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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pruitthealth - Marietta | 50 Saine Drive SW<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observations and staff interviews, and review of the facility policy titled, Disposal of Medications, the facility failed to ensure expired medications were removed from active medication storage areas and unavailable for use in one of two medication rooms (first floor medication room) reviewed. This deficient practice had the potential to affect 51 residents receiving medications on the unit.Findings include:Review of the facility policy titled Disposal of medications revised 12/15/2026 indicated under Policy Statement: It is the policy of ?company name' Pharmacy Services that medications which have expired, been discontinued, or remain in the healthcare center after a patient/resident's discharge shall be removed from active stock and placed in disposal.Observation on 02/25/2026 at 10:30 AM of medication storage was conducted in the first-floor medication room and medication carts. During inspection of medication stock, the following expired medications were observed stored with active medications and available for administration:One container of lidocaine oral solution with a manufacturer's expiration date of 02/23/2026.Three IV (intravenous) bags of daptomycin with manufacturer expiration dates of 02/21/2026.Interview on 02/25/2026 at 10:45 AM with Licensed Practical Nurse (LPN) JJ revealed that medications are routinely checked for expiration; however, the nurse confirmed the expired medications remained in the medication room at the time of observation.Interview on 02/25/2026 at 10:49 AM with the acting Director of Nursing (DON) confirmed that expired medications were expected to be removed immediately upon expiration and either returned to the pharmacy or disposed of in accordance with 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 |
|---|---|---|

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to ensure oxygen equipment was safely maintained and monitored for two of nine residents (R) (R70 and R83) reviewed for oxygen use. Specifically, the facility failed to remove an oxygen tank from a resident room that was unsecure and unattended (R70) and failed to date respiratory supplies and to keep an oxygen concentrator filter free of debris (R83). The deficient practices had the potential to create accident hazards, improper oxygen administration, and impaired oxygen delivery.Findings include:1. Review of the Electronic Health Record (EHR) for R70 revealed the resident was admitted with diagnoses including but not limited to Alzheimer's disease, unspecified dementia, Type 2 diabetes mellitus, generalized anxiety disorder, gastro-esophageal reflux disease, dysphagia, lymphedema, and repeated falls.Review of the Minimum Data Set (MDS) assessment dated [DATE] for R70 documented in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. A review of Section O (Special Treatments, Procedures, Programs) revealed the residents received Occupational Therapy, Physical Therapy, and Respiratory Therapy; however, oxygen (O2) therapy was not indicated.Review of physician orders for R70 revealed no physician order for oxygen therapy.Review R70's care plan revealed the care plan did not identify O2 therapy as a treatment and did not contain interventions related to O2 use or oxygen equipment.Observation and resident interview on 02/24/2026 at 10:59 AM revealed an unsecure and unattended O2 tank in the R70's room (room [ROOM NUMBER]). When asked if he used the O2 tank, R70 stated, No, take it with you.Observation on 02/25/2026 at 12:23 PM in R70's room (Room121) revealed an unsecure and unattended O2 tank present.Interview on 02/26/2026 at 9:02 AM with Licensed Practical Nurse (LPN) AA revealed R70 was not on O2 and was currently on hospice services. When asked if O2 tanks should be in residents' rooms when not in use, she stated she did not think so. LPN AA identified potential negative outcomes including a fire hazard and the possibility the tank could fall.Interview on 02/26/2026 at 9:16 AM with the Director of Nursing (DON) revealed if a resident did not have a physician order for O2 that R70 should not have O2 in the room. The DON identified potential negative outcomes including accident hazards related to the O2 tank being in the room unsecure and unattended, the possibility of someone placing O2 on the resident without an order, a medication error, and staff not recognizing O2 use due to lack of signage.Interview on 02/26/2026 at 9:23 AM with Regional Corporate Clinical Nurse (RCCN) II revealed R70 was not supposed to have an O2 tank in the room. She stated staff were expected to be observant for O2 tanks in resident rooms and remove them if the resident does not have an order, especially if there was no signage indicating O2 use. She identified a potential negative outcome including staff administering O2 without a physician order.2. Review of the EHR for R83 revealed a BIMS score of 1, indicating severe cognitive decline.Observation on 02/24/2026 at 11:51 AM, R83 was observed in his room receiving O2 via nasal cannula at 3 liters per minute delivered by O2 concentrator. The O2 concentrator was observed in operation; however, the external filter appeared visibly soiled with accumulated dust and debris. The nasal cannula was not dated. A nebulizer machine was present in the room; however, no date was observed on the nebulizer components/supplies.Observation on 02/25/2026 at 1:15 PM of R83 revealed R38 in his room receiving O2 via nasal cannula at 3 liters per minute delivered by an O2 concentrator. The O2 concentrator was in operation; however, the external filter remained visibly soiled with accumulated dust and debris. The nasal cannula remained undated.Observation on 02/26/2026 at 9:55 AM of R83 revealed that the resident had an O2 concentrator in the room. The external filter of the O2 concentrator appeared visibly soiled with accumulated dust and debris. A nasal cannula was observed in use; however, the cannula was not dated.Interview on 02/25/2026 at 02:10 PM with Licensed Practical Nurse (LPN) DD revealed when asked about O2 administration and management, she stated that, per her understanding, facility policy<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | does not require O2 nasal cannulas to be dated. She further stated that nursing staff were responsible for cleaning the O2 concentrator, including the filter. She reported that O2 tubing was stored in plastic bags and was routinely changed weekly on Sunday nights by the night shift staff.Interview on 02/25/2026 at 3:00 PM with Registered Nurse (RN) GG, Case Mix Director revealed when asked about O2 administration practices, she stated that when a resident was receiving O2 therapy, an Oxygen in Use sign was placed on the resident's door in accordance with safety protocols. She further stated that nasal cannulas were typically stored in a plastic bag at the resident's bedside when not in use and were routinely changed weekly on Sunday nights. She further stated that, to her knowledge, facility policy did not require O2 nasal cannulas to be dated.Interview on 02/26/2026 at 10:20 AM with Regional Nurse (acting DON) confirmed that the O2 concentrator filter was dirty upon inspection. She stated that the concentrator was the responsibility of the hospice provider and indicated that the facility would notify the hospice unit regarding the equipment's condition for follow-up. She also affirmed that the facility policy did not require that O2 cannulas be dated. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>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.<br>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. |