STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115482	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossings at East Lake of Journey Llc, The	304 Fifth Avenue Decatur, GA 30030

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, staff and resident interviews, record reviews, and review of facility policies titled, Infection Prevention and Control Program, Infection Preventionist, and Enhanced Barrier Precautions, the facility failed to maintain an effective infection prevention and control program. Specifically, the facility failed to ensure staff consistently used the required Personal Protective Equipment (PPE) in accordance with Enhanced Barrier Precautions (EBP) protocols, failed to conduct required infection surveillance audits, and failed to demonstrate staff competency through completed infection control competency checkoffs. The deficient practices created the potential to contribute to the transmission of infectious organisms among residents, staff, and visitors.Findings Include:Review of the facility policy titled Infection Prevention and Control Program revised 3/20/2025, revealed under Policy Explanation and Compliance Guidelines: . 3. a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services. b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee. 16. a. All staff shall receive training . regarding the facility's infection prevention and control program, including policies and procedures. b. All staff shall demonstrate competence in relevant infection control practices. c. Direct care staff shall demonstrate competence in resident care procedures established by our facility.Review of the facility policy titled Infection Preventionist revised 2/1/2024 revealed under Policy Explanation and Compliance Guidelines: . 12. a. Develop and implement an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections in order to provide a safe, sanitary and comfortable environment. e. Oversight of resident care activities.Review of the facility policy titled Enhanced Barrier Precautions revised January 2026 revealed under Policy Explanation and Guidelines: . 1. a. All staff receive training on enhanced barrier precautions . and are expected to comply with all designated precautions. b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. 2. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: . i. Wounds and/or indwelling medical devices (e.g. feeding tubes .) .3. a. Make gowns and gloves available immediately outside the resident's room. d. The infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. 4. High-contact resident care activities include: . d. Providing hygiene. f. Changing briefs or assisting with toileting.Observation on 1/13/2026 at 3:19 pm revealed Certified Nursing Assistant (CNA) GG provided hygiene care including a brief change to R2 without adhering to required EBP protocols. Despite signage posted on the resident's door indicating required precautions and the availability of PPE outside the room, the CNA entered the resident's room without donning (putting on) a gown while providing direct care to a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115482	A. Building B. Wing	01/14/2026

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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	resident with multiple wounds and receiving tube feeding.Interview on 1/13/2026 at 3: 32 pm with CNA GG confirmed that she did not wear the required gown while providing care to R2. CNA GG stated that she believed the resident did not have a condition that required EBP precautions.Interview and record review conducted on 1/12/2026 at 11:17 am with the Infection Preventionist (IP) revealed the facility failed to maintain documentation of required infection control surveillance and staff competency validation. Specifically, the IP was unable to provide evidence of ongoing audits for critical infection prevention practices, including but not limited to hand hygiene compliance, proper use of PPE, and equipment cleaning and disinfection. The IP produced a total of nine Peri Care/Hand Washing Audit Tool forms completed during a single month of October 2025 for the previous 12 months and stated that no additional infection control audits had been conducted. The IP further stated that she had not been auditing staff and was not aware that routine surveillance auditing was required, questioning whether this was a new expectation. In addition, upon request, the IP was unable to produce any staff infection control competency checkoffs for the previous 12 months. No competency validation documentation related to hand hygiene, PPE use, or other infection prevention practices was provided by the Director of Nursing (DON).Interview on 1/14/2026 at 10:20 am with IP revealed that she expected staff to wear PPE when providing direct contact with a resident who was on EBP.Interview on 1/14/2026 at 10:44 am with the DON revealed that his expectation was for staff to follow established protocols for direct resident care and to use PPE as required. The DON stated that staff were expected to follow their training. The DON further stated that leadership conducted walk-throughs; however, no formal infection control audits were conducted, and no written audit documentation was maintained. The DON stated that CNA competencies were completed during orientation; however, when asked to produce documentation of CNA infection control competency checkoffs, the DON was unable to provide any records.