

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Sandy Springs Center for Nursing and Healing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 S Johnson Ferry Road Atlanta, GA 30319	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observations, staff and resident representative interviews, record reviews and review of the facility's policy titled, Housekeeping Guidelines, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, clean, comfortable and homelike environment for residents. Findings include:</p> <p>During review of the facility's policy document titled, Housekeeping Guidelines, Daily Resident/Patient Room Cleaning, undated, revealed, The room cleaning tasks should be performed in the following order: 1. Straighten up the residence room. 2. Dust all flat surfaces with a cloth and disinfectant, clean the air vent covers, and spot clean all necessary areas. 3. Dust mop the floor and sweep all trash and debris to the door and pick it with the dustbin. 4. Empty and clean the trash cans and put in a new liner if necessary. 5. Wet mop the room using disinfectant, ensuring A caution floor sign is in use.</p> <p>During the initial observations of the facility on 12/15/2025 at 11:15 am, all units toured had a lingering foul odor noted. The flooring on the East and [NAME] units revealed stains and spills with trash on the floors. Residents' rooms were observed with large stains and spills. The Terrace unit, some rooms were observed with stains on the flooring and furniture, food particles and spills on the floors.</p> <p>During an observation/interview on 12/16/2025 at 9:00 am with the EVS Director revealed stains and food particles on the floors in the halls and in some residents' rooms. The EVS Director revealed that the floors had not been mopped in days and stated, this isn't just from one day. The EVS Director revealed he noted foul odors in the facility stating, it smells like urine, and someone sprayed something to mask the smell. The EVS Director went on to reveal that she had ordered parts for the repair of broken cleaning equipment. She admitted to not being able to have the floors stripped and waxed.</p> <p>During an interview on 12/16/2025 at 12:00 pm with R9's daughter she stated, three times a week I come here and there's stuff all over the floor and not just on my mom's side but on the neighbor's side as well. Now her roommate can walk and move around so I don't know if they just expect her to clean it up, but she'll spill like coffee all over the floor and it's just sticky and they'll just leave it there and I don't think she could mop it up.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/17/2025 at 12:00 pm of the facility revealed continued stains on the floors in the hallway on the East and [NAME] unit. Resident's rooms continue to require sweeping and mopping. Furniture on the Terrace unit remained stained and the walls on the Terrace unit revealed red-colored stains on the wall.</p> <p>During an interview on 12/18/2025 at 9:59 am with the Director of Nursing (DON) revealed that he was aware that there were a number of sanitary issues that needed addressing and they were currently working on those issues.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, interviews, and record review, the facility failed to ensure medications were secured, one of three medication carts on the East wing was left unlocked and unattended. The deficient practice had the potential to cause harm to residents located on the East Wing Unit by allowing unauthorized access to medications. Findings include: Per the Facility's Medication Storage Policy, dated October 1, 2025, all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, and medication rooms). Only authorized personnel will have access to the keys to locked compartments. During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Observation on 12/18/2025 at 8:38 am, during a tour of the East Wing Unit, a medication cart (Middle Cart) positioned to the left of the East Wing Nursing Station was left unlocked. There were no licensed nurses or other authorized staff present in the hallway. The cart contained multiple medications (i.e. oral medications in blister packs, PRN (as needed medications), topical treatments and controlled (locked) substances. This cart remained unattended for approximately 15 minutes before staff returned. On 12/18/2025 at 8:53 am, the Assistant Director of Nursing observed and confirmed that the medication cart (Middle Cart) positioned to the left of the East Wing Nursing Station was unlocked and unattended. On 12/18/2025 at 8:55 am, the Unit Manager observed that the medication cart (Middle Cart) positioned to the left of the East Wing Nursing Station was unlocked and unattended. On 12/18/2025 at 9:15 am, the Director of Nursing (DON) confirmed that leaving the medication cart unlocked and unattended was deficient practice. The DON stated that the expectation was that medication carts remain locked at all times when not in the direct possession of a licensed nurse.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, staff interviews, and record review, the facility failed to ensure one of two facility ice machines located in the service hallway of the East Wing Unit was free from visible dirt and debris. This deficient practice had the potential to affect all residents who received ice from this ice machine. Findings include: On 12/16/2025 at 2:38 pm, during an inspection of the ice machine on the East Wing of the Facility, visible brown/black residue was present along the interior chute. Slime-like buildup was observed on the underside of the ice shield. Loose particulate debris was present in the ice collection bin. The ice machine was actively producing ice at the time of observation. During an observation/ interview of the ice machine on 12/16/2025 at 2:38 pm on the East unit revealed black substance inside the lid with dust particles around the front of the machine on the inside. The Director of Maintenance (DM) confirmed that the machine needed to be cleaned and confirmed the observation. The DM denied the Dietary Department being responsible for the cleaning and maintenance of the ice machine. During an interview on 12/16/2025 at 2:38 pm with the DM, it was revealed that cleaning the ice machine was the responsibility of the Housekeeping Department and that he was unaware of the cleaning schedule of the ice machine. The DM revealed that the machine was down for a few weeks and that he replaced the water filtration system. The DM admitted that it needed cleaning when he replaced the part and stated that he had to empty the machine while it was down for repair. During an interview with the Housekeeping Supervisor on 12/16/2025 at 2:59 pm, it was revealed that her department was not responsible for the cleaning of the ice machine. The Housekeeping Supervisor stated that the DM was responsible for cleaning the ice machine. The Housekeeping Supervisor also stated that she and others did some research after the meeting and was able to confirm that it was the DM's responsibility to clean the ice machines. Additionally, the Housekeeping Supervisor stated that the DM had been made aware that it was the Maintenance Department's responsibility to clean the ice machines. The Housekeeping Supervisor confirmed that neither the Housekeeping Department nor the Facility Maintenance Department had been cleaning the ice machines due to each one thinking that it was the other one's responsibility for the task. Review of the Ice Machine Cleaning Log for the past 90 days showed no documented cleaning. Per the Corporate Risk Manager, there was no formal policy that spoke to whose responsibility it was to clean the ice machines.</p>		