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	08/20/2025

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 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. Based on observation, staff interviews, record review, and facility policy review, the facility failed to implement the Care Plan related to a mechanical lift transfer for one of three residents (Resident (R)7) reviewed for mechanical lift transfers in a total sample of 14 residents. The deficient practice placed the residents at risk of harm due to the inappropriate transfers.Findings include:Review of the facility policy titled, Comprehensive Care Plans, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.Review of the 4/30/2025 Activities of Daily Living Care Plan located in the Care Plan tab of the EMR revealed, Use Mechanical Lift for transfers x2 staff assistance.Review of the facility investigation dated 6/17/2025 revealed, CNA [certified nurse aide] stated that during transfer from wheelchair to bed, the resident slid to the floor. R7 stated, It was because I had on these socks. R7 denied hitting his head and denied any pain. Resident stated, while laughing, I slid off the bed when she was trying to put me in bed because of the socks on me.I'm okay, I slid down on my butt.During an interview on 8/18/2025 at 3:12 pm, the Director of Nursing (DON) was asked if CNA4 transferred R7 without the mechanical lift and another staff person. The DON stated, Yes, but I think this was updated after the fall. The DON was told that the mechanical lift intervention with two staff was on the care plan at the time of admission. The DON stated, Ok.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, staff interviews, and record review, the facility failed to follow nutrition orders for one of three residents (Resident (R)5) reviewed who received nutrition via a feeding tube. This failure placed R5 at risk for health complications and weight loss.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R5 was readmitted to the facility with a diagnosis of spastic quadriplegia cerebral palsy (a severe form of cerebral palsy that affects all four limbs and the trunk).Review of the revised 9/4/2023 Feeding Tube Care Plan located in the Care Plan tab of the EMR revealed, R5 is receiving fluids and nutrients via a tube secondary to Dysphagia Swallowing [difficulty swallowing] problem.Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 6/17/2025 revealed that R5 had a both a gastrostomy tube (feeding tube in the stomach) and a jejunostomy tube (feeding tube in the jejunum which is part of the small intestine) for nutrition. She was assessed as being severely cognitively impaired.Review of an Order Summary dated 7/10/2025 located in the EMR under the Orders tab by the Registered Dietician (RD) revealed, Every 24 hours for nutrition Osmolyte 1.5 Continuous: Give formula at 32ml/hour (milliliters per hour) via j-tube [jejunostomy]. In addition, R5 was to have a one hour stop time for staff to check for residual [to see if there was formula that had not been digested].During an observation on 8/18/2025 at 2:15 PM, R5's tube feeding pump was turned off and the feeding tube was disconnected from the pump however, the container of Osmolyte 1.5 was still hanging on the pole. Licensed Practical Nurse (LPN)3 entered the room with a new container of Osmolyte 1.5 and began to hang the container on the pole. LPN3 was asked how long was R5 to have her feeding tube pump off during the day. LPN3 stated, It's off from 10:00 AM to 2:00 PM each day.During an interview on 8/20/2025 at 2:15 PM, the [NAME] President (VP) for Nutrition was asked if R5 was to have her tube feedings held from 10:00 AM to 2:00 PM per the nurse's statement. The VP stated, The only order I have is for her to have the tube feedings held for one hour and then check for residuals. The VP further stated, I think she (RD) mentioned at one point there was a 10-2PM hold on the tube feedings, when she returned from the hospital however, we did not have Osmolyte 1.2 and only had Osmolyte 1.5, so she converted the Osmolyte 1.5 to meet the same nutrition values as the Osmolyte 1.2. The RD wanted it to be run continuously at 32ml/hour as R5 experiences vomiting.During an interview on 8/20/2025 at 2:25 PM, LPN4 stated, I wrote the order (for the tube feedings) when she came back from the hospital. She had an order for Osmolyte 1.2, but we only had Osmolyte 1.5 so, the RD came in and wrote a new order for Osmolyte 1.5 at 32ml/hour continuously.Review of the Discontinued Orders located in the Order Summary tab of the EMR revealed, Jevity 1.5 at 55ml/hr. for 20 hours a day. On at 2PM and off at 10AM. Start date: 10/16/2024 and discontinued on 7/1/2025.During an interview on 8/20/2025 at 2:36 PM, the Director of Nursing (DON) was asked what his expectation was regarding following the RD's nutrition orders. The DON stated, My expectation is that the orders are to be followed.

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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. Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for two of 14 sampled residents (Residents (R) 5 and R9). The facility failed to utilize EBP for R5 and R9, who shared a room and had both gastric and jejunostomy feeding tubes for nutrition. This failure placed the residents at risk of increased transmission of infection.Findings include:1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R5 was admitted to the facility with a diagnosis of spastic quadriplegic cerebral palsy (a severe form of cerebral palsy).Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 6/17/2025 revealed R5 was assessed by staff to be severely impaired in cognition and had a feeding tube for nutrition.Review of the Feeding Tube Care Plan revised 9/4/2023 located in the Care Plan tab of the EMR revealed, R5 is receiving fluids and nutrients via a tube secondary to dysphagia, swallowing problem. An 11/3/2024 Intervention included, Enhanced Barrier Precautions.During an observation and interview on 8/19/2025 at 2:38 PM, Registered Nurse (RN)1 entered R5's room and provided oral care. RN1 did not wear a gown when providing resident care. RN1 confirmed she did not utilize EBP.2. Review of the admission Record located in Profile tab of the EMR revealed R9 was admitted to the facility with a diagnosis of cerebral palsy.Review of the annual MDS located in the MDS tab of the EMR with an ARD of 6/5/2025 revealed R9 was assessed by staff to be severely impaired in cognition and was provided nutrition through a feeding tube.Review of the Feeding Tube Care Plan revised 9/26/2023, located in the Care Plan tab of the EMR revealed, R9 is receiving all fluids and/or nutrients via a tube secondary to dysphagia, DZ [disease] process. An 11/3/2024 intervention included Enhanced Barrier Precautions.During an observation and interview on 8/19/2025 at 2:43 PM, CNA7, after finishing washing R5's face, obtained a new washcloth and provided care to R9. CNA7 stated, I was not made aware of the need for EBP when caring for R5 or R9. During an interview on 8/19/2025 at 4:30 PM, the Director of Nursing (DON) stated, There should have been a sign on the door and staff should have utilized the PPE [personal protective equipment.]