STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115276	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Marietta	50 Saine Drive SW Marietta, GA 30008

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 - Few	Provide and implement an infection prevention and control program. Based on observations and staff interviews, the facility failed to ensure appropriate hand hygiene practices were performed during wound care treatment for one of six residents (R) (R6) with pressure ulcers. This deficient practice had the potential to increase the risk of transmission of infection. Findings include:Review of the electronic medical records (EMR) revealed R6 was admitted with diagnoses that included but not limited to Alzheimer's disease with late onset, severe dementia, paraplegia, peripheral vascular disease, underweight/low BMI (body mass index), dysphagia (difficulty swallowing), and Stage IV pressure ulcer of the sacral region.Review of the resident's care plan revealed: (Problem Start Date: 09/18/2025) reflected interventions intended to reduce risk of complications and infection, including: weekly wound assessments with measurements, treatment as ordered, use of a low-air-loss (LAL) mattress, use of positioning/off-loading devices (e.g., wedges/boots), keeping the resident clean and dry, keeping linens clean/dry/wrinkle free, enhanced barrier precautions, nutritional support/dietary involvement, and coordination/communication with hospice and the wound provider. Wound provider documentation dated 02/20/2026 described a sacral pressure injury clinically staged as Stage IV, with measurements documented and drainage described as mild serous with no odor and no peri-wound erythema, and the wound status noted as improving.Observation on 02/25/2026 at 9:05 AM of wound care for R6 performed by Licensed Practical Nurse (LPN) CC, Wound Care Nurse revealed R6 lying on a specialty mattress and was identified as severely impaired and dependent on staff for care. LPN CC donned (put on) gloves and removed the soiled dressing. After removing the soiled dressing, LPN CC removed her gloves and donned a new pair of gloves; however, hand hygiene was not performed between glove removal and application of new gloves. The wound was cleansed per treatment order. During the procedure, gloves were again removed and replaced; however, hand hygiene was not performed between glove changes. The wound dressing was then applied per the treatment protocol, the resident was repositioned, and the soiled dressing was removed from the room.Interview on 02/25/2026 at 9:20 AM with LPN CC CC revealed when asked about performing hand hygiene between glove changes, she stated she was unaware that hand hygiene was required between removing and donning a new pair of gloves during wound care.Interview on 02/25/2026 at 9:40 AM with Registered Nurse (RN) II, Corporate Nurse who was acting as the Director of Nursing (DON) confirmed that the expectation was for licensed nursing staff to perform hand hygiene between glove changes in accordance with infection control standards and facility policy.

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