STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Manor, Incorporated	2455 Oak Grove Church Road Carrollton, GA 30117

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and facility policy review, the facility failed to develop a documented water management plan that included an assessment to identify where Legionella and other waterborne pathogens could grow and spread and what control measures were in place, and the facility failed to implement a program of enhanced barrier precautions (EBP) to assist in the prevention of cross contamination for residents with areas of risk. Specifically, appropriate personal protective equipment (PPE) was not worn for one resident (Resident (R) 3) during high contact care, hand hygiene was not performed during a tube feeding for R28, and signage on the door for R88 was not clear as to the procedures for contact isolation for visitors. These failures had the potential to affect all residents in the facility. Findings include: 1. During an interview on 04/23/26 at 8:55 AM, the Administrator advised that the facility did not have a Legionella water program. During an interview on 04/25/26 at 3:34 PM, the Maintenance Supervisor (MS) stated he had not been aware of the requirement for a Legionella water program. During an interview on 04/25/26 at 1:48 PM, the Administrator stated that an expectation was that the facility would be doing the water program. Review of the facility policy titled Legionella Water Management Program, revised September 2022, revealed: Policy Statement, Our facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team.2. The water management team consists of at least the following personnel:a. The infection preventionist;b. The administrator;c. The medical director (or designee);d. The director of maintenance; ande. The director of environmental services.3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease.4. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program.5. The water management program includes the following elements:a. An interdisciplinary water management team (see above);b. A detailed description and diagram of the water system in the facility, including the following:(1) Receiving;(2) Cold water distribution;(3) Heating;(4) Hot water distribution; and(5) Waste.c. The identification of areas in the water system that could encourage the growth and spread ofLegionella or other waterborne bacteria, including the (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: 115638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2026
NAME OF PROVIDER OR SUPPLIER Carrollton Manor, Incorporated		STREET ADDRESS, CITY, STATE, ZIP CODE 2455 Oak Grove Church Road Carrollton, GA 30117	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	following:(1) Storage tanks;(2) Water heaters;(3) Filters;(4) Aerators;(5) Showerheads and hoses;(6) Misters, atomizers, air washers, and humidifiers;(7) Hot tubs;(8) Fountains; and(9) Medical devices such as CPAP machines, hydrotherapy equipment, etc.d. The identification of situations that can lead to Legionella growth, such as:(1) construction;(2) water main breaks;(3) changes in municipal water quality;(4) the presence of biofilm, stale, or sediment;(5) water temperature fluctuations;(6) water pressure changes;(7) water stagnation; and(8) inadequate disinfection.e. Specific measures used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants);f. The control limits or parameters that are acceptable and that are monitored;g. A diagram of where control measures are applied;h. A system to monitor control limits and the effectiveness of control measures;i. A plan for when control limits are not met and/or control measures are not effective; andj. Documentation of the program.6. The water management program is reviewed at least once a year, or sooner if any of the following occur:a. The control limits are consistently not met;b. There is a major maintenance or water service change;c. There are any disease cases associated with the water system; ord. There are changes in laws, regulations, standards or guidelines. 2. Review of R3's admission Record, dated 04/25/26 and located in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease, urinary obstruction, and emphysema. Review of R3's comprehensive care plan, dated 02/09/26 and found in the EMR under the Care Plan tab, revealed the resident had an indwelling urinary catheter in place, but did not address EBP related to the catheter. Review of R3's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/23/26 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated R3 had an indwelling urinary catheter in place at the time of the assessment. Review of R3's Physician's Order Report, found in the EMR under the Orders tab, revealed an order dated 04/23/26 for the resident's use of an indwelling urinary catheter size 16 French with a 10 cubic centimeter (cc) bulb. There was no order in the record for R3 to be on EBP related to his catheter. During an observation on 04/24/26 at 9:12 AM, Certified Nurse Aide (CNA) 14 provided catheter-related care to R3 in his room. There was no signage on R3's door or in his room to indicate he was to be on EBPs, and no PPE, such as gowns, gloves, or masks, was in the area of R3's room. CNA14 wore gloves while providing direct care related to R3's catheter, including emptying urine from the catheter to discard in the resident's toilet. CNA14 did not wear a gown during the duration of the observation. During an interview with CNA14 on 04/24/26 at 9:20 AM, she stated she had not heard of EBP and did not know whether R3 was supposed to be on EBP or not. She stated she always wore gloves when providing catheter care to the resident, but never put on a gown while providing his care. During an interview with CNA16 on 04/24/26 at 9:24 AM, she confirmed she worked regularly with R3 and was aware of the resident's catheter. She incorrectly indicated residents in the facility on Transmission-Based Precautions (TBP) were on EBP and stated there was no one on the unit on which R3 lived who required EBPs. She stated she wore gloves while providing care to the residents on the unit, including R3, but did not wear a gown. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Carrollton Manor, Incorporated		STREET ADDRESS, CITY, STATE, ZIP CODE: 2455 Oak Grove Church Road Carrollton, GA 30117	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Housekeeper (HSK) 1 on 04/24/26 at 9:32 AM, she confirmed she did most of the cleaning on R3's hallway, including making beds, cleaning bathrooms, and general cleaning of high-touch areas. She stated she did not know what EBP was. She stated she always wore gloves while cleaning residents' rooms, and she changed the gloves each time she left a room; however, she did not wear a gown when cleaning any of the rooms in the hallway. During an interview with the Director of Nursing (DON) on 04/24/26 at 4:14 PM, he stated the facility had attempted to roll out EBP at some point last October or November, he thought, but that administration had become sidetracked with something else, and EBP had not been completely rolled out in the facility. He stated that signs were supposed to be placed on the doors of residents on EBP, and that a shelf was supposed to be in each room with PPE on it to indicate when a staff member was required to wear a gown or mask. The DON stated that facility staff should follow EBP, and the facility would work to roll out the process. 3. Review of R28's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] with diagnoses including vascular dementia and anoxic brain damage. Review of R29's Care Plan dated 04/10/26 and located under the Care Plan tab of the EMR revealed, The resident requires tube feeding for nutrition/hydration. The approaches included providing tube feeding as ordered and checking the tube for placement and residual. Review of R28's EMR under the Orders tab revealed a physician's order, dated 04/21/26, for Diabetisource 1.2 tube feeding to be administered continuously for 20 hours at 60 milliliters per hour. During an observation on 04/23/26 at 10:27 AM in R28's room, Licensed Practical Nurse (LPN) 6 was observed as she initiated the tube feeding. She donned gloves upon entering the room, but did not don a gown. She then closed the door and pulled the curtain closed, uncovered R28's feeding tube, and repositioned R28, using the same gloved hands. She then touched her hair to brush it out of the way and began to turn on the feeding tube pump. Using the same gloved hands, she touched her hair to move it out of the way again and then used a syringe to inject air through the feeding tube and also to check the residual stomach contents. LPN6 then touched her hair again before she hooked up the feeding tube to the pump. She then doffed her gloves and used hand sanitizer. During an interview on 04/23/26 at 10:40 AM, LPN6 stated she did not notice that she had touched her hair while initiating the tube feeding and stated, I have to be careful; I can't go home and wash this hair. She added that she should have changed her gloves after touching her hair before providing resident care. She also stated she did not know what EBP was, but was never told to wear a gown when providing care for feeding tubes. During an interview on 04/25/26 at 10:17 AM, LPN2 stated staff should follow EBP and wear gowns and gloves when providing care for a feeding tube. During an interview on 04/25/26 at 6:01 PM, the Infection Preventionist (IP) stated nursing staff were expected to keep their hair back as part of the uniform. They should not touch their hair while providing care, but if they do, they should doff their gloves, sanitize their hands, and don a new pair of gloves. The IP stated LPN2 should have used a gown when initiating the tube feeding for R28. The facility's Enhanced Barrier Precautions Policy, revised December 2024, revealed, 1. Enhanced (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Barrier Precautions (EBPs) refer to infection prevention and control interventions designed to reduce transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities . apply when: b. A resident is NOT known to be infected or colonized with any MDRO, HAS a wound or indwelling medical devices, and DOES NOT have secretions that are unable to be covered or contained; and c. Contact precautions do not apply . Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies . EBPs imply targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply . Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: . g. changing linens h. prolonged high contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc and j. wound care (any open skin requiring a dressing. 4. Review of R88's admission MDS with an ARD of 03/23/26 located in the EMR revealed a facility admission date of 03/16/26 with medical diagnoses of atrial fibrillation, renal insufficiency, and respiratory failure. The resident was discharged from the facility on 04/22/26. Review of R88's EMR under the Miscellaneous tab revealed a positive urine culture on 04/01/26 and a subsequent positive Clostridium difficile (C. diff/bacterium causing severe, often antibiotic-associated diarrhea) culture on 04/14/26. During an observation on 04/21/26 at 10:58 AM, R88 was observed lying in bed with his door partially opened. There was a sign on the door indicating the resident was in isolation. There was no information to direct visitors on the precautions to take or to seek guidance from a staff member. During an interview on 04/25/26 at 12:34 PM regarding the lack of EBP for residents with risk, the IP responded, We ordered these caddies [for PPE], only had a certain number - put in room appropriate at the time for EBP, such as an IV [intravenous catheter], peg [gastrostomy] tube, foley [indwelling urinary catheter], urostomies, and wounds. If you're having to go in and change a draining wound, you should have on gowns/gloves. I've told the wound care nurses, Certified Nursing Assistant's (CNAs), and the nurses. Regarding residents on other isolation, such as contact isolation and how visitors would be advised of the need for personal protective equipment (PPE), the IP confirmed there is nothing for visitors to be directed to the nurse as the State had told us we couldn't have anything like that. When asked how visitors would know to wear PPE, the IP did not have an answer and confirmed if PPE were in a box in the room or hanging on the door and the door was open, a visitor would have no clue.

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	115638	A. Building B. Wing	04/25/2026

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on facility document review, staff interview, and facility policy review, the facility failed to ensure an antibiotic stewardship program was developed and implemented. This failure had the potential to increase the risk of adverse events, including the development of antibiotic-resistant organisms (commonly called superbugs) from unnecessary or inappropriate antibiotic use for all 86 residents currently residing in the facility. Findings include: Review of the last three months of tracking/trending infections document provided by the facility revealed there was no documentation of whether an infection met any defined criteria for infection and antibiotic treatment, or if the antibiotic prescribed was effective for any identified organisms. During an interview on 04/25/26 at 11:42 AM, the Infection Preventionist (IP) stated he was in charge of the antibiotic stewardship program, but did not receive a monthly report of antibiotic use and just found out last week during a training that the facility should be using McGeers criteria (standardized surveillance definitions used to identify and track infections). The IP stated, Up until now, that I'm aware of, [determination of] infections were not based on any national criteria, just the nurse documenting [for example] saying foul smelling urine, confusion, and dysuria or frequency. When asked about if antibiotic stewardship program was being used, the IP responded, We do; when I see someone is being talked about with confusion, I ensure they are being changed every two hours. Again, I don't know; there is a specific place to document that the resident was on an appropriate antibiotic. Currently, there is no place on the tracking/trending that notes if the antibiotic was appropriate or if an infection did or did not meet a criteria for infection. During an interview on 04/25/26 at 1:48 PM, the Administrator stated an expectation is that the antibiotic stewardship program had been instituted. Review of the facility policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised December 2016, revealed:Policy StatementAntibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.Policy Interpretation and Implementation1. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee.2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics.a. Therapy may require further review and possible changes if:(1) the organism is not susceptible to antibiotic chosen;(2) the organism is susceptible to narrower spectrum antibiotic;(3) therapy was ordered for prolonged surgical prophylaxis; or(4) therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics.3. At the conclusion of the review, the provider will be notified of the review findings.4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include:a. resident name and medical record number;b. unit and room number;c. date symptoms appeared;d. name of antibiotic (see approved surveillance list);e. start date of antibiotic;f. pathogen identified (see approved surveillance list);g. site of infection;h. date of culture;i. stop date;j. total days of therapy;k. outcome; andl. adverse events.