

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Pruitthealth - Marietta		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50374</p> <p>Based on staff interviews, record reviews, and review of the facility policy titled Care Plans, the facility failed to develop a care plan for one resident (R)(R715) of 49 sampled related to amount of assistance needed to provide care during a transfer. Actual harm occurred on 11/5/2024 when R715 was hit on the head by the mechanical lift swing when Certified Nursing Assistant (CNA) KK attempted a transfer alone. This resulted in bruising to the left eye of R715.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Care Plan dated 7/27/2023 documented It is the policy of the health center for each resident to have a person-centered care plan. (2) Care plan will be updated to reflect changes to approaches, as necessary, that result from significant changes in conditions or needs. (4) Care plans will be updated by nurses or any other interdisciplinary team member so that the care plan will reflect the resident's needs at any given moment.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) dated [DATE] documented R715 had a Brief Interview of Mental Status (BIMS) score of 99 indicating severe cognitive impairment. Further review in the MDS Section GG revealed upper extremity impairment on one side and lower extremity impairment on both sides, and dependent care for Activities of Daily Living (ADLs).</p> <p>Review of Progress Note dated 11/6/2024 documented Call to resident side in dinning [sic] hall. Upon walking noted a difference in facial area. Walked up to examine and there was a large area of discoloration on the left side of the resident's forehead.</p> <p>Review of statement written by CNA KK dated 11/8/2024 revealed that R715 was being assisted from chair to bed by using the Hoyer lift with no assistance from another CNA. When the strap was released the top of the lift swing hit R715 across the head.</p> <p>Review of the Physician's Order dated 11/6/2024 documented Bruise: Assess Neurological Status if affected area is on face/head/neck or cause of injury is unknown.</p> <p>During an interview on 1/16/2025 at 4:25 pm with the Director of Nursing (DON), it was confirmed that everybody is responsible for updating the care plan. The care plan should be updated when there is need or change that had been noticed with the residents. Staff are expected to be updated and follow the care plan as soon as possible.</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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F 0656  Level of Harm - Actual harm  Residents Affected - Few	Interview on 1/16/2025 at 4:42 pm with the Administrator stated we will reeducate on how to pull the information from the electronic record and hold the staff accountable for following the care plan.  Cross refer F689

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50940</b></p> <p>Based on observations, staff interviews, record review, and review of the facility policy titled, Medication Administration: General Guidelines, the facility failed to adhere to accepted standards of quality care by crushing medications that cannot be opened or crushed in one out of seven residents observed during a medication pass, and not measuring the correct dosage of Diclofenac ointment (nonsteroidal anti-inflammatory drug (NSAID) used to reduce pain and inflammation) in one out of seven residents (R) (R12) who have diclofenac ointment ordered.</p> <p>This deficient practice could result in serious adverse effects, including an increased risk of medication side effects or reduced efficacy due to improper administration techniques.</p> <p>Findings include:</p> <p>A review of the facility policy Medication Administration: General Guidelines revised 4/10/2019 reveals that Medications are administered as prescribed. 2. Medications are administered in accordance with written orders of the attending physician .If a dose seems excessive considering the resident's age or condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the physician is contacted for clarification prior to the administration of the medication. 21. Liquid dosage forms may be used whenever physically practical in place of solid tablets that would have to be crushed and especially for administration through enteral feeding tubes. The nurse checks with their provider pharmacy to determine if a liquid form is available and covered by the applicable payment program. The physician is contacted for a new order before changing the dosage, unless the physician has previously authorized that alternate dosage forms of the ordered drug may be used if necessary and appropriate. 22. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a patient/ resident has difficulty swallowing or is tube fed using the following guidelines:</p> <p>-long-acting or enteric-coated dosage forms should generally not be crushed and require a physician-specific order to do so. The physician must record in the medical records that the benefit of crushing the dosage form outweighs any potential risk.</p> <p>-The need for crushing medications is indicated on the patient/ resident paper MAR or e-MAR so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety and alternatives, if appropriate, during paper MAR or e-MAR reviews.</p> <p>R12 was admitted to the facility on [DATE] with diagnoses including, but not limited to old cerebral infraction, aphagia and dysphagia, pneumonia, gastroesophageal reflux disease, chronic pain syndrome, dysarthria and anarthria, and pain in left knee.</p> <p>A review of the most recent Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 9, indicating the resident has moderate cognitive deficit. Section K, Swallowing/Nutrition Status, indicated the resident is on a mechanically altered diet. Section J indicates that the resident is experiencing pain.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Orders dated 6/2/2021 reads: Resident gets medication crushed and takes them orally.</p> <p>Review of the Orders for diclofenac sodium gel [over-the-counter (OTC)] gel; 1%; amount. 4 grams (g); topical with a start date of 5/27/2022. Apply 4g to the left knee four times daily.</p> <p>Review of the Orders for potassium chloride capsule, extended release; 10 milliequivalent (mEq); amount 3 capsules; oral with a start date of 1/16/2025. Special Instructions: for hypokalemia. Do Not Crush. Ok to open capsule and pour in apple sauce.</p> <p>Review of the Orders for rivastigmine tartrate; 3 milligram (mg); 1 cap; oral with a start on 11/2/2023. Special Instructions: Do not crush.</p> <p>During the med pass conducted on 1/16/2025 at 8:45 am by a Licensed Practical Nurse (LPN) AA on a R12, it was observed that when administering medications to the resident, she crushed them finely and mixed them with water, stating that the resident could not swallow them. Upon reviewing the medications, some medications, such as extended-release potassium chloride capsules and rivastigmine tartrate capsules, were identified to not be opened or crushed, as indicated on the medication package and in the order. LPN AA agreed that she should have contacted the pharmacist or the doctor to explore alternative forms of the medications.</p> <p>When further observing the LPN AA administering Diclofenac gel to the resident, LPN AA was noted to squeeze an unmeasured amount of the ointment into a small medicine cup, locking the tube back into the med cart, and proceeded to the resident's room. When LPN AA was questioned about how she ensured she was administering the doctor-ordered 4 grams (g) of the gel, the LPN AA admitted she did not know how to measure it correctly.</p> <p>An interview with a Unit Manager (UM) for the first floor, LPN BB on 1/16/2024 at 12:00 pm revealed that if a resident cannot swallow a pill, they would call the pharmacy to clarify if a medication could be crushed, or if it could be changed to another form. She further reported that they would then reach out to the doctor to get it okayed by the MD. UM LPN BB reported that the correct way of measuring the diclofenac ointment is to squeeze the gel on a measuring card to ensure the correct dosage is administered.</p> <p>During an interview with UM LPN CC on 1/16/2025 at 12:05 pm she revealed that if a resident cannot swallow a medication, the nurse should first call the pharmacy to see whether the medication can be changed to another form. UM LPN CC reported the correct way of measuring and administering diclofenac ointment, was to just squeeze the gel into a small medication cup. UM LPN CC further reported that she would use somewhere around 5-15 ml but was unclear on the precise amount. When asked about using the measuring card that comes with the medication UM LPN CC revealed that she was unaware of the measuring card.</p> <p>During an interview with the Director of Nursing (DON) on 1/16/2025 at 12:50 pm, it was revealed that if a resident has problems swallowing medication and the extended-release capsule cannot be opened or crushed, they call the pharmacy and then a doctor to get it switched to another form, if possible. The DON then stated that they do not measure and administer it liberally when referring to the correct way of measuring diclofenac ointment. The DON acknowledged not being aware that the ointment comes with a measuring card and was not sure if there was a policy concerning this.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/16/2025 at 3:15 pm Pharmacist DD revealed that they write special instructions on the Medication Administration Record (MAR) if a medication cannot be crushed or if a capsule cannot be opened. She further stated that nurses often notice and inform the pharmacy services when a resident has difficulty swallowing. At this point the pharmacy would advise them if an alternative form is available. Nurses then return to the doctor to have the order changed. The DON further explained that when a resident is admitted to the facility, and their medications are entered, the staff are attentive for signs of dysphagia and notifying pharmacists. In such cases, alternative forms of medication are explored. For instance, potassium chloride (KCL) can be switched to a liquid form, and rivastigmine (Exelon) also comes in a transdermal form.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50374</p> <p>Based on observations, staff and resident interviews, record review, and review of the facility's policy titled, Occurrence Reduction Plan, the facility failed to provide adequate staff to prevent injuries while using a mechanical lift for one of 49 sampled residents (R) (R715). Actual harm occurred on 11/5/2024 when R715 was hit on the head by the mechanical lift swing when Certified Nursing Assistant (CNA) KK attempted a transfer alone. This resulted in bruising to the left eye of R715.</p> <p>Findings included:</p> <p>A review of the facility's policy titled, Occurrence Reduction Plan, dated 1/29/2021 documented Reporting all occurrences of unknown origins to the Administrator or design immediately. Participating in investigations of unknown occurrences as outlined in the abuse prohibition policies.</p> <p>A review of the Electronic Medical Record (EMR) revealed that R715 was admitted to the facility on [DATE] with diagnoses that included primary cerebral ischemia (blood flow to the brain), osteoarthritis (breaks down joint bone and cartilage) contracture (left hand) (hardening of muscles) functional quadriplegia (loss of ability of all four limbs) lumbar region without neurogenic claudication (back and leg pain) spinal stenosis (weakness in arms and legs), and other lack of coordination.</p> <p>A review of the most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that R715 had a Brief Interview of Mental Status (BIMS) score of 99 indicating severe cognitive impairment. Further review of the MDS Section GG revealed upper extremity impairment on one side and lower extremity impairment on both sides, and dependent care for Activities of Daily Living (ADLs).</p> <p>Review of Progress Note dated 11/6/2024 documented Call to resident side in dining [sic] hall. Upon walking noted a difference in facial area. Walked up to examine and there was a large area of discoloration on the left side of the resident's forehead.</p> <p>A review of Observation Detail List Report dated 11/6/2024 at 8:40 pm indicated an alteration in the skin that consisted of a skin tear on the right arm and right leg.</p> <p>A review of CNA KK's written statement dated 11/8/2024 which she documented that she was assigned 11 residents and seven of the residents required assistance via a [NAME] lift. CNA KK reported that she was able to get assistance with six of her residents but there was no one available to assist her with the seventh resident. CNA KK then reported that she used the [NAME] lift to transfer the resident from the chair to the bed. It is during this time that the top of the lift swing bumped the resident in the head after it swiveled out of control after the strap was released. CNA KK reported that she did not see any signs of injury to the resident, and she proceeded to give the resident a bed bath. Later that morning CNA KK reported that she transferred the resident from bed to chair and the resident still did not have any visible injury to her head.</p> <p>A review of the Facility's Investigation dated 11/14/2024 documented Following a thorough investigation of the injury of unknown origin involving R715 the CNA KK statement, we were able to substantiate the resident was injured after R715 head was bumped by the Hoyer lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/16/2025 at 11:16 am the Assistant Director of Nursing (ADON) stated he is familiar with the incident on R715 but could not recall the event in detail. He stated he was the one who provided the in-service education on the usage of mechanical lifts after the incident. ADON revealed the education consisted of the proper use of the mechanical lifts, how many people should be present when doing mechanical lifts, the correct sling size and how to use it, and making sure the resident behaviors are appropriate at the time to carry out the safe transfer. He continued to state the training was demonstrated and the staff had to do a return demonstration. ADON further confirmed CNAs know how to work with residents regarding mobility. They are expected to look at it under ADL care area in the electronic health record (EHR) for functional abilities.</p> <p>During an interview on 1/16/2025 at 4:32 pm the Administrator and Senior Nurse Consultant (SNC) confirmed the facility's policy states there should be two people when transferring a resident with a mechanical lift. The Administrator stated all nursing staff are educated and checked off on proper usage of the mechanical lifts before working on the floor. They continued to state they have a process that involves random audits with mechanical lifts. SNC stated the Director of Nursing (DON) is responsible for overseeing monitoring for safe transfers. If the staff are not properly using the mechanical lifts on the residents, then that staff member will be suspended while an investigation is pending. Further, the Administrator confirmed she expected staff to follow the policy and training that have been provided.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50940</b></p> <p>Based on observations, resident and staff interviews, and review of facility policy titled Transmission Based Isolation Precautions, the facility failed to maintain sanitary conditions for two of 50 sampled residents (R)(R23 and R3). Specifically, oxygen equipment (nasal cannula) was hung over the humidifier and touched the floor when not in use for R23 and the facility failed to use appropriate Personal Protection Equipment (PPE) for a resident R3 on Enhanced Barrier Precautions (EBP) of 50 sampled residents. This deficient practice could risk equipment contamination, increasing the likelihood of infections and health complications.</p> <p>Findings include:</p> <p>1.A policy on maintaining oxygen supplies, such as nasal cannulas, under sanitary conditions was requested but not provided.</p> <p>A review of the Electronic Medical Record (EMR) revealed that R23 was admitted to the facility on [DATE] with diagnoses including, but not limited to intracerebral hemorrhage, pneumonia, nasal congestion, pulmonary nodule, acute respiratory failure with hypoxia, and COVID-19.</p> <p>A review of the recent Quarterly Minimum Data Set (MDS) dated [DATE] documented R23 had a Brief Interview for Mental Status (BIMS) of 14 indicating intact cognition. Further review of the MDS revealed that R23 received oxygen therapy.</p> <p>Review of the care plan dated 1/14/2025 for R23 revealed a problem: Resident needs nebulizer treatment/Oxygen (O2) use related to history of pneumonia, respiratory failure, COVID-19 with a goal that Resident will not exhibit signs of hypoxia (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse) with approach: Monitor oxygen saturation via pulse oximetry as ordered/needed, administer nebulizer treatment/O2 as ordered.</p> <p>A review of the Physician Orders for R23 revealed an order dated 11/18/2024 for O2 at 2 liters (L) via nasal cannula (NC) as needed to keep O2 saturation (sat) above 95%. Change respiratory supplies weekly on Sundays.</p> <p>During an observation on 1/14/2025 at 12:04 pm in the resident's room, R23 was resting in bed. The oxygen concentrator was on, but the resident was not wearing the nasal cannula. The long tubing of the nasal cannula was connected to the concentrator, draped over it, tangled on top, and with portions touching the floor, rather than being stored hygienically in the bag attached to the concentrator. The resident stated that she does not use oxygen continuously, only as needed.</p> <p>During an observation on 1/15/2025 at 9:00 am R23 was resting in bed, asleep, and comfortable. The oxygen tubing was connected to the concentrator in the same manner as observed the previous day, not stored in a bag.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 1/15/2025 at 11:00 am with the Assistant Director of Nursing (ADON) while in R23's room, ADON confirmed the O2 was not bagged. ADON reported that O2 tubing should be bagged when not in use and should not be placed on the floor or the concentrator. He stated that he would provide R23 with new tubing.</p> <p>50878</p> <p>2. A review of the Transmission Based Isolation Precautions policy, effective date 3/1/2019, section five, Enhance Barrier Precautions (EBP) revealed that Enhanced Barrier Precautions expand the use of personal protective equipment (PPE) and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi-drug resistant organisms (MDROs) to staff hands and clothing. The use of gown and gloves for high-contact resident care activities is indicated when contact precautions do not otherwise apply, for nursing home residents with wounds and or indwelling devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.</p> <p>Review of the electronic medical record for R3 was admitted to the facility on [DATE] following hospitalization . She was admitted to the facility with diagnoses that included but were not limited to the wound of right elbow, unstageable pressure ulcer of sacral region, stage II, Bacteremia, Unspecified fracture of lower end of left radius, and encounter for attention to gastrostomy.</p> <p>A review of the annual minimum data set (MDS) dated [DATE], revealed Section M which indicated R3 had a stage II pressure ulcer/injury on the sacrum, which was in place at admission to the facility. R3 also was being treated for a right elbow unstageable wound by off-site wound care provider.</p> <p>Review of the care plan revealed that R3 had an abrasion of unknown origin to left elbow at admission on 12/11/2024. Last review of care plan was 1/16/2024. Care plan last reviewed 1/16/2025 notes tube feeding creates risk for aspiration, weight loss and dehydration. Risks for MDRO due to this medical device.</p> <p>Review of the physician orders for R3 regarding wound care on elbow states effective R3 was placed on Enhanced Barrier Precautions effective 12/12/2024 due to wound with wound vac. Physician's orders for Gastrostomy bolus of Jevity 1.5 five times a day and to check for residual before feeding. If residual is greater than 100 mL, hold feeding and call MD for further orders. Check tube placement prior to medication administration/flushes. During medication administration times, flush tube with 15 milliliters (mLs) water before and after medications and 5 mLs with each medication.</p> <p>On 1/15/2025 at 8:39 am, licensed practical nurse LPN LL, was observed sitting next to R3 reclusing percutaneous (peg) tube. He stated that he had just completed her bolus feeding. At the time of this observation no PPE was in use. It was noted that the room of R3 was not marked for EBP although the matrix indicated Stage II pressure ulcers and g-tube feeding. LPN LL left room with supplies remaining on the side table, formula bottle and syringe unlabeled. LPN LL continued his med pass to other residents. There was a cart for personal protective equipment available in the hallway however none was donned.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50803</p> <p>Based on observations, resident interviews, and staff interviews, the facility failed to maintain a safe, functional, sanitary, and comfortable environment as evidenced by wedged items in privacy curtain and dust build up in PTAC in room [ROOM NUMBER], a loose PTAC unit in room [ROOM NUMBER], peeling trim near the second floor shower room, substances on the floor/tile in the A-Hall shower room, black and black/brown substances in the ceiling of kitchen dish washing room and dry storage area. This deficient practice had the potential to jeopardize the health and safety of all 106 residents in the facility in three resident rooms, two of four shower rooms, and the kitchen.</p> <p>Findings include:</p> <p>Observation made on 1/14/2025 at 11:27 am in room [ROOM NUMBER] revealed a privacy curtain rail with a brown item wedged into the end of the railing and exposed insulating spray foam on the left wall of the PTAC unit.</p> <p>Observation made on 1/14/2025 at 11:55 am in room [ROOM NUMBER] revealed a loose PTAC unit.</p> <p>Observation made on 1/14/2025 at 12:01 pm in room [ROOM NUMBER] revealed dust buildup on filter of the PTAC unit.</p> <p>Observation made on 1/14/2025 at 12:12 pm the entrance of the B-Hall second-floor shower room and room [ROOM NUMBER] revealed peeling trim.</p> <p>Observation made on 1/15/2025 at 12:00 pm in the A-Hall first-floor shower room revealed orange substances on the floor of the shower room floor and ceiling vent.</p> <p>Observation made on 1/16/2025 at 4:30 pm in the A-Hall first-floor shower room revealed clusters of black substances between the tiles of the shower.</p> <p>Observation made on 1/16/2025 at 4:50 pm in the kitchen dish washing room revealed clusters of black substances on the ceiling and in the kitchen dry storage room there were brown and black substances on the ceiling vent.</p> <p>An interview with the resident council on 1/14/2025 at 3:08 pm revealed concerns about black substances in the A-hall shower room on the first floor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Pruitthealth - Marietta		STREET ADDRESS, CITY, STATE, ZIP CODE  50 Saine Drive SW Marietta, GA 30008	

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview and observation with the Maintenance Director on 1/16/2025 at 4:07 pm confirmed the missing part from the curtain rail, buildup on PTAC filter and exposed insulating foam spray in room [ROOM NUMBER], a loose PTAC filter in room [ROOM NUMBER], clusters of black substances on the ceiling in the kitchen dish room and in the kitchen pantry, substances in the first floor shower room ceiling, floor and tile. The Maintenance Director further confirmed the peeling trim near the second-floor shower room. He acknowledged that he was unaware of these concerns. He reported that he expected staff to identify concerns in resident rooms and around the facility and report them in the facility's electronic building management system. He further stated he is the only maintenance employee and has no assistants, so it is challenging to address all the concerns in the building right away.</p> <p>An interview with the Administrator on 1/16/2025 at 5:36 pm revealed she has been in the role since the end of July 2024. She stated that PTAC units should be checked and cleaned weekly and ceiling vents should be cleaned monthly. She further stated that there should be no negative outcomes since these concerns will be addressed immediately.</p> <p>A policy for the environment was requested but not provided.</p>