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	12/19/2025

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

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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 Food safety requirements the facility failed to label, store, prepare and discard food under sanitary conditions. In addition, the facility failed to ensure cleanliness of the kitchen floors and equipment used for residents. The deficient practices created an unsanitary kitchen environment that increased the potential for cross contamination and foodborne illness for 43 of 47 residents receiving oral diets.Findings include:Review of the facility's policy titled, Food safety requirements, implemented on 4/1/2025 documented under Policy Explanation and Compliance Guidelines number 3- iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers so it is used by its use by date or frozen discarded. Documented under 7.e Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad.During the initial observation tour of the kitchen on 12/16/2025 beginning at 8:55 am with the Registered Dietician (RD) and [NAME] (C) II, the following concerns were identified and confirmed:-A stand-up fan with the blades and grill were covered in dirt and dust.-The kitchen floor under the sinks was missing tiles with grease and dirt built up in addition to a sticky substance covering the floor in that area.-Freezer one contained a bag of hashbrowns without a date or label. -Freezer two contained an opened package of hot dogs wrapped in plastic wrap without a date or label and one cheese pizza without a date or label. -Freezer three contained an opened clear plastic bag of fries without a date or label; one opened plastic bags of what appeared to be breaded cheese sticks without a date or label; five frozen cheese pizzas without a date or label; a pullout drawer with a sticker dated 10/9/2024 that contained a plastic bag of what appeared to be chicken tenders that were not dated or labeled and two clear bags of hashbrowns that were not dated or labeled.-Cooler one contained cheese slices wrapped in plastic wrap without a date or label and a bowl of coleslaw with an expiration date of 12/12/2025.-Cooler two contained a clear bag with four heads of cabbage that were wilted with patches of yellow leaves with black spots without a label or date and two bags of greens with a use by date of 12/5/2025. -A shelf located across from the three stand up freezers contained a plastic tote with various opened bags of expired pasta; a bag of macaroni with a use by date of 12/10/2025; a bag of pasta with a use by date of 10/16/2025; a bag of pasta with an expiration date of 12/5/2025; a bag of pasta not labeled or dated, and a bag of pasta with a use by date of 11/30/2025.- CII and other dietary aids were observed without hair coverings.During the tour, RD confirmed and verified all identified concerns and revealed the staff need a lot of education on labeling, dating, and discarding items. RD removed most of the items and discarded them as they were identified. She stated the kitchen was due for a deep cleaning and did not know when it was last cleaned. She confirmed the dirty fan, the sticky floor with dirt and grease build up and missing tiles. CII confirmed she did not have a hair covering on along with the other aids but put them on as soon as the surveyor entered the kitchen. Observation and interview on 12/17/2025 at 11:40 am with RD revealed the ice machine located in break room off the dining room that is used for the residents contained a black/brown substance on the inside ceiling and was also dripping water. RD verified there was a dark substance and the water dripping from the inside ceiling of the ice maker.Interview on 12/17/2025 at 11:48 am (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with the Administrator revealed she did not know when the ice maker was last cleaned. The Administrator shut down the ice machine and got it cleaned/corrected during the survey. She confirmed the concerns identified in the kitchen from 12/16/2025. She stated it was her expectation that the kitchen staff follow policy and maintain the cleanliness of the kitchen, wear hair coverings, label, date, and discard items appropriately.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, staff interviews, and the facility policy, Disposal of Garbage and Refuse the facility failed to ensure the outdoor garbage and refuse area was maintained in a sanitary manner, creating the potential for harboring pests and insects. The facility census was 47.Findings include:A review of the facility policy titled, Disposal of Garbage and Refuse last revised on 3/26/2025 documented: 7. Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized.Observations on 12/16/2025 at 10:06 am, 12/17/2025 at 8:38 am, and 12/18/2025 at 8:45 am revealed trash scattered on the ground outside of the dumpster including paper, plastic, and food container waste products. In addition, there were wooden pallets leaning against the wooden fence surrounding the dumpster. Interview on 12/18/2025 at 10:01 am with the Administrator confirmed the presence of trash on the ground in the dumpster area and the wooden pallets leaning against the wooden fence surrounding the dumpster. The Administrator revealed trash is picked up three times a week and trash gets spilled. She stated the trash company will not dispose of the wooden pallets and that the Maintenance Director leans them against the dumpster fence and discards them himself.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled Resident Self Administration of Medications, the facility failed to ensure unauthorized medications were not stored at the bedside for four residents (R) (R5, R21, R36 and R45) of 40 sampled residents. The deficient practice had the potential for other residents and visitors to access unsecured medications stored in the residens' rooms. Findings include: A review of the facilities policy titled, Resident Self-Administration of Medication, dated 2024 revealed that a resident may only self-administer medications after the facility's interdisciplinary team (IDT) has determined which medications may be self-administered safely. Guideline number 4. reveals that results of the IDT assessment are recorded on the Medication Self-administration assessment form and placed in resident's medical record. Bedside medication storage is permitted if it does not present a risk to other residents and stored in a manner that prevents access by other residents. 1.A review of the most recent Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Patterns) that R36 has a Brief Interview for Mental Status (BIMS) score of 14 that indicated little to no cognitive impairment. Section I (Active Diagnosis) revealed diagnosis of but not all-inclusive diabetes melitis (DM), depression, knee pain, digestive surgery, atrial fibrillation, and hypertension. A record review revealed that R36 did not have an IDT self-administration assessment or physician order to self-administer medications. An observation on 12/16/2025 at 10:01 am in room [ROOM NUMBER] where R36 resided revealed that Flonase (prescription nasal spray) was on the bedside table within view of other residents/visitors. A second observation on 12/17/2025 at 10:32 am revealed that the Flonase remained on bedside table and zinc oxide over the counter (OTC) cream was on the table within view of other residents/visitors. An observation and interview on 12/17/2025 at 10:54 am with LPN GG verified that Flonase nasal spray and zinc oxide were on the bedside table belonging to R36. She confirmed that he was not assessed to self-administer medications and that he should not store medication at the bedside. An interview with the Director of Nursing on 12/17/2025 at 2:21 pm confirmed that residents should be assessed to allow them to self-administer medications. She stated the resident should be care planned to self-administer. She revealed that no one is to self-administer medications in the facility. She confirmed that medication should not be stored at the bedside. 2.Observation and interview with R45 on 12/16/2025 at 11:58 pm who resided in room [ROOM NUMBER]A revealed a bottle of OTC nasal spray sitting on the resident's bedside stand within view of other residents and/or visitors entering the room. R45 stated the medication was being used without the supervision of staff. Review of the electronic health record (EHR) for R45 revealed the following diagnoses that included but not limited to paroxysmal atrial fibrillations and respiratory infections. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for R45 revealed in Section C (Cognitive Patterns) a Brief Interview Mental Status Score (BIMS) of 14, which indicated little to no cognitive impairment. Review of the active physician orders as of 12/17/2025 for R45 revealed there was no documented order for the nasal spray. Additionally, there was no order for the self-administration of medications. Review of the electronic health record (EHR) for R45 revealed there was no self-administration assessment or care plan regarding self-administering medications. During an observation and interview on 12/17/2025 at 9:37 am with Unit Nurse Supervisor-Register Nurse (RN) and Director of Nursing (DON), both confirmed the medication was in the room. They reported being unaware of the nasal spray in the room. 3. Observation on 12/16/2025 at 1:54 pm of room [ROOM NUMBER] belonging to R21 revealed the following medication and medication products sitting on her bedside rolling table: zinc oxide creams and cough drops. Review of the electronic health record (EHR) for R21 revealed the following diagnoses that included but not limited to hypertension and atherosclerotic heart disease of native artery without angina pectoris. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for R21 revealed in Section C (Cognitive Patterns) a Brief Interview Mental Status Score (BIMS) of 13, which indicated little to no cognitive impairment. Review of the active physician orders as of 12/16/2025 for R21 revealed there was no documented order for the self-administration of medications. Review of the electronic health record (EHR) for R21 revealed there was no self-administration assessment or care plan regarding self-administering medications. Observation and interview on 12/20/2025 at 10:51 pm with the DON confirmed the medications were in the room and immediately removed the medication. She stated the resident was not assessed to self-administer medications. 4. Observation on 12/16/2025 at 11:44 pm of room [ROOM NUMBER] assigned to R5 revealed the following OTC medication products: zinc oxide cream, jar of vapor rub, and package of cough drops within open view of residents/visitors entering the room. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for R5 revealed in Section C (Cognitive Patterns) a Brief Interview Mental Status Score (BIMS) of 11, which indicated moderate cognitive impairment. Review of the physician orders dated 12/23/2025 for R5 revealed there was no documented active order for the observed OTC medications. Additionally, there was no active order for the self-administration of medications. Review of the electronic health record (EHR) for R5 revealed there was no self-administration (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment or care plan regarding self-administering medications. During an observation and interview on 12/17/2025 at 10:03 am with the DON and Nurse Supervisor, both confirmed the medications should not be stored in the resident's room and removed the medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to develop and/or implement a comprehensive person-centered care plan related to nail care and pain management for three of 40 sampled residents (R) (R24, R35 and R42). The deficient practice had the potential to affect the quality of life for the residents.Findings include: A review of the facility policy titled, Comprehensive Care Plans, dated 2/2/2025 documented that the facility was to Develop and implement comprehensive person-centered care plan for each resident, consistent with resident rights, than includes measurable objectives and time frames to meet a residents' medical, nursing, mental, and psychosocial needs and all services that are identified in the residents' assessment and meet professional standards of quality. 1. A review of the electronic medical record (EMR) revealed that R35 was admitted to the facility with diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction effecting left non-dominant side encounter for attention to gastrostomy essential (primary) hypertension, anxiety disorder, unspecified peripheral vascular disease, Alzheimer's, and major depressive disorder. A review of the annual Minimum Data Set (MDS) assessment dated [DATE] for R35 revealed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. In addition, Section GG (Functional Abilities and Goals) revealed the resident was dependent on staff for personal hygiene. A review of the care plan dated 8/18/2025 documented an intervention that included but not limited to Staff to provide shower and nail care per schedule and when needed. Observation with interview on 12/16/2025 at 11:00 am with R35 revealed his fingernails were long with a black substance underneath the tips of the nails. R35 was able to verbally express he wanted his nails trimmed and cleaned. Observation on 12/17/2025 at 9:05 am with R35 revealed his fingernails were long with a black substance underneath the tips of the nails. Observation with interview on 12/18/2025 at 12:06 pm with R35 revealed his fingernails were long with a black substance underneath the tips of his nails. R35 was able to verbally express he wanted his nails trimmed and cleaned. Interview on 12/18/2025 at 12:23 pm with the Director of Nursing (DON) confirmed that R35's nails were long and had a black substance underneath. She stated that Certified Nurse Assistants' (CNA) should follow the care plan interventions by cleaning and trimming nails. She confirmed the care plan was not being implemented. Interview on 12/18/2025 at 1:43 pm with the MDS Coordinator verified R35's care plan included interventions to address nail care; specifically for fingernails to be cleaned and trimmed. MDS Coordinator confirmed that staff were not providing care according to the care plan as evidenced by R35's nails being long and dirty with a black substance under the tip of the nail. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of the electronic medical record (EMR) for R42 revealed the most recent Quarterly Minimum Data Set (MDS) dated [DATE] Section C (Cognitive Patterns) that R42 has a Brief Interview for Mental Status (BIMS) score of seven indicated severe cognitive impairment. Section I (Active Diagnosis) revealed diagnosis of but not all-inclusive amputation of right great toe, neuromuscular dysfunction of bladder, protein-calorie malnutrition, depression, urethritis, depressive disorder, stage four pressure ulcer of sacrum, type two diabetes mellitus. A review of the care plan dated 12/8/2025 revealed that R42 had a focus statement regarding activities of daily living (ADL) self-care performance deficit at risk of not having needs met in a timely manner. An observation and interview with R42 on 12/16/2025 at 9:29 am revealed that R42 had long and dirty fingernails. R42 was able to verbally express she did not want her nails that long and wanted them cut. An observation and interview with R42 on 12/17/2025 at 10:34 am revealed R42 fingernails remain long and dirty and she would like her fingernails cut. An interview with Director of Nursing (DON) on 12/18/2025 at 12:32 pm confirmed that staff should follow the care plan. An interview with MDS Coordinator on 12/18/2025 at 1:45 pm confirmed that staff are to provide care according to the care plan. 3. A review of the admission Record for R24 revealed an admission date of 11/20/2025 with primary diagnosis: multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing. A record review revealed that R24 had a physician order dated 12/5/2025 for tramadol HCL [hydrochloride] oral tablet 50mg (Milligrams) give one tablet by mouth every eight hours as needed [PRN] for pain. A review of the Comprehensive Care Plan dated 11/20/2025 and revised 11/24/2025 for R24 revealed there is no problem or interventions documented to address pain management or controlled medication use on the Comprehensive Care Plan and according to physician orders. An interview with MDS Coordinator on 12/18/2025 at 1:45 pm confirmed that staff are to provide care according to the care plan and Interdisciplinary Team, Infection Preventionist, Unit Manager and/or Director of Nursing can update the care plan for changes.

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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, interviews, record review, and review of the facility's policy titled Activities of Daily Living, the facility failed to ensure that Activities of Daily Living (ADL) care services were provided for two of 40 sampled residents (R) (R35 and R42) related to nail care. This failure placed the residents at risk for diminished quality of life. Findings include: A Review of the facility's policy revised on 1/14/2025 titled Activities of Daily Living documented Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. Under policy explanation and compliance guidelines 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. A review of the electronic medical record (EMR) revealed that R35 was admitted to the facility with diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction effecting left non-dominant side encounter for attention to gastrostomy essential (primary) hypertension, anxiety disorder, unspecified peripheral vascular disease, Alzheimer's, and major depressive disorder. A review of the annual Minimum Data Set (MDS) assessment dated [DATE] for R35 Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. In addition, Section GG (Functional Abilities and Goals) revealed the resident was dependent on staff for personal hygiene. A review of the care plan dated 8/18/2025 for R35 documented an intervention that included but not limited to Staff to provide shower and nail care per schedule and when needed. Observation with interview on 12/16/2025 at 11:00 am with R35 revealed his fingernails were long with a black substance underneath the tips of the nails. R35 was able to verbally express he wanted his nails trimmed and cleaned. Observation on 12/17/2025 at 9:05 am with R35 revealed his fingernails were long with a black substance underneath the tips of the nails. Observation with interview on 12/18/2025 at 12:06 pm with R35 revealed his fingernails were long with a black substance underneath the tips of his nails. R35 was able to verbally express he wanted his nails trimmed and cleaned. Interview on 12/18/2025 at 12:15 pm with Certified Nurse Aid (CNA) HH stated that she does not like to cut resident nails, so she asks the wound care nurse to complete nail care. She revealed nails are cleaned at bath time which is every other day or everyday if the resident prefers. She revealed she was the CNA who last gave R35 a bath on 12/17/2025. She stated she cleaned R35's nails and knew they were long but confirmed she did not trim his nails or ask the wound nurse to trim his nails. Interview on 12/18/2025 at 12:20 pm with the wound care nurse revealed that she does not normally cut resident nails. She revealed that no one has recently asked her to trim any residents' nails including R35's but that she would do it if asked. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview during observation rounding on 12/18/2025 at 12:23 pm with the Director of Nursing (DON) confirmed R35's nails were long and had a black substance underneath the tips of the nails. She stated that CNAs should be cleaning nails on bath days, which is every other day and should trim nails when needed or everyday according to resident preferences. 2. A review of the electronic medical record (EMR) for R42 revealed the most recent Quarterly Minimum Data Set (MDS) dated [DATE] Section C (Cognitive Patterns) that R42 has a Brief Interview for Mental Status (BIMS) score of seven indicated severe cognitive impairment. Section I (Active Diagnosis) revealed diagnosis of but not all-inclusive amputation of right great toe, neuromuscular dysfunction of bladder, protein-calorie malnutrition, depression, urethritis, depressive disorder, stage four pressure ulcer of sacrum, type two diabetes mellitus. A review of the care plan dated 12/8/2025 revealed that R42 had a focus statement regarding activities of daily living (ADL) self-care performance deficit at risk of not having needs met in a timely manner. An observation and interview with R42 on 12/16/2025 at 9:29 am revealed that R42 had long and dirty fingernails. R42 was able to verbally express she did not want her nails that long and wanted them cut. An observation and interview with R42 on 12/17/2025 at 10:34 am revealed R42 fingernails remain long and dirty and she would like her fingernails cut. An observation and interview with Certified Nurse Assistant (CNA) BB confirmed that R42 had long and dirty fingernails. CNA BB stated that nurses and CNAs are responsible for cutting fingernails. An observation and interview with the Wound Care Nurse (WCN) on 12/18/2025 at 10:34 am revealed that R42's fingernails were long and dirty. She confirmed they need to be cleaned and cut. WCN stated the Certified Nurse Assistants are responsible for cutting residents' fingernails. An observation and interview with the Unit Manager on 12/18/2025 at 11:24 am confirmed that R42's fingernails were long and that R42 would like her fingernails cut. An interview with the DON on 12/18/2025 at 12:32 pm revealed that CNA staff are responsible for maintaining fingernails during bath time. She confirmed that there was no reason for R42's fingernails to be so long and dirty and that staff should have addressed R42's fingernails.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and review of policy titled, Controlled Substance Administration and Accountability, the facility failed to reconcile controlled narcotic medications for one resident (R) (R24) out of 40 sampled residents. This deficient practice had the potential to place residents at risk of clinical complications and drug diversion. Findings include:Review of the facility's policy titled, Controlled Substance Administration and Accountability dated 2024 documented: the facility promotes safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. Documented under General Protocols: (F) All controlled substances are accounted for obtained from a non-automated medication cart or cabinet are recorded on the designated usage form.the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record.A review of the most recent Quarterly Minimum Data Set (MDS) dated [DATE] for R24 revealed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) score of eight indicating moderate cognitive impairment. Section I (Active Diagnosis) revealed diagnoses of but not all-inclusive hypertension, renal insufficiency, multiple fractures of ribs, and motor vehicle accident.A review of care plan dated 11/20/2025 for R24 revealed there is no problem or interventions documented to address pain management or controlled medication use. A record review revealed that R24 had a physician order dated 12/5/2025 for tramadol HCL [hydrochloride] oral tablet 50mg (Milligrams) give one tablet by mouth every eight hours as needed [PRN] for pain.An observation and interview with Licensed Practical Nurse (LPN) DD on 12/17/2025 revealed that the narcotic count on the reconciliation form for R24 did not match the number of tablets remaining in the medication card. LPN DD stated that the night shift nurse told her during shift-to-shift report that she administered PRN medication at 12:30 am on 12/17/2025 to R24. The controlled substance form revealed that the last dose administered was 12/15/2025. LPN DD confirmed that there was no documentation of a dose administered during night shift in the narcotic control book, medication administration record (MAR), or progress note.An interview with the Unit Manager on 12/17/2025 at 3:56 pm revealed that the controlled substance count was wrong. The night shift LPN did not record the dose of tramadol on the narcotic log or MAR but wrote on shift-to-shift communication report that she gave the medication last night.An interview with the Director of Nursing (DON) on 12/17/2025 at 2:11 pm confirmed there was a narcotic discrepancy for the tramadol belonging to R24. She stated that pharmacy started the narcotic count sheet when the medication is delivered. She stated that each nurse on each shift must verify the count every shift. The nurses are to document the time they give a narcotic to a resident. When a count is wrong, they are to notify the DON and Administrator that the controlled substance count was wrong. She stated the oncoming nurse should not take the keys if the controlled substance count was wrong.An interview with the Administrator on 12/17/2025 at 2:20 pm confirmed there was a controlled substance discrepancy and that they consulted the pharmacist for next steps. An interview with the Pharmacist Consultant on 12/18/2025 at 11:54 am revealed that he was not notified of the narcotic discrepancy. He stated that the manifest (reconciliation form) was sent with the medication and each nurse is to document the administration of controlled medications.

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	12/19/2025

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, and facility policy titled, Medication Administration, the facility failed to ensure a medication error rate of less than five percent (%). A total of 36 medication opportunities were observed, with three errors for one resident (R) (R23) by one nurse giving medications resulting in an 8.33% medication error rate. This deficient practice has the potential to place residents at risk of clinical complications and diminished quality of life. Findings include:A review of the policy titled Medication Administration, dated 2025 documented the principles of medication administration include the right resident, right medication, right dosage, right route, right time, and right documentation. Review medication administration record (MAR) and compared to medication source (bubble pack, vial, etc.) with medication administration record (MAR) to verify resident name, medication name, form, dose, route, and time.A review of physician orders for R23 revealed:-Buspirone HCL [hydrochloride] oral table give 20mg [milligrams] by mouth three times a day for anxiety disorder.-Sertraline HCL oral tablet 100mg give two tablets by mouth one time a day related to major depressive disorder.-Sucralfate 1GM [gram] tablet give 1 [one] tablet by mouth two times a day related to gastro-esophageal reflux disease without esophagitis.A review of the medication card for R23 Sucralfate revealed special directions to give on an empty stomach.An observation of LPN GG on 12/17/2025 at 7:49 am during a medication pass revealed that R23 received sucralfate 1 GM tablet along with the other medications while eating breakfast. Additional observation revealed that buspirone HCL medication card contained 10mg tablets, the directions documented buspirone (anxiety medication) give 20 mg three times a day; R23 received one 10 mg tablet but should have received two tablets. Finally, during the same observation, R23 received one tablet of sertraline HCL 100mg, but should have received two tablets. An interview with LPN GG on 12/17/2025 at 10:57 am confirmed that R23 did not receive sucralfate on an empty stomach, received one tablet of 10mg buspirone, and one tablet of sertraline 100mg. LPN GG confirmed she did not administer the medications according to the MAR and medication card directions, which resulted in three errors.An interview with the Medical Director on 12/17/2025 11:42 am revealed residents should receive medication as ordered. He confirmed that R23 should have received two tablets, each of sertraline and buspirone. The expectation is that the nurses will follow the written orders listed on the MAR.An interview with the Pharmacist Consultant on 12/18/2025 at 11:54 am revealed that the nurse should have given two tablets each of sertraline and buspirone. He confirmed that the timing of the sucralfate should be on an empty stomachAn interview with the Director of Nursing (DON) on 12/18/2025 at 12:32 pm revealed that sucralfate was to be administered on an empty stomach. She confirmed the nurses are to administer medication the right way, right dose, right amount, right person, and right time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review and the facility policies titled, Infection Prevention and Control Program, Hand Hygiene, and Transmission Based Precautions, the facility failed to follow safe and appropriate infection control practices for two of five residents (R) (R 16 and R 31) reviewed for infection control and one room (room [ROOM NUMBER]) on one of three hallways observed for Transmission based precautions. These deficient practices have the potential to place residents and staff at risk for cross-contamination and the spread of infections.Findings include:Review of the facility policy titled, Infection Prevention and Control Program, dated 8/1/2025 documented under policy statement the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable disease and infections. In addition, regarding linens on page four documented solid linen shall be collected at the bedside and placed in linen bag .soiled linen shall not be kept in resident's room or bathroom.Review of the facility policy titled Hand Hygiene, dated 1/14/2025 documented that all staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations of the building. This includes after handling contaminated objections, between resident contacts, before applying and after removing personal protective equipment (PPE), including gloves.Review of the facility policy titled, Transmission Based precautions, dated 4/1/2024 documented the facility is to take appropriate precautions to prevent transmission of pathogen's mode of transmission. residents have a private room accommodation and will wear a fit tested N95 or higher-level respirator and other appropriate PPE while delivering care to the resident.1. An observation and interview on 12/16/2025 at 10:35 am revealed a Housekeeper (HK) KK applied a gown, gloves and surgical mask and entered room [ROOM NUMBER]. On the outside door was a sign reflecting the resident was under Airborne Precautions. An interview with HK KK confirmed she was wearing a gown, gloves, and surgical mask instead of the recommended N95 mask (mask rated to help protect against airborne organisms.)An observation of LPN DD on 12/16/2025 at 11:51 am revealed she donned a gown, gloves and surgical mask before entering room [ROOM NUMBER]. During the medication pass LPN DD left the room door open to the hallway while she prepared medications on the med cart located outside the room. The sign located on the outside part of the door read Airborne Precautions and to keep the door closed. LPN DD exited out the door of the adjoining room [ROOM NUMBER] creating potential contamination between the two rooms.An observation and interview of CNA JJ on 12/17/2025 at 8:18 am revealed CNA JJ entered room [ROOM NUMBER] wearing a gown, gloves, and a surgical mask. CNA JJ revealed that airborne precautions require mask, gown, and gloves and confirmed that she was wearing a surgical mask and should wear an N95 mask.An interview with UM on 12/17/2025 at 3:56 pm revealed the resident in room [ROOM NUMBER] was on transmission based Airborne Precautions related to chicken pox. UM stated airborne precautions mean the staff should keep door closed, good hand washing, dispose of items and wear a surgical mask, gloves, and gown. The UM stated she was unaware of the N95 mask requirement, until she reviewed the policy. An interview with Director of Nursing on 12/18/2025 at 12:32 pm revealed for the residents under airborne precautions, the staff must wear a gown, N95 mask, gloves and possibly a face shield. She confirmed the resident in 303 is considered a private room and the door should always remain closed. She confirmed staff should not be wearing surgical masks for airborne precautions. 2. An observation of Wound Care Nurse (WCN)/Infection Preventionist on 12/17/2025 at 8:40 am revealed that during wound care for R 31 she changed gloves without using hand sanitizer between glove changes. After completion of wound care for R31, she moved over to provide a dressing change to g-tube site for R16 who resided in the same room. She did not clean her hands after removing the gloves and did not change the gown. She changed gloves and did not disinfect (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands before applying new gauze around gastrostomy tube site.An interview with WCN/Infection Preventionist on 12/17/2025 at 9:10 am revealed she did not disinfect her hands between glove changes and between residents. She confirmed the hand sanitizer was not on the bedside table but across the room on the dresser. She confirmed the gown was not changed between residents and acknowledged it should have been changed.