STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115502	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jasper Point of Journey LLC	618 Gennett Drive Jasper, GA 30143

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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 observations, staff interviews, record review, facility policy review, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to establish and maintain an infection prevention and control program (IPCP) for recording incidents of infections identified under the facility's IPCP, surveillance, tracking and trending, and the corrective actions taken by the facility and failed to ensure heavy duty gloves were available for the laundry room for 49 of 49 census residents. These failed practices had the potential to affect the 49 residents residing in the facility.Findings include:Review of a facility's policy titled, Laundry Handling & Processing Policy, dated 2/1/2025, indicated .Laundry in a healthcare facility may include bed sheets, blankets, towels' personal clothing' patient apparel, gowns, and other linens. The overall risk of disease transmission during the laundry process is low, infection has not been linked to laundry procedures in residential care facilities, even when consumer versions of detergents and laundry additives are used. Employees must don appropriate PPE [Personal Protective Equipment] (e.g., tear-resistant reusable gloves, gown/apron, and/or face shield/goggles) to sort personals prior to washing.Review of a facility's policy titled, Infection Prevention and Date Control Program, dated 3/20/2025, indicated .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.Review of a document titled, Centers for Disease Control (CDC).National Healthcare Safety Network (NHSN).Long Term Care Facility Component Tracking Infections in Long-Term Care Facilities., located at https://www.cdc.gov/nhsn/pdfs/ltc/ltcf-manual-508.pdf, dated January 2020, indicated .Surveillance is defined as the ongoing systematic collection, analysis, interpretation, and dissemination of data. A facility infection prevention and control (IPC) program should use surveillance to identify infections and monitor performance of practices to reduce infection risks among residents, staff, and visitors. Information collected during surveillance activities can be used to develop and track prevention priorities for the facility. When conducting surveillance, facilities should use clearly defined surveillance definitions that are collected in a consistent way. This method ensures accurate and comparable data regardless of who is performing surveillance.1. During an interview on 11/21/2025 at 1:26 pm, the Director of Nursing (DON) stated he was the current Infection Preventionist (IP). The DON stated he was in the process of completing September 2025 and October 2025 infection control surveillance. During this interview, a review was conducted of the data from February 2025 through August 2025 and the following data was missing: no surveillance, no tracking or trending, and no line listing of the residents who had current infections and the corrective action taken. The DON stated there was no evidence that IC audits were completed by the previous DONs. The DON stated it was important to have line listing of people who have infections and who were on antibiotics to ensure the residents were on the proper antibiotics and if corrective action needed to be taken. The DON stated that the facility needed a visual representation to look for trends and localizations of certain infections. The DON confirmed there was no surveillance data from February 2025 to August 2025 and confirmed there was no associated analysis. 2. An observation was conducted on 11/21/2025 at 1:53 pm, and there were no heavy-duty gloves available for the laundry (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room staff to use. The DON was present and confirmed this observation. During an interview on 11/21/2025 at 1:54 pm, the Accounts Manager for Laundry Services confirmed that there were no heavy-duty protective gloves present for the staff to utilize.During an interview on 11/21/2025 at 1:58 pm, Laundry Aide (LA) 1 confirmed she never used heavy-duty gloves when sorting soiled laundry and only utilized disposable gloves. During an interview on 11/21/2025 at 2:04 pm, the Accounts Manager stated it was important for staff to use the heavy-duty gloves while sorting soiled linens since it was a potential infection control matter and staff could get poked by a used needle.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident family member and staff interviews, and facility policy review, the facility failed to ensure personal information was kept confidential for one of one resident (Residents (R) 10) reviewed for privacy of 34 sample residents. This failure had the potential to cause emotional distress.Findings include:Review of a facility's undated policy titled, Your Rights and Protections as a Nursing Home Resident indicated .As a nursing home resident, you have certain rights and protection under Federal and state law that help ensure you get the care and services you need. You have the right to be informed, make your own decisions, and have your personal information kept private.Review of R10's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease.Review of R10's quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 8/29/2025 indicated the resident had a Brief Interview for Mental Status (BIMS) score of nine out of 15 which, revealed the resident was moderately cognitively impaired.During an observation conducted on 11/17/2025 at 10:30 pm, R10 was in bed. On the right side of her bed hanging from the wall was a document titled, Bowel and Bladder Record Data Collection Tool, dated 11/17/2025, which indicated the staff was collecting data on the resident for bowel and bladder cares.During an observation conducted on 11/18/2025 at 1:57 pm, the Bowel and Bladder Record Data Collection Tool, dated 11/18/2025, was hanging on the right side of R10's bed. R10 was sitting in her wheelchair. An interview was conducted with a Family Member (F1) during this observation. F1 stated the resident had church members who would visit her and this confidential information was posted for anyone to read. An attempt was made to interview R10, but it was not successful.During an interview on 11/19/2025 at 9:56 am, Certified Nurse Aide (CNA) 1 confirmed that the Bowel and Bladder Record Data Collection Tool was always kept on R10's wall next to her bed.During an interview on 11/21/2025 at 1:20 pm, the Administrator stated that it was his understanding that the Bowel and Bladder Record Data Collection Tool was in R10's side table drawer and not on the wall posted in the resident's room.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident family member and staff interviews, record review, and facility policy review, the facility failed to include proper reasons for a discharge/transfer for one of one resident (Resident (R) 10) reviewed for discharge of 34 sample residents. This had the potential for the resident to have significant stress. Findings include:Review of a facility's policy titled, Transfer and Discharge (including AMA [Against Medical Advice]), dated 3/20/2025 indicated .It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions.The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility.The safety of individuals in the facility is endangered due to the clinical or behavioral status of theResident.The health of individuals in the facility would otherwise be endangered.The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.The facility ceases to operate.Review of R10's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease.Review of R10's quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 8/29/2025 indicated the resident had a Brief Interview for Mental Status (BIMS) score of nine out of 15, which revealed the resident was moderately cognitively impaired.Review of an untitled document, provided by the facility, referred to as an involuntary transfer/discharge notice, dated 10/22/2025 and sent to R10's Family Member (F) 1. The letter revealed .Due to concerns that have been addressed by the facility but have not been deemed acceptable by the Responsible Party. These events have caused the need for this 30-Day Notice to transfer or discharge.A review of R10's EMR failed to contain evidence that the facility staff were unable to provide care for the resident. In addition, the clinical records failed to indicate that the resident was a danger to self or to others.During an interview on 11/18/2025 at 1:49 pm, F1 stated he was aware the reasons for the involuntary transfer/discharge notice were inappropriate and had currently appealed the facility's decision.During an interview on 11/21/2025 at 1:20 pm, the Administrator confirmed R10 was not a danger to self or to others and this was an oversight on the transfer/discharge requirements.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interviews, record review, and facility policy review, the facility failed to ensure a resident and Resident Representative (RR) received a written transfer agreement and bed hold notice for one (Resident (R)59) out of two reviewed for transfers from a sample of 34 residents. This failure had the potential to affect the resident and their RR by not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired, and contribute to the possibility of denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital.Findings include:Review of facility's policy titled, Transfer and Discharge (including AMA) dated 3/20/2025 indicated, 3. The facility's transfer/ discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge; b. The effective date of transfer or discharge; c. The specific location (such as the name of the new provider or description and/ or address if the location is a residence) to which the resident is to be transferred or discharged .Review of the facility's undated policy titled, Bed Hold Policy indicated, Regardless of a resident's payer status, you are required to notify all long-term resident and/ or family in advance with a bed hold notice . If necessary, you may document a conversation with family by phone using name, date, time, and details of conversation on bed hold form. You must still mail out the bed hold.Review of R59's Progress Notes located under the Prog Note tab in the Electronic Medical Record (EMR) dated 2/1/2025 at 3:40 pm revealed the resident was transported to the emergency room.Review of R59's EMR revealed no documentation that R59 or the RR was provided the transfer notice or bed hold policy for the hospital transfer dated 2/1/2025. An interview on 11/21/2025 at 3:31 pm with the Social Services Director (SSD) revealed she was unable to locate the transfer notice/ bed hold notice for the resident's transfer to the hospital on 2/1/2025.An interview on 11/21/2025 at 3:45 pm with the Administrator revealed the facility sent the transfer notice to the hospital and social services called the RR.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interviews, the facility failed to ensure the comprehensive assessment accurately reflected a facility fall for one (Resident (R) 4) of two residents reviewed for falls in the sample of 34 residents. This failure had the potential for unmet care needs.Findings include:Review of R4's admission Record located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses of muscle weakness, difficulty walking, and a need for assistance with personal care.Review of R4's hospital After Visit Summary paperwork located under the Misc tab of the EMR dated 7/3/2025 revealed the resident had a fall resulting in a contusion of left shoulder and a closed head injury.Review of R4's Care Plan located under the Care Plan tab of the EMR revealed the resident was at risk for falls or fall related injury related to having impaired mobility. On 7/3/2025, the Care Plan revealed the resident had a fall. Staff were educated/reeducated on proper procedure when using a Hoyer lift (mechanical lift), date initiated 7/3/2025.Review of R4's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 8/15/2025 revealed the resident did not have any falls. During an interview with R4 on 11/18/2025 at 10:57 am, she confirmed she had a fall from the mechanical lift and was sent to the emergency room.During an interview on 11/21/2025 at 1:05 pm with the Regional Minimum Date Set Coordinator (MDSC) she confirmed R4's fall on 7/3/2025 should have been documented on her quarterly MDS with an ARD of 8/15/2025 to ensure accuracy.

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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, staff interviews, record review, and facility policy review, the facility failed to ensure residents' care plans reflected current level of care for two of 34 sample residents (Resident (R) 4 and R54) reviewed for care plans. This failure had the potential to affect resident care outcomes. Findings include:Review of the policy titled, Comprehensive Care Plans, dated 3/20/2025, revealed, It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs.1.Review of R4's admission Record located under the Profile tab of the electronic medical record (EMR) the resident was admitted to the facility on [DATE] with a diagnosis of Post Traumatic Stress Disorder (PTSD) and bipolar disorder.Review of Resident 4's Progress Notes located under the Prog Note tab in the EMR revealed on 2/26/2025 the resident had trauma screening conducted that indicated PTSD and bipolar disorder.Review of Resident 4's Care Plan located under the Care Plan tab of the EMR did not document PTSD or bipolar disorder.Review of Resident 4's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 8/15/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R4 was cognitively intact. The MDS further revealed R4 sometimes self-isolated. Diagnoses revealed bipolar disorder and PTSD.During an interview with the Regional Minimum Data Set Coordinator (MDSC) on 11/21/2025 at 1:05 pm, the MDSC confirmed R4 should have been care planned for PTSD and bipolar disorder so there would be interventions in place if issues were to arise from the diagnoses. 2.Review of R54's admission Record located in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with anxiety disorder and depression. The record also revealed he was diagnosed with psychotic disorder with hallucinations on 5/13/2025.Review of R54's significant change of condition Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 8/18/2025 and located in the MDS tab of the EMR, revealed a Staff Assessment for Mental Status (SAMS), which indicated short- and long-term memory problems. The MDS also indicated R54 had diagnosis of anxiety disorder, depression, and psychotic disorder. Review of R54's Care Plan, revealed there were no care plans addressing R54's diagnosis of major depressive disorder or psychotic disorder with hallucinations. During an interview on 11/21/2025 at 1:05 pm, the Regional MDSC stated there should be care plans for major depressive disorder and psychotic disorder. The care plan gives staff directions when behaviors are exhibited.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and facility policy review, the facility failed to ensure one (Resident (R)4) out of four reviewed for accidents out of a total sample of 34 residents was properly secured during a Hoyer lift (mechanical lift) transfer and sustained a fall. This had the potential for the resident to sustain serious injury. Findings include:Review of a facility's policy titled, Accidents and Supervision, dated 2/1/2024, indicated . The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.Identifying hazard(s) and risk(s).Evaluating and analyzing hazard(s) and risk(s).Implementing interventions to reduce hazard(s) and risk(s).Monitoring for effectiveness and modifying interventions when necessary.Review of R4's admission Record located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses of muscle weakness, difficulty walking, and a need for assistance with personal care.Review of R4's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an assessment reference date (ARD) of 8/15/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. The MDS noted that R4 was dependent on staff for transferring.Review of R4's Progress Notes located under the Prog Note tab of the EMR dated 7/3/2025 at 12:30 pm revealed the resident had a fall from a mechanical (Hoyer) lift.Review of R4's hospital after visit summary paperwork located in the EMR under the Misc tab dated 7/3/2025 revealed the resident had a fall resulting in a contusion of left shoulder and a closed head injury. There resident was not admitted to the hospital and no new orders were received. Review of R4's Care Plan located under the Care Plan tab of the EMR revealed the resident was at risk for falls or fall related to having impaired mobility. The Care Plan noted the resident had a fall on 7/3/2025 and staff was educated/reeducated on proper procedure when using Hoyer lift, date initiated 7/3/2025.During an interview with R4 on 11/18/2025 at 10:57 am, she confirmed she had fallen from the mechanical lift and was sent to the emergency room.During an interview with Administrator on 11/21/2025 at 3:45 pm, the Administrator confirmed the resident had fallen from a mechanical lift that was being operated by one staff member and two staff members should have been present. The Administrator confirmed staff were educated and trained on the proper use of the mechanical lift and that the Certified Nursing Assistant (CNA) involved was suspended for three days and retrained.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, record review, and facility policy review, the facility failed to provide respiratory care in accordance with professional standards for one of one (Resident (R) 21) residents reviewed for respiratory care out of a total sample of 34 residents. Specifically, respiratory equipment, such as nebulizer masks, were not stored in a sanitary manner and physician orders for oxygen levels were not followed. The deficient practice had the potential for a risk of infection and respiratory distress. Findings include:Review of facility's policy titled, Oxygen Administration with a revision date of 2/14/2024, noted Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Policy Explanation and Compliance Guidelines Oxygen is administered under orders of a physician.Staff shall perform hand hygiene and don (put on) gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include. keep delivery devices covered in plastic bag when not in use.Review of facility's policy titled, Oxygen Concentrator with a revision date of 2/16/2025, noted Policy: The purpose of this policy is to establish responsibilities for the care and use of oxygen concentrators. Policy Explanation and Compliance Guidelines:.Oxygen is administered under orders of the attending physician. Use of the concentrator: The nurse shall verify physician's order for the rate of flow and route of administration of oxygen (mask, nasal cannula, etc.) . Keep turned off when set up for use in the resident's room, but not actively in use.Review of R21s admission Record located in the electronic medical record (EMR) under the Profile tab revealed R21 was admitted on [DATE] with a diagnoses of chronic obstructive pulmonary disease (COPD), respiratory failure with low oxygen (hypoxia), chronic cough, and bronchitis.Review of R21s quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/30/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R21 was cognitively intact. Special Treatments, Procedures, and Programs revealed oxygen therapy.Review of R21s Care Plan located in the EMR under the Care Plan tab revealedR21 had a potential at risk for altered respiratory status related to her diagnoses of COPD, and respiratory failure, date initiated 6/15/2024. Oxygen as ordered, date initiated 6/15/2024.Give nebulizer treatments as ordered, date initiated: 6/15/2024. Oxygen as needed (PRN). R21 used oxygen therapy routinely or as needed and is at risk for ineffective gas exchange. This is related to her diagnosis. of COPD, date initiated 8/8/2024. Administer oxygen therapy per physician's orders, date initiated: 8/8/2024.Review of R21s Physician Orders located in the EMR under the Orders tab revealed keep nebulizer mask stored in a clean storage bag at all times every shift. Start date 8/06/2024. 2 (liters) L Oxygen (as needed) PRN through nasal cannula as needed for hypoxia oxygen saturation below 90% Start Date 9/2/2024. Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams (MG)/3 milliliter (ML) 3 ml inhale orally every six hours as needed for SOB [shortness of breath] Start date 1/15/2025.During an observation on 11/18/2025 at 10:34 am, R21 was in her room observed with oxygen at three liters per minute (LPM) through nasal cannula. R21 had a nebulizer mask sitting on the bedside table not in a storage bag.During an observation on 11/18/2025 at 3:38 pm, R21 was sitting in bed with oxygen through nasal cannula running at three LPM. R21's nebulizer mask was sitting on the bedside table not in a storage bag.During an observation on 11/19/2025 at 1:40 pm, revealed R21's nebulizer mask was sitting on bedside table not in storage bag.During an interview on 11/21/2025 at 1:39 pm, Assistant Director of Nursing (ADON), at R21's bedside, confirmed the resident's oxygen was set on three liters, and the nebulizer was not in a storage bag.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the clinical records were complete for one of three residents (Resident (R) 10) reviewed for pressure ulcers out of a total sample of 34 residents. This failure created the opportunity for inaccurate medical records to be accessible to staff.Findings include:Review of a facility's policy titled, Verbal Orders, dated 2/14/2024, indicated .Physician orders may be received by telephone, by a licensed nurse or other licensed or registered healthcare specialist who are legally authorized to do so.Review of R10's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease.Review of R10's EMR quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 8/29/2025 indicated the resident had a Brief Interview for Mental Status (BIMS) score of nine out of 15, which revealed the resident was moderately cognitively impaired.Review of a document provided by hospice titled, Patient Care Verbal Order, dated 9/8/2025, indicated .For Pressure Wound: Using aseptic technique perform wound care to coccyx. Remove old dressings from wound then cleanse wound with wound cleanser. [or normal saline] .Gently pat wound dry. Apply skin prep to intact skin surrounding wound. Pack wound with gauze packing. Cover wound with comfort foam dressing. Redress wound 7 x per week. May redress wound as needed for displacement or if dressings are soiled. Perform for duration of end-of-life-care or until healed. As directed. Review of R10's EMR titled Treatment Administration Record (TAR) located under the Orders tab for September 2025 failed to contain evidence that the hospice wound care orders were transcribed correctly. The September 2025 TAR indicated .Sacral wound clean with wound cleanser, fill wound bed with kerlix soaked in wound cleanser and xeroform cover with sacral pad. Daily/PRN [as needed] until resolved.Review of R10's EMR titled TAR located under the Orders tab for October 2025 failed to contain evidence that the hospice wound care orders were transcribed correctly. The 10/25 TAR indicated .Sacral wound clean with wound cleanser, fill wound bed with kerlix soaked in wound cleanser and xeroform cover with sacral pad. Daily/PRN until resolved every day.Review of R10's EMR titled TAR located under the Orders tab for November 2025 failed to contain evidence that the hospice wound care orders were transcribed correctly. The November 2025 TAR indicated .Sacral wound clean with wound cleanser, fill wound bed with kerlix soaked in wound cleanser and xeroform cover with sacral pad. Daily/PRN until resolved every day shift for wound healing.Review of R10's EMR titled Physician Orders located under the Orders tab, dated 11/4/2025, indicated to clean the resident's sacral wound with wound cleanser, fill wound bed with kerlix soaked in wound cleanser and xeroform cover with sacral pad and as needed if loose or soiled.Review of R10's EMR titled Physician Orders located under the Orders tab, dated 11/5/2025, indicated that hospice was to provide wound care by cleaning the resident's sacral wound with wound cleanser, to fill wound bed with kerlix soaked in wound cleanser and apply xeroform with sacral pad daily until resolved.During an interview conducted on 11/21/2025 at 3:59 , the [NAME] President (VP) of Clinical Services confirmed that R10's treatment order was transcribed incorrectly and that the order came through as a verbal order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115502	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jasper Point of Journey LLC	618 Gennett Drive Jasper, GA 30143

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to offer one of five residents (Resident (R) 26) reviewed for flu/pneumonia vaccinations out of 34 sample residents and/or their representatives the opportunity for the residents to be vaccinated in accordance with nationally recognized standards. In addition, the facility failed to have an acute policy displaying the CDC's recommendation. This practice had the potential to increase the risk for residents to contract pneumonia.Findings include:Review of a facility's policy titled, Infection Prevention and Control Program, dated 3/20/2025, indicated .Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere.Review of R26's electronic medical record (EMR) titled, admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of his admission.Review of R26's EMR titled, Immunizations located under the Immun (Immunization) tab indicated the resident had Pneumovax 23 [pneumococcal polysaccharide (PPSV23)] on 1/27/2010.Review of a document provided by the facility titled, admission Packet contained a document titled, Informed Consent for Pneumococcal Vaccine, indicated .The Advisory committee on Immunization Practice recommends two pneumococcal vaccines for adults [AGE] years of age or older' it is recommended that adults 65 or older receive a dose of the pneumococcal conjugate (PCV13) and the pneumococcal polysaccharide (PPSV23) for the best protection against pneumococcal disease.If you are 65 or older and have NOT had a pneumonia vaccine, you should receive one dose of PCV13 now, and in one year get a dose of PPSV23. If you have had a pneumococcal vaccine after the age of 65, then you received the PPSV23, and should receive a dose of PCVl3 at least one year after your last dose of PPSV23.During an interview on 11/21/2025 at 1:26 pm, the Director of Nursing (DON) confirmed he was not aware of the current CDC pneumococcal vaccinations. The DON stated it was important to have an accurate policy on vaccinations to ensure the staff provided the most accurate information to residents and/or their representatives.