STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115314	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Austell	1700 Mulkey Rd Austell, GA 30106

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide information about how to apply for and use Medicare and Medicaid benefits. Based on record review, and family member and staff interviews, the facility failed to ensure one of one resident reviewed for billing (Resident (R) 3's) Family Member (F1) was provided with a timely refund for paying for a private room and failed to review the resident's billing for accuracy. As a result of this deficient practice, the resident was billed for excessive charges, and the bill was sent to collections for an unjustified charge.Findings include:Review of R3's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, revealed an admission date of 1/5/2024 and discharge date of 2/1/2024.During an interview on 7/1/2025 at 10:07 AM, Family Member (F) 1 explained the desire to have R3 in a private room and on 1/10/2024 they paid $3720, as requested by the facility for the private room, being reassured that everything else was covered by Medicare and the supplemental insurance. F1 had a concern about being billed for over $5600 and called the facility several times concerning the bill. During an interview on 6/30/2025 at 10:45 AM, the Business Office Manager (BOM) provided documentation from the business office files for R3 and confirmed there was a billing entry error for R3 resulting in being billed for 484 days of private room care when the actual days were 22 days. F1 had paid $3720 on 1/10/2024 for R3 to have care in a private room. When the error was revealed, a refund of $992 was sent to R3.Review of R3's Resident Statement, dated 2/19/2024 and provided by the facility revealed an outstanding balance of $56,296 for 484 days for a private room.Review of the debt collection letter, provided by the facility to R3 dated 4/26/2024 revealed a past due amount of $56,296, requesting immediate payment to the facility.Review of R3's Resident Statement, dated 11/22/2024 and provided by the facility revealed a refunded amount of $992.During an interview on 7/2/2025 at 2:47 PM, the Administrator confirmed refunds should be sent in a timely manner when a refund was due to a resident/resident family member.Review of the admission agreement, signed by R3 dated 1/5/2024 and provided by the facility revealed, Refunds. Any overpayments made by the Resident and held by the Facility will be refunded as soon as possible after any outstanding insurance claims have been verified and paid.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, family member and staff interviews, record review, and facility policy review, the facility failed to ensure residents received timely and necessary treatments for their conditions for two of 24 sampled residents (Resident (R) 1 and R4). These failures placed the residents at risk for their conditions to worsen by receiving delayed treatment. Findings include: Review of the facility's policy titled Medication Administration: General Guidelines, dated 04/10/29 indicated . Medications are administered in accordance with written orders of the attending physician. 1. Review of R1's Face Sheet located in the resident's electronic medical record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility with diagnoses including but not limited to senile degeneration of /the brain, not elsewhere classified, wedge compression fracture of second lumbar vertebra, scabies, and other nonspecific skin eruptions.Review of R1's EMR under the Resident Census tab indicated R1 was enrolled on Hospice services as of 12/11/2024. Review of R1's Progress Note dated 3/13/2025 and located in the resident's EMR under the Progress Note tab, indicated a staff member noticed spotted redness on R1's hands. The staff asked R1 what had happened and R1 stated she was itchy all over. The Progress note indicated the Nurse Practitioner (NP) was notified and ordered hydrocortisone 1% cream apply topically twice daily for 14 days. The Progress Note indicated R1's responsible party was notified of the change of condition. Review of R1's Progress Note, dated 3/6/2025 in the resident's EMR under the Progress Note tab indicated the nursing staff was notified by the Certified Nurse Aide (CNA) staff that R1's rash was distributed on R1's bilateral upper extremities and chest area, the Physician Assistant (PA) was present in the facility doing rounds and was able to assess the rash. The Progress Note indicated the PA ordered triamcinolone ointment treatment; two times a day for R1's rash.Review of R1's Progress Note, dated 4/2/2025 and located in R1's EMR under the Progress Note tab indicated R1's rash on the bilateral upper extremities and chest area had not improved. Skin treatment applied as ordered. Review of R1's Progress Note, dated 4/4/2025 and located in R1's EMR under the Progress Note tab indicated that triamcinolone acetonide cream was applied to the rashes.Review of R1's Progress Note, dated 4/8/2025 and located in R1's EMR under the Progress Note tab indicated R1's rash appeared to be spreading on different parts of her body, and the Nurse Practitioner (NP) and Responsible Person (RP) were made aware. The Progress note indicated that R1 denied itching or discomfort. A further note dated 4/8/2025 indicated the NP ordered hydrocortisone 1% (percent) cream, and a dermatology consult, and the RP was notified.Review of R1's Medication Administration Record (MAR) located in R1's EMR indicated R1 had a dermatology visit on 5/6/2025, and the Physician ordered mometasone ointment (topical ointment used to treat skin inflamed skin conditions) 0.1 %, .Amount to Administer: small amount; topically twice a day. The recommendation was for R1 to return to the Dermatologist in two weeks if the rash was not better.Review of R1's Patient Handout, dated 6/26/2025 and located in R1's EMR under the Orders tab, indicated R1 was seen by the Dermatologist on 6/25/2025, more than five weeks after the initial consultation instead of two weeks as the Dermatologist had recommended that she return if the rash was not improved. The Patient Handout contained the following information: Step one (every day)-permethrin 5% topical cream-apply neck to entire body overnight, wash off in am and repeat in one week, step one as directed-Ivermectin three milligram (mg) tablet take three tablets by mouth as a single dose and repeat in one week, and step two (as directed) triamcinolone acetonide 0.1% topical cream apply to affected areas on body twice a day as needed for itching.Review of R1's MAR, dated June 2025 and located in in R1's EMR under the Orders tab, indicated an order for Permethrin cream [a medication used to treat scabies and lice]; 5%, amount to administer: as appropriate, daily, and topically, the ivermectin [used to treat parasitic worm infections in humans] three mg tabs.three tablets by mouth as a single dose to be repeated in a week and triamcinolone acetonide 0.1% topical cream as needed for itching were being administered. According to the MAR the orders for this treatment were dated 6/26/2025, the same day R1 saw the Dermatologist.During an interview with Family Member (FM) 2 on 7/1/2025 at 3:00 PM, FM2 stated she attended a care plan meeting last Friday and she was told that it was the hospice staff's fault that R1's medicine did not arrive at the facility until 6/28/2025. She said R1 has had the rash for a while. FM2 said R1 finally saw the Dermatologist on 6/26/2025 and the medicine did not start until 6/28/2025. During an interview with Licensed Practical Nurse (LPN) 5 on 7/1/2025 at 3:30 PM, LPN5 called the facility pharmacy and was told that the Physician did not send the e-script (electronic prescription) to the Pharmacy until 6/27/2025, so the medicine was sent to the facility either Friday night (6/27/2025) or Saturday morning (6/28/2025), and the treatment plan was initiated

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and facility policy review, the facility failed to ensure one of three residents reviewed for falls (Resident (R) 12) out 24 sampled residents, had adequate supervision and the resident and/or family had been trained to transfer the resident from her wheelchair to a personal vehicle. The deficient practice had the potential for R12 to sustain a fall and cause harm.Findings include:Review of a facility policy titled Occurrences dated 1/11/2024 indicated .The healthcare center recognizes that due to the fragility of the patient/residents served, there is an increased risk of occurrences that may result in injury to the patient/resident and/or others. To prevent occurrences, each patient/resident will be observed and assessed for risks. Appropriate, realistic interventions will be implemented in accordance with their plan of care.Review of R12's electronic medical record (EMR) titled Resident Face Sheet located under the Resident tab indicated the resident was admitted to the facility on [DATE].Review of R12's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 01/30/25 located Aspen MDS Viewer indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which revealed the resident was cognitively intact. The assessment indicated the resident had impairments of her upper and lower extremities. The assessment indicated the resident was dependent on staff for transfers from bed to a chair and from a chair to the bed.Review of R12's Physical Therapy Treatment Encounter Note(s), dated 2/6/2025 and provided by the facility indicated the resident was a fall risk due to a right-side hemiplegia (stroke) and was dependent on staff for chair to bed and from bed to chair transfers.Review of R12's EMR titled Care Plan located under the RAI (Resident Assessment Instrument) tab dated 11/20/2024 revealed the resident was identified as being at risk for falls related to weakness, pain, and lack of coordination.During an interview on 6/30/2025 at 12:02 PM, R12 confirmed she was taken to a medical appointment (on 2/6/2025) and was not picked up by the facility. R12 stated her son needed to place her in the back of his car and transport her back to the facility.During an interview on 6/30/2025 at 2:58 PM, the Administrator stated the facility had no policy on transportation of a resident. The Administrator stated that depending on a resident's mobility, a family member could transport a resident back to the facility.During an interview on 7/1/2025 at 2:23 PM, the Director of Rehabilitation (DOR) stated that R12 was dependent on staff for transfers and stated rehabilitation did not provide the family with education on performing safe transfers with the resident. The DOR stated she would not have provided family education for transferring a resident to and from a car due to safety and her right sided paralysis.(Cross Reference F774)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to ensure the timely administration of a medication for one of three residents reviewed for medications (Resident (R) 4) out of a total sample of 24 residents. Specifically, R4 had multiple medications, and insulin administered late over six months. This had the potential for a reduction in the effectiveness of the medications. In addition, the late administration of fast acting and long-acting insulin had the potential to control levels of blood sugar.Findings include:Review of the facility's policy titled Medication Administration: General Guidelines dated 7/22/2024 indicated . Medications are to be administered as prescribed.Review of R4's electronic medical records (EMR) titled Resident Face Sheet indicated the resident was admitted to the facility on [DATE].a. Review of R4's Order History dated 8/16/2023 and provided by the facility indicated the physician ordered gabapentin (anticonvulsant medication used to treat nerve pain) 300 milligrams (mg) to be administered twice a date at 9:00 AM and 5:00 PM.b. Review of R4's Order History dated 2/9/2024 and provided by the facility indicated the physician ordered Hiprex (medication used to prevent UTIs) 1 gram to be administered twice a day at 9:00 AM and 5:00 PM.c. Review of R4's Order History dated 12/26/2024 and provided by the facility indicated the physician ordered Humalog five units to be administered with meals at 9:00 AM, 1:00 PM, and 5:00 PM.d. Review of R4's Order History dated 12/26/2024 and provided by the facility indicated the physician ordered Humalog solution to be administered subcutaneous as follows: If the resident's blood sugar was less than 65, to call the physician; if the resident's blood sugar was between 201 and 250 to administered three units; if the resident's blood sugar was 251 to 300 to administered six units; if the resident's blood sugar was 301 to 350 to administer eight units; and if the resident's blood sugar was 351 to 400 to administer 10 units. The order specifically indicated before meals and at bedtime scheduled at 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM.e. Review of R4's Order History dated 5/2/2025 and provided by the facility indicated the physician ordered carvedilol tablet 25 mg to be administered twice a day at 9:00 AM and 5:00PM.f. Review of R4's Order History dated 5/20/2025 and provided by the facility indicated the physician ordered Tresiba insulin pen (three units) was to be administered once a day at 9:00 AM.Review of R4's Medication Administration History (MAH) provided by the facility from January 2025 to May 2025 revealed:Review of the documents provided by the facility for the month of January 2025 the MAH indicated Hiprex was administered late to R4 on the following dates: on 1/1/2025 the 9:00 AM dose was not administered until 11:00 AM and the 5:00 PM dose was not administered until 1/2/2025 at 12:23 AM; on 1/2/2025 the 9:00 AM dose was not administered until 3:49 PM and the 5:00 PM dose was not administered until 7:46 PM; on 1/4/2025 the 9:00 AM dose was not administered until 11:06 AM and the 5:00 PM dose was not administered until 7:40 PM; on 1/5/2025 the 9:00 AM dose was not administered until 11:38 AM; on 1/7/2025 the 9:00 AM dose was not administered until 11:12 AM; on 1/8/2025 the 5:00 PM dose was not administered until 10:49 PM; on 1/11/2025 the 9:00 AM dose was not administered until 11:02 AM and the 5:00 PM dose was not administered until 9:17 PM; on 1/12/2025 the 9:00 AM dose was not administered until 11:33 AM and the 5:00 PM dose was not administered until 6:44 PM; on 1/18/2025 the 9:00 AM dose was not administered until 12:07 PM; and on 1/21/2025 the 9:00 AM dose was not administered until 11:30 AM and the 5:00 dose was not administered until 7:16 PM.Review of documents provided by the facility titled MAH for the month of February 2025 indicated the Hiprex was administered late to R4 on the following dates: on 2/1/2025 the 5:00 PM dose was not administered until 7:51 PM; on 2/2/2025 the 9:00 AM dose was not administered until 1:39 PM; on 2/4/2025 the 9:00 AM dose was not administered until 10:25 AM and the 5:00 PM dose was not administered until 7:13 PM; on 2/5/2025 the 9:00 AM dose was not administered until 12:06 PM; on 2/7/2025 the 9:00 AM dose was not administered until 12:06 PM; on 2/6/2025 the 9:00 AM dose was not administered until 10:39 AM; on 2/7/2025 the 5:00 PM dose was not administered until 10:12 PM; on 2/9/2025 the 9:00 AM dose was not administered 10:43 AM and the 9:00 PM dose was not administered until 7:38 AM; 02/10/25 the 9:00 AM dose was not administered until 12:41 PM; on 2/10/2025 the 9:00 AM dose was not administered until 12:41 PM; on 2/11/2025 the 9:00 AM dose was not administered until 10:22 AM; on 2/12/2025 the 9:00 AM dose was not administered until 12:06 PM; and on 2/13/2025 the 5:00 PM dose was not administered until 9:58 PM.Review of documents provided by the facility titled MAH for the month of February 2025 indicated the Humalog five units was administered late to R4 on the following dates: 2/1/2025 indicated the 9:00 AM dose was not administered until 10:50 AM and

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and record review, the facility failed to ensure one of three residents (Resident (R) 12) reviewed for transportation out of a total sample size of 24 residents, was picked up from a medical appointment by the facility's transportation. This failure placed residents at risk for unsafe transportation to a medical appointment from the facility.Findings include:Review of R12's electronic medical record (EMR) titled Resident Face Sheet located under the Resident tab indicated the resident was admitted to the facility on [DATE].Review of R12's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 1/30/2025 located under the survey shell indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which revealed the resident was cognitively intact.During an interview on 6/30/2025 at 10:26 AM, Certified Nurse Aide (CNA) 2 confirmed she left R12 at her medical appointment on 2/6/2025. CNA2 stated CNA1 was to pick the resident up.During an interview on 6/30/2025 at 10:29 AM, CNA1 stated there was a delay at R12's medical appointment and she was scheduled to clock out at 5:00 PM. CNA1 stated she informed the resident's son that she could not wait to take the resident back to the facility, so the son brought the resident back to the facility.During an interview on 6/30/2025 at 12:02 PM, R12 stated she was left at a medical appointment, and her son had to place her in the back of his car and this hurt her leg.During an interview on 6/30/2025 at 2:58 PM, the Administrator stated the facility did not have a policy on transportation for residents but stated her expectation was if the facility provided the transportation to the medical appointment for the resident, then the resident needed to be picked up by the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to ensure that clinical records were complete and contained accurate documentation for one of 24 residents sampled residents (Resident (R) 4). This failure had the potential for R4 not to receive accurate care.Findings include:Review of a facility's policy titled Medication Administration: General Guidelines dated 4/10/2019 indicated . Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.Review of R4's electronic medical records (EMR) titled Resident Face Sheet indicated the resident was admitted to the facility on [DATE].Review of documents provided by the facility titled Medication Administration History (MAH) for the month of January 2025 indicated R4's Hiprex was not documented as administered on the following dates: 1/3/2025 at 9:00 AM; 1/19/2025 at 9:00 AN; and on 2/13/2025 there was no documented evidence the resident received her Hiprex.Review of R4's Order History dated 8/16/2023 and provided by the facility indicated the physician ordered gabapentin (anticonvulsant medication used to treat nerve pain) 300 milligrams (mg) to be administered twice a date at 9:00 AM and 5:00 PM and Hiprex (methenamine Hippurate) tablet; 1 gram; amt: 1; oral Special Instructions: Take with meals.Review of a document provided by the facility titled MAH for the month of February 2025 indicated R4's gabapentin was not documented as administered to R4 on the following date: there was no documented evidence the medication was administered on 2/1/2025 at 5:00.Review of documents provided by the facility titled MAH for the month of May 2025 indicated R4's gabapentin was not documented as administered on the following dates: on 5/4/25 and on 05/05/2025 the 5:00 PM dose had no documented evidence that the gabapentin was administered to R4; and on 5/25/2025 the 5:00 PM dose had no documented evidence that the gabapentin was administered to R4.Review of documents provided by the facility titled MAH for the month of May 2025 indicated R4's Hibrex was not documented as administered on the following dates: on 5/4/2025 and on 5/5/2025 5:00 PM dose had no documented evidence that the gabapentin was administered to R4; and on 5/25/2025 the 5:00 PM dose had no documented evidence that the gabapentin was administered to R4.Review of R4's Order History dated 5/2/2025 and provided by the facility indicated the physician ordered carvedilol tablet 25 mg to be administered twice a day at 9:00 AM and 5:00PM.Review of documents provided by the facility titled MAH for the month of June 2025 indicated R4's carvedilol 5:00 PM dose was not documented as administered on 6/28/2025.During an interview on 7/2/2025 at 12:48 PM, the Director of Nursing (DON) stated that his expectation was for the nurses to document that medications were administered and this was part of the standard of care.