STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115313	A. Building B. Wing	01/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Brookhaven	3535 Ashton Woods Drive NE 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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled MDS Assessment Accuracy, the facility failed to ensure Minimum Data Set (MDS) assessments were coded accurately for 4 of 47 sampled residents (R) (R100, R12, R88, and R66). This deficient practice had the potential to place R100, R12, R88, and R66 at increased risk of not receiving care and services according to their needs. Findings include: Review of the facility's policy titled MDS Assessment Accuracy, dated 5/1/2006, revealed the Policy Statement included, It is the policy of this healthcare center that each Minimum Data Set (MDS) reflect the acuity and the medical status of each patient/resident in accordance with acceptable professional standards and practices. 1. Review of the Face Sheet for R100 revealed the resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, bipolar disorder. Review of the Annual MDS for R100, dated 8/27/2025, revealed that Section A (Identification Information) documented the resident was not currently considered by the state-level II Preadmission Screening and Resident Review (PASRR) process to have serious mental illness and/or intellectual disability or a related condition. Review of the care plan for R100 revealed a care plan area of the resident has a PASRR Level II related to a bipolar diagnosis. In an interview on 1/18/2026 at 8:45 am, the MDS Coordinator confirmed the resident had a PASRR Level II dated 3/25/2024, and the Annual MDS dated [DATE] indicated the resident did not have a PASRR Level II. She stated the MDS should be coded according to the resident's status. Review of the Quarterly MDS assessment for R12, dated 12/10/2025, revealed that Section P (Restraints) documented that 'other' restraints were used less than daily. Review of the care plan for R12 revealed no care plan area for the use of restraints. Review of the physician's orders for R12 revealed no restraints orders. Review of the progress notes for R12 revealed no notes of restraints in use. In an interview on 1/17/2025 at 1:15 pm, the MDS Coordinator confirmed that the Quarterly MDS assessment dated [DATE] for R12 documented the use of restraints. She stated that restraints were not used for R12, and this was an error in coding. She further stated that she would submit a revised submission. In an interview on 1/18/2026 at 12:00 pm, the Director of Health Services (DHS) stated the MDS Coordinator was responsible for ensuring the MDS assessments were coded accurately. She further stated she expected the MDS assessments to be coded accurately to reflect the resident's status at the time of the assessment. She stated that an inaccurate assessment could adversely affect the resident's care. 2. Review of the Face Sheet revealed R88 was admitted to the facility with diagnoses of but not limited to dementia, unspecified depression, and unspecified altered mental status. Review of R88's Annual MDS assessment dated [DATE] revealed a BIMS score of 4, indicating severe cognitive impairment. Further review of Section P (Restraints and Alarms) documented a code (continued on next page)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 0, denoting no wandering or elopement alarms in use. Review of R88's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 6, also indicating severe cognitive impairment. Further review of Section P (Restraints and Alarms) again documented a code of 0, indicating no wandering or elopement alarms in use. Review of R88's comprehensive care plan identified the following problem statement: Presence of behavior — wanders unsafely; wander guard in place. Review of physician's orders for R88 revealed an order from 6/17/2024 to check the function of the wander guard to the left ankle every shift, During an interview conducted on 1/17/2026 at 3:38 pm, the MDS Coordinator confirmed that R88 was not coded correctly on both the Annual MDS dated [DATE] and the Quarterly MDS dated [DATE]. The MDS Coordinator stated that accurate coding was essential because it directly supported the development and implementation of an appropriate resident care plan. 3. Review of the Face Sheet revealed R66 was admitted to the facility with diagnoses of but not limited to unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of R66's quarterly MDS assessment dated [DATE] revealed BIMS score of 14, indicating little to no cognitive impairment. Further review in Section P (Restraints and Alarms) revealed R66 was documented as 0 for no wandering/elopement alarms in use. Review of the care plan revealed R66 is at risk for elopement for exit seeking behaviors with interventions to apply wander guard alarm system. Review of Physician's Orders for R66 revealed an order dated 5/30/2025 to check the function of wander guard to right wrist every shift. Interview on 1/17/2026 at 3:38 pm with the MDS Coordinator stated when completing a resident assessment, she looked through the electronic medical record (EMR) to assist with her coding. The MDS Coordinator confirmed that R66 was not coded correctly on the MDS and it was missed moving and clicking too quickly. Interview on 1/17/2026 at 3:55 pm with the Director of Health Services (DHS) stated she expected the MDS to be updated to close time for accuracy and the MDS was responsible for conducting audits to ensure the assessment was current.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a Preadmission Screening and Resident Review (PASRR) Level II for one of one resident (R) (R1) reviewed from a sample of 47 residents. This deficient practice had the potential to place R1 at increased risk for not receiving the necessary behavioral health services and support needed to meet R1's needs.Findings include: Review of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Post Traumatic Stress Disorder (PTSD), major depressive disorder, and anxiety disorder. Review of the admission Minimum Data Set (MDS) assessment for R1, dated 11/6/2025, revealed Section A (Identification Information) documented the resident was not currently considered by the State Level PASRR process to have a serious mental illness and/or intellectual disability or a related condition. Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 13 (indicating little to no cognitive impairment). Section I (Active Diagnoses) documented anxiety, depression, and PTSD. There were no neurological diagnoses marked. Review of the care plan for R1 revealed a Problem area dated 12/30/2025, of psychotropic drug use, and the resident received antidepressant medication related to depression. Review of the physician orders for R1 revealed an order dated 1/12/2026 for trazodone 50 milligrams (mg) for depression, unspecified. An order dated 11/3/2025 for bupropion HCl sustained˜release 12-hour tablet, 150 mg, one tablet via gastric tube twice daily at 9:00 am and 5:00 pm for depression, unspecified. Review of the EMR for R1 revealed no PASRR Level II. During an interview on 1/17/2026 at 1:38 pm, the Social Service Coordinator (SSC) stated her responsibilities included the oversight of the PASRR processes. She was unable to confirm whether R1 had a PASRR Level II but stated she would review her records and follow up with the surveyor. She acknowledged that submitting PASRR documentation was part of her responsibilities. During a follow-up interview on 1/18/2026 at 9:03 am, the SSC confirmed that R1 did not have a PASRR Level II submitted. She stated this was an oversight.

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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 observations, record review, resident and staff interviews, and review of the facility policy titled, Care plan, the facility failed to follow approaches described in the care plan for one of 16 residents (R) (R69) receiving Restorative Nursing care. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs, and a diminished quality of life.Findings include:Review of the facility policy titled Care Plans revised on 10/21/2025 revealed a policy statement of it is the policy of the health care center for each patient/resident to have a person centered baseline care plan followed by a comprehensive care plan developed following completion of the minimum data set (MDS) and Care area assessment (CAA) portions of the comprehensive assessment according to the Resident Assessment Instrument (RAI) Manual and the patient/resident choice. The care plan approach serves as instructions for the patient/resident's care and provides continuity of care by all partners. short and concise instructions, which can be understood by all partners. Review of the care plan for R69 revealed Problems listed as but not limited to resident requires training and skill practice in transfer, resident require PROM (passive range of motion) to left hand to prevent further contractures six days a week, and resident requires splint/brace assistance to left hand six days a week. Further review revealed approaches documented as but not limited to resident will transfer to and from bed to chair and sit to stand, place resident in restorative nursing program for PROM and splinting as tolerated to left hand.During an interview on 1/17/2026 at 2:23 pm with the Director of Nursing (DON) and Regional Nurse Consultant, the DON revealed that restorative care was care planned. She stated she expected the restorative nursing staff to provide restorative care as described in the care plan. She confirmed that the care plan for R69 had a problem area of Resident requires training and skill practice in transfer with an approach of resident will safely transfer to and from bed to chair as sit to stand in rw (rolling walker). start date 10/24/2025 and a problem of Resident requires splint/brace assistance to left hand x 6 days per week with an approach of Place resident in restorative program for splinting as tolerated to left hand. Once a day dated 7/1/2025 and a problem Resident requires PROM to left hand to prevent further contractures x 6 days a week with an approach Place resident in restorative nursing program for PROM to left hand dated 7/3/2025.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observations, staff and resident interviews, record review, and review of the policy titled, Restorative Nursing Program, the facility failed to provide services to maintain and or prevent further decrease in range of motion or mobility for one of 16 Residents (R) (R69) receiving Restorative Nursing care. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs, and a diminished quality of life.Findings include:Review of the policy titled Restorative Nursing Program revised 11/4/2021 revealed a Policy Statement: it is the policy of this healthcare center to provide restorative nursing which actively focuses on achieving and maintain optimal physical mental and psychological functioning and wellbeing of the patient/resident. Restorative Nursing program is under the supervision of a Registered Nurse (RN) or a License Practical Nurse (LPN) and restorative nursing services are provided by Restorative Nursing Assistants (RNAs), Certified Nursing Assistants (CNAs) and other qualified staff. Nursing assistants/aides must be trained in techniques that promote resident involvement in the activity.Review of the electronic medical record (EMR) revealed R69 was admitted to the facility with pertinent diagnoses including but was not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Cerebral infarction, and difficulty in walking.Review of R69's annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/26/2025 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicates R69 was cognitively intact. Section G, functional status, revealed R69 required partial to moderate assistance with showers/bathing, upper body dressing and substantial maximal assistance with toileting, lower body dressing, putting on and taking off footwear, sit to stand, and chair / bed-to-chair transfer. Review of Progress Notes revealed a nursing note was entered on 7/3/2025, 7/10/2025, 8/7/2025, 9/12/2025, 10/16/2025, 11/20/2025 and 12/18/2025 indicating R69 was on restorative nursing and staff applied splint and perform exercises. The note dated 12/18/2025 indicated R69 was assisted with transfer from bed to chair and from chair to bed with one staff assist.Review of Restorative Nursing Notes for minutes for transferring revealed:December of 2025 five entries total were made: Three were documented as not observed and two were documented as no information.January 2026 two entries were noted: One was documented as not observed and one was documented as no information. Review of Restorative Nursing Notes for minutes for splint or brace assistance revealed:October of 2025, 22 entries were made: Seven entries were documented as Minutes - 15, tolerance: fair, Progress improved. Eight entries were documented as minutes 15, tolerance fair, progress no change. Five entries were documented as no information. Two entries were documented as refused. November of 2025 the notes revealed 18 entries: Seven were documented as 15 minutes, tolerance fair and progress no change. One entry was documented 15 minutes, tolerance fair, and progress improved. One entry was documented as refused. Three entries were documented as not observed. Six entries were documented as no information.December of 2025 the notes revealed 12 entries: Five entries were marked as no information. Seven were marked not observed.January of 2026 the notes revealed six entries: Five were marked no information. One was marked not observed.Review of Restorative Nursing Notes for minutes for passive range of motion (PROM)November 2025 the notes revealed 18 entries: Seven entries were documented as 15 minutes, tolerance fair, and progress no change. One entry was documented as 15 minutes, tolerance fair, and progress improved. One entry was documented as refused. Six entries were documented as no information. Three entries were documented as not observed.December 2025 the notes revealed 12 entries: Seven entries were documented as not observed. Five entries were documented as no information.January 2026 the notes revealed six entries: One entry was documented as not observed. Five entries were documented as no information.Review of the EMR revealed Physician's Orders for R69 included but not limited to splint to left hand 4 - 7 hours per day as tolerated with monitoring of (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	edema, skin integrity and pain and was dated 6/17/2025.Observations and interview with R69 on 1/16/2026 at 10:10 am revealed R69 was in bed and he stated he wanted to get up but staff do not get him up into a wheelchair at all. He revealed he received physical therapy but since the discharge from therapy services he has not been gotten up to a chair or wheelchair on a regular basis. He stated he felt as though he would lose the abilities he had obtained during therapy. Observed that R69 did not have a splint/brace on his left hand.Observations and interview with R69 on 1/17/2026 at 12:35 pm revealed R69 was in bed in his room. He reported staff did not offer to assist him to a chair the morning of 1/17/2026 nor did he ask to be assisted to a chair. He stated he did have a splint for his left hand but the last time he used it was several weeks ago and now he was unsure where it was. He stated he did want to get up into a chair. No splint/brace was noted to be on his left hand/extremity.Interview with CNA BB on 1/17/2026 at 1:45 pm, CNA BB stated she could find residents who needed restorative care by looking at their care plan she also revealed that when she documented in the EMR under the Activity of Daily Living (ADL) tab she could see restorative nursing that needed to be completed so she would only document no information because she was not the Restorative Aide. She stated only the Restorative Aide documented the actual restorative care given.interview with CNA CC on 1/17/2026 at 2:03 pm revealed that after residents finished rehab, some residents were transferred to the long-term care unit, and they assisted them with ambulation, range of motion, and placement of splints. She stated she could find which residents needed restorative nursing care in the EMR. She revealed that she documented restorative care in the EMR. She stated she documented the time spent with the residents and the activity performed. She stated when a resident refused twice, they reported this to the Restorative Nursing Supervisor who refers them back to rehab. An interview on 1/17/2026 at 2:23 pm with the Director of Nursing (DON) and the Regional Nurse Consultant, the DON revealed the process for a resident to be placed on restorative nursing care. A therapist from the therapy department evaluated the resident based on their needs and documented orders for restorative nursing, then the next step was the resident was placed on restorative nursing. She stated the Restorative Aide could print a list of residents from the EMR who were on restorative care and it would list the activities that the CNA needed to assist each resident with. She stated the Restorative Aide and CNAs could go to the point of care section of the EMR and it would show the restorative nursing activity that needed to be documented on. She stated only restorative aides documented restorative care and other CNA's who had been trained in restorative nursing could document the restorative care provided, but not all CNAs were trained in restorative care. She reported there was a Restorative Aide working six days a week. She stated that restorative nursing care should be documented when performed and the Restorative Nurse documented once a month. She confirmed and verified documentation of the restorative nurse documented a note on 7/3/2025, 7/10/2025, 8/7/2025, 9/12/2025, 10/16/2025, 11/20/2025 revealing the resident was receiving restorative nursing care and staff were applying a splint and performing exercises and in December 2025, the note revealed the resident was assisted with transfer from bed to chair and from chair to bed with one staff assist. She confirmed and verified the restorative aide documentation revealed in December of 2025 and January of 2026 the transfer assistance was not documented as completed.Review of the notes related to splint or brace assistance: The DON verified and confirmed for October of 2025 of the 22 entries made, only 15 documented the care was given and two entries documented the resident refused; the other five entries were documented and no information. She verified and confirmed in November of 2025, of the 18 entries made eight were documented as care was completed and one entry documented the resident refused, the other nine entries were documented as not observed or no information. She verified and confirmed that in December of 2025 there were 12 entries, five were documented as no information and seven were documented as not observed. She verified and confirmed that in January of 2026 only six entries had been made and five were documented as no information, and one as not observed. In review of the notes related to PROM she verified and confirmed in November of 2025 the documentation supported eight entries indicated (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the care was completed, six entries were documented as on information and three were documented as not observed. In December of 2025 she verified and confirmed the PROM was documented seven times as not observed and five times as no information. She verified and confirmed that the PROM was documented in January of 2026 one time as not observed and five times as no information. She stated her expectation was that staff document effectively and efficiently the care the Restorative Aide/Nurse provided, and if the resident refused care, the restorative aide should document the refusal and notify the nurse. She revealed R69 should receive restorative care 15 minutes a day, six days a week for each area noted under restorative care.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and record review, the facility failed to ensure one of 47 sample resident's (R) (R41) food preferences/needs were being accommodated, specifically for food allergies.Findings include:Review of R41's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating little to no cognitive impairment.Review of R41's banner on the electronic medical record (EMR) revealed caffeine was listed as an allergy.Review of the care plan for R41 revealed caffeine was listed as an allergy.Review of the meal ticket for R41 revealed caffeine was listed as an allergy.During an observation and interview on 1/16/2026 at 12:00 pm with R41 stated the dietary department consistently gave her coffee and she was allergic to caffeine. She further stated she did not touch it and unclear why it was overlooked when it was printed on the meal ticket.An observation on 1/17/2026 at 9:14 am of R41 with her meal tray confirmed there was a cup of coffee on her meal tray.During an interview on 1/17/2026 at 2:20 pm with the Dietary Manager (DM), he stated himself and the dietary aides were responsible for ensuring the meal tickets and meal trays were accurate. The DM further confirmed that coffee was a caffeinated beverage they give to residents on their breakfast tray. The DM was unsure of R41's allergies and if she was receiving caffeinated or decaffeinated beverage on her tray. However, he stated the nursing staff on the units should also be checking the meal tickets to ensure the tray was accurate before delivering it to the resident.During an interview on 1/17/2026 at 2:30 pm with R41, she stated when her meal tray was delivered, the staff did not verbalize if her coffee beverage was caffeinated or decaffeinated. An interview on 1/18/2026 at 12:58 pm with the Director of Health Services (DHS) stated upon admission they reviewed the residents' allergies on the hospital records and from there it would be stated throughout the EMR. The DHS continued to state the dietary staff were expected to verify the meal ticket with the meal tray and the nursing staff delivering the trays were to also confirm the meal ticket with the meal trays.