in June. Observation and interview with R81 on 8/26/2025 at 10:20 am revealed that his finger and toenails remain long. He expressed that he would like them cut. Observation and interview with R81 on 8/28/2025 at 9:17 am revealed that he was resting in bed and stated the facility has not addressed his toes yet. A Hospice nurse was present in the room. In an interview on 8/28/2025 at 9:55 am, the Hospice RN Case Manager stated that he did not cut nails. He stated that he refers residents to the facility for nail care. (continued on next page)

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	115424	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reserve at Appling of Journey Llc, The	6698 Washington Road Appling, GA 30802

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/28/2025 at 9:33 am, the Nurse Practitioner (NP) stated that he did not address nail care, and a referral was made to the wound care nurse or to the podiatrist for residents with diabetes.

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 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. Based on observations, staff interviews, and record review, the facility failed to deliver oxygen (O2) per physician order for one of eight residents (R) (R74) receiving O2 therapy. The deficient practices had the potential to place R74 at risk of respiratory complications.Findings include:Review of the electronic medical record (EMR) for R74 revealed diagnoses, including but not limited to shortness of breath (SOB).Review of the Quarterly Minimum Data Set (MDS) assessment for R74, dated 6/5/2025, Section C (Cognitive Patterns) documented a Brief Interview of Mental Status (BIMS) score of 1, indicating severe cognitive impairment. Section O (Special Treatments, Procedures, and Programs) documented that oxygen was not administered while a resident.Review of the Order Summary Report for R74 revealed an order dated 8/18/2025 for O2 at 2 liters per minute (LPM) via a nasal cannula (NC) every shift for SOB. Observations on 8/25/2025 at 11:29 am and 8/26/2025 at 9:17 am revealed R74 was receiving O2 via a NC. Further observation revealed that the flow rate for the O2 was set at 3 LPM. During an observation and interview on 8/26/2025 at 4:08 pm, Licensed Practical Nurse (LPN) OO revealed she was unaware of the O2 order for R74. LPN OO stated the nurse should check the O2 rate each shift, and further stated she had not checked R74's O2 flow rate this date. During an interview on 8/26/2025 at 4:23 pm, the Director of Nursing (DON) confirmed the O2 order for R74 was 2 LPM. The DON stated the O2 flow rate should be checked every shift, and O2 should be administered as ordered by the physician.