STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115427	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thomasville Vistas of Journey LLC	120 Skyline Drive Thomasville, GA 31757

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to ensure that 17 Residents (R) (R2, R4, R5, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20) call lights were within reach while the residents were in their bed. This deficient practice had the potential to cause delayed assistance, potential for falls and unmet needs. The facility census is 49 residents. Findings include: All observations on 06/02/2026 and 06/08/2026 were made in the presence of the Maintenance Director during call light functional checks and verification of nonfunctional call lights. 1. Review of the admission Record revealed R2 was admitted to the facility with diagnoses including but not limited to chronic combined systolic congestive and diastolic congestive heart failure, type 2 diabetes mellitus, protein-calorie malnutrition, and hypertension. Review of the care plan dated 12/31/2025 revealed R2 has an Activities of Daily Living (ADL) self-care performance deficit and is at risk for not having needs met in a timely manner. One intervention directs staff to encourage the resident to use the call light to request assistance before attempting ADLs that cannot be performed independently.Observations revealed the following:On 06/02/2026 at 2:06 PM, R2 was in room [ROOM NUMBER]-A. The call light was draped over the bed rail and hanging above the floor. The call light was not within the resident's reach.On 06/03/2026 at 2:23 PM, R2 was lying in bed with eyes closed. The call light was not within reach of the resident.On 06/08/2026 at 12:19 PM, R2 was lying in bed. The call light was attached to the bed frame and was not within reach of the resident.2. Review of the admission Record revealed R4 was admitted to the facility with diagnoses including, but not limited to, type 2 diabetes mellitus, cardiomyopathy, hypertension, and thyrotoxicosis. Review of the care plan dated 05/22/2024 revealed R4 requires assistance with ADL care related to decreased mobility, surgical wound, disease process and generalized weakness. An intervention directs staff to encourage the resident to use call light to request assistance before ADLs that cannot be performed independently. Observations revealed the following:On 06/02/2026 at 2:32 PM, R4 was in room [ROOM NUMBER]-B lying in bed. The call light was hanging from the lower bed frame with the call button facing the floor. The call light was not within reach of the resident.On 06/03/2026 at 2:27 PM, the call light was observed on the floor and was not within reach of the resident.3. Review of the admission Record revealed R5 was admitted to the facility with diagnoses including, but not limited to, type 2 diabetes mellitus, hypertension, protein-calorie malnutrition, and atrial fibrillation. Review of the care plan dated 08/21/2025 revealed R5 has an ADL self-care performance deficit and is at risk for not having needs met in a timely manner. An intervention directs staff to encourage the resident to use call light to request assistance before attempting ADLs that cannot be performed independently. An observation on 06/08/2026 at 12:09 PM of room [ROOM NUMBER]-B revealed a new call light hanging on the wall with the plastic wire still attached. The call light was not within reach of the resident. 4. Review of the admission Record revealed R7 was admitted to the facility with diagnoses including, but not limited to, Alzheimer's disease, vascular dementia, type 2 diabetes mellitus, and diverticulosis of the intestine. Review of the care plan dated 04/22/2025 revealed R7 has an ADL self-care performance deficit and is at risk for not having needs met in a timely manner. Interventions include providing a safe environment by ensuring the call light is within reach, adequate low glare (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lighting is available, and the bed is in the lowest position with wheels locked. Observation on 06/02/2026 at 1:48 PM, R7 was lying in bed in room [ROOM NUMBER]-B. The call light was attached to the lower bed frame behind the headboard and was not within reach of the resident. 5. Review of the admission Record revealed R8 was admitted to the facility with diagnoses including but not limited to, rhabdomyolysis, Parkinson's disease, and hypertension. Review of the care plan dated 10/23/2025 revealed R8 has an ADL self-care performance deficit and is at risk for not having needs met in a timely manner. Interventions include providing a safe environment by ensuring the call light is within reach and encouraging the resident to use the call light to request assistance before attempting ADLs that cannot be performed independently. Observation on 06/02/2026 at 1:57 PM, revealed R8 was lying bed in 103-A. The call light was not within reach of the resident. 6. Review of the admission Record revealed R9 was admitted to the facility with diagnoses including, but not limited to, hypertension, peripheral vasculare disease, and protein-calorie malnutrition Review of the care plan dated 08/28/2024 revealed R9 has an ADL self-care performance deficit and is at risk for not having needs met in a timely manner. An intervention directs staff to ensure a safe environment by keeping the call light within reach. Observations revealed the following:On 06/02/2026 at 2:19 PM, R9 was lying in bed in room [ROOM NUMBER]-A. The call light was located under the head of the bed and was not within reach of the resident.On 06/03/2026 at 2:26 PM, the call light was observed on top of the three-drawer bedside cabinet and was not within reach of the resident.7. Review of the admission Record revealed R10 was admitted to the facility with the diagnoses including, but not limited to, Parkinson's disease, type 2 diabetes mellitus, osteomyelitis, vascular dementia, and hypertension. Review of the care plan dated 08/19/2024 revealed R10 has an ADL self-care performance deficit related to cognitive impairment, functional limitations in range of motion or decreased mobility and pain. Interventions include providing a safe environment by ensuring the call light is within reach, the bed in lowest position, and the wheels locked.Observations revealed the following:On 06/02/2026 at 1:42 PM, R10 was in room [ROOM NUMBER]-B. No call light was observed at the bedside. A bell was present on the bedside table; however, it was not within reach of the resident. The resident was unable to ring the bell.On 06/08/2026 at 12:14 PM, a flat call light was observed on the bedside table next to the head of the bed. The call light was not within reach of the resident. 8. Review of the admission Record revealed R11 was admitted to the facility with diagnoses including, but not limited to, hypertension, depression, and cerebral infarction. Review of the care plan dated 01/16/2026 revealed R11 has an ADL self-care performance deficit and is at risk for not having needs met in a timely manner. Interventions include providing a safe environment by ensuring the call light is within reach, the bed is in the lowest position, and the wheels are locked.Observations revealed the following:On 06/02/2026 at 2:10 PM, R11 was lying in bed in room [ROOM NUMBER]-A. The call light was observed on the floor underneath the bed and was not within reach of the resident.On 06/08/2026 at 12:06 PM, R11 was observed lying in bed. The call light was on the floor and was not within reach of the resident. 9. Review of the admission Record revealed R12 was admitted to the facility with the following diagnoses that included but are not limited to type 2 diabetes mellitus, retention of urine, history of falling, and vascular dementia.9. Review of the admission Record revealed R12 was admitted with diagnoses including, but not limited to, type 2 diabetes mellitus, urinary retention, history of falls, and vascular dementia. Review of the care plan dated 12/5/2024 revealed R12 has an ADL self-care performance deficit and is at risk for not having their need met in a timely manner. Interventions include providing a safe environment by ensuring the call light is within reach, the bed is in the lowest position, and the wheels are locked.Observations revealed the following:On 06/02/2026 at 2:08 PM, R12 was seated in a wheelchair at the foot of the bed in room [ROOM NUMBER]-A. The call light was observed on the floor behind the headboard and was not within reach of the resident.On 06/03/2026 at 2:25 PM, R12 was seated in a wheelchair at the foot of the bed. The call light was not within reach of the resident. The call light was draped over the head of the bed with the call button hanging toward the floor. 10. Review of the admission Record (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed R13 was admitted to the facility with diagnoses including, but are not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, peripheral vascular disease, Alzheimer's disease, and gastrostomy. An observation on 06/02/2026 at 2:03 PM revealed lying in bed in room [ROOM NUMBER]-A. The call light was on the floor next to the wall and was not within reach of the resident. 11. Review of the admission Record revealed R14 was admitted to the facility with diagnoses including, but not limited to, hypertension, obstructive sleep apnea, gastro-esophageal reflux disease, coronary angioplasty status and thrombocytopenia. An observation on 06/02/2026 at 2:36 PM, revealed R14 in room [ROOM NUMBER]-B. The call light was on the floor and was not within reach of the resident. 12. Review of the admission Record revealed R15 was admitted to the facility with diagnoses including, but not limited to dementia, disorder of lung, and history of transient ischemic attach (TIA) and cerebral infarction An observation on 06/02/2026 at 2:03 PM revealed R15 in room [ROOM NUMBER]-B. The call light was on the floor and not within reach of the resident. 13. Review of the admission Record revealed R16 was admitted to the facility with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, ventricular tachycardia, and hypertension. Review of the care plan dated 07/18/2024 revealed R16 has an ADL self-care performance deficit and is at risk for not having needs met in a timely manner. Interventions include providing a safe environment by ensuring the call light is within reach and bed is in the lowest position with wheels locked. Observations revealed the following:On 06/02/2026 at 1:36 PM, R16 was lying in bed in room [ROOM NUMBER]-B. The call light was not within reach of the resident.On 06/08/2026 at 12:17 PM, the call light was observed on the floor underneath the bed and was not within reach of the resident.14. Review of the admission Record revealed R17 was admitted to the facility with the following diagnoses including but not limited to, hypertensive heart disease, asthma and chronic cough.Review of the care plan dated 12/20/2025 revealed R17 has an ADL self-care performance deficit and is at risk of not having needs met in a timely manner. Interventions include providing a safe environment by ensuring the call light is within reach and the bed is in the lowest position with wheels locked. Observation on 06/08/2026 at 12:13 PM, R17 was observed lying in bed in room [ROOM NUMBER]-A. The call light was on the floor and was not within reach of the resident. 15. Review of the admission Record revealed R18 was admitted to the facility with diagnoses including, but not limited to, Alzheimer's disease, hypertension, dementia, and atherosclerotic heart disease of native coronary artery. Review of the care plan dated 7/2/2024 revealed R18 has an ADL self-care performance deficit and is at risk for not having needs met in a timely manner. Interventions include providing a safe environment by ensuring the call light is within reach and the bed is in the lowest position with wheels locked. An observation on 06/08/2026 at 12:15 PM, R18 was observed in room [ROOM NUMBER]-B. The wall-mounted call light system had been removed. A bell was present; however, it was not within reach of the resident. 16. Review of the admission Record revealed R19 was admitted to the facility with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infraction affecting the right dominant side, cerebral infarction, urinary retention, and hypertension. Review of the care plan dated12/21/2024 revealed R19 is at risk for falls related to impaired balance and history of falls. Inventions include placing the resident's call light within reach and encouraging the resident to use the call light to request assistance as needed. An observation on 06/08/2026 at 12:18 PM R19 was observed in room [ROOM NUMBER]-A. The call light was on the floor on the left side of the bed and was not within reach of the resident. 17. Review of the admission Record revealed R20 was admitted with diagnoses including, but not limited to, hypertension, radiculopathy lumbar region, cerebral infarction, and need for assistance with personal care. Review of the care plan dated 06/02/2026 revealed R20 has an alteration in musculoskeletal status related to radiculopathy, other signs and symptoms involving musculoskeletal system. Interventions include anticipating and meeting the resident's needs, ensuring the call light is within reach, and responding promptly to requests for assistance. On 06/08/2026 at 12:18 PM, R20 was observed lying in bed in room [ROOM NUMBER]-A. The call light was on the floor (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and was not within reach of the resident.During an interview on 6/8/2025 at 12:01 pm, the Maintenance Director revealed that he saw the call lights that were on the floor or below the bed frames and not within the residents' reach. He continued to state that he had put a few call lights back in reach of the resident but not all of them. And that a vendor will be here today to repair the call lights. During an interview on 6/8/2026 at 3:30 pm, the Director of Nursing (DON) revealed that the call lights should be within reach of the residents. Housekeeping, maintenance director or anyone (staff) who enters the room can put the call light within reach. If a call light is not within reach that means rounds are not being done. And CNAs or nurses making rounds can put the call light within reach of the resident and the call light should be in reach at all times. During an interview on 6/8/2026 at 3:40 pm, the Administrator revealed that he expects any staff who enters a residents' room and the call light is not in reach, should put the call light within reach. Staff need education.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and observations, the facility failed to ensure that call light communication system was functioning to allow the residents to call for assistance in four out of 25 residents' rooms (114A, 109B, 112B, 201A). Findings include:During an observation on 06/02/2026 at 1:28 PM, with the Maintenance Director, each residents' room call lights were checked and the following lights were non-operative and did not respond when the call light button was pressed for the following rooms. Observation on 06/02/2026 at 1:34 PM, revealed that the call light in room [ROOM NUMBER]-A was not functioning. When activated, the light above the resident's door did not illuminate to indicate a request for assistance. An observation on 06/02/2026 at 1:38 PM revealed that the call light in room [ROOM NUMBER]-B was not functioning. No alternative method for the resident to request assistance was observed.Observation on 06/02/2026 at 1:42 PM revealed that room [ROOM NUMBER]-B did not have a functioning call light cord. A broken plug without a cord was observed in the wall-mounted call light panel. A bell was present on the bedside table; however, it was not within the resident's reach. The resident was unable to use the bell to request assistance.During the observation, the Assistant Maintenance Director brought a replacement call light cord into the room and provided it to the Maintenance Director. After the replacement cord was installed, the call light system remained nonfunctional.Observation on 06/02/2026 at 2:10 PM revealed that the call light in room [ROOM NUMBER]-A did not illuminate outside the resident's room when activated, preventing staff from knowing the resident had requested assistance.Observation on 06/08/2026 at 12:15 PM revealed that the wall-mounted call light device in room [ROOM NUMBER]-B had been removed. A bell was present; however, it was not within the resident's reach. During an interview on 06/08/2025 at 12:01 PM, the Maintenance Director revealed that a vendor scheduled to repair the call light system that day.At the time exit on 06/08/2026, the call lights system had not been repaired.