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	12/05/2025

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

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 0656 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled Care Plans, the facility failed to develop and implement comprehensive, person-centered care plans for two of 47 sampled residents (R) (R62 and R117) related to transfer needs for R62 and accommodation of needs for call light access for R117. This deficient practice resulted in actual harm to R62 on 12/5/2025 when staff improperly transferred the resident without using a gait belt.Findings included:A review of the facility's policy titled Care Plans, reviewed 1/21/2025, revealed under the section admission Comprehensive Plan of Care, Step 3: The comprehensive person-centered care plan is developed to include measurable goals and timeframes to meet a patient/resident's medical, nursing and psychosocial needs, the services that are to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial needs that are identified in the comprehensive assessment. Further review of this section, step 4: 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, should be written and have a relationship to the problem and goal(s) . Some interventions require all disciplines to be involved in the implementation, while others may only involve specific team members. When approaches that involve the CNA (Certified Nursing Assistant) have been added to the care plan, those approaches should also be included on the CNA Care Record or Resident Profile/Care Plan. 1. A review of the Electronic Medical Record (EMR) revealed R62 was admitted to the facility on [DATE] and pertinent diagnoses, including but not limited to right tibial shaft fracture (subsequent encounter), morbid obesity, generalized muscle weakness, and lack of coordination. Observation and interview on 12/5/2025 at 12:10 pm with R62 revealed a 3×3 bandage on her right knee. She reported falling earlier that morning between 10:00 and 11:00 am while transferring from her bed to her wheelchair. R62 reported that she attempted to scoot into the wheelchair using her left leg, as she was non-weight-bearing on her right leg, when her left leg gave out and she began to fall. The CNA present did not provide hands-on assistance and only attempted to grab R62's pants, which were loose, failing to prevent the fall. R62 fell onto her right knee, causing a laceration, and then struck her head. She reported that her nurse bandaged the knee. R62 stated that physical therapy always uses a gait belt with hands-on assistance, but nursing staff and CNAs typically do not, and she had not refused assistance; in fact, she asked for it. A gait belt was visible and accessible in her room. R62 became tearful during the interview, expressing concern about her knee injury delaying recovery and stating she just wants to go home. (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 0656 Level of Harm - Actual harm Residents Affected - Few	A review of R62's progress note dated 12/5/2025 at 12:17 pm indicated that the Certified Nursing Assistant (CNA) notified staff that the resident was on the floor. The nurse responded and obtained vital signs. A body audit revealed a swollen area in the middle of the head and a wound on the right knee. The resident denied pain or discomfort. The nurse notified the Nurse Practitioner (NP), who ordered an X-ray of the right knee and instructed staff to monitor for any changes and report immediately. The resident's son was notified and stated he was on his way to the facility. Neuro-checks were initiated. A review of R62's Census entry dated 12/5/2025 at 1:35 pm indicated that the resident was transported to the hospital. This event was documented solely in the electronic medical record Census, with no accompanying progress note entered. A review of the written statement of the event, submitted by CNA TT after being interviewed by the surveyor, read: When I walked in the room, she asked for help to be transferred into the wheelchair. I went to help her in the chair I was standing on the left side of the resident the wheelchair was locked and next to the bed she went to stand up I grab her pants and she turned to sit in chair and her leg buckle went to the floor very quickly face forward, I rolled her over and place a pillow under head and went and got the nurse. The statement does not explicitly indicate that CNA TT provided hands-on physical assistance to R62 during the transfer, despite R62 asking for help. Additionally, the statement describes that CNA TT moved R62 after the fall by rolling her over and placing a pillow under her head before notifying the nurse, which is contrary to facility policy requiring a licensed nurse to assess a fallen resident before any movement. By moving R62, CNA TT potentially placed the residents at further risk of injury. A review of R62 admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated R62 was cognitively intact, and that R62 had impairment of the lower extremities. A review of the Care Area Assessment (CAA) on the admission MDS dated [DATE] indicated R62 was identified with problems in the areas of functional status, falls, mobility, pain, and chronic disease conditions. A review of R62's care plan dated 9/17/2025 indicated a problem of risk for falls related to generalized weakness, impaired physical mobility related to recent hospitalization, and potential for pain related to a right tibial fracture. Goals included, but were not limited to, preventing injury related to falls. Interventions included, but were not limited to, assisting with transfers and toileting as needed. An interview on 12/5/2025 at 12:47 pm with CNA TT revealed she was present in the room when R62 attempted to transfer from the bed to the wheelchair. She stated R62 was sitting on the side of the bed, with the wheelchair wheels locked, and as R62 stood and attempted to transfer, she buckled. Reported that she reached toward R62 by grabbing her pants, but the pants came up and R62 landed on the floor. She confirmed that she did not make contact or provide physical assistance prior to the resident beginning to fall. When asked whether R62 had refused assistance or indicated she wanted to transfer independently, she stated, No, she did not say anything like that. She is the type who needs to do it herself, and we always do that with her. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	An interview on 12/5/2025 at 1:42 pm with the Director of Nursing (DON) revealed that CNAs are expected to follow the care plan when assisting residents with transfers. 2. A review of the admission record revealed that R117 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, nontraumatic intracerebral hemorrhage, acquired absence of right upper limb above elbow, acquired absence of left upper limb below elbow, acquired absence of right leg above knee, and acquired absence of left leg above knee. A review of the quarterly Minimum Data Set (MDS) assessment for R117, dated 10/2/2025, revealed she presented with a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate to severe cognitive impairment, and that R117 required total assistance for all care to include eating, oral hygiene, toileting, bathing, and dressing. A review of the care plan dated 8/22/2025, revealed that R117 had no indication or problem statement regarding R117's inability to use the upper extremities to activate the call light. Care plan approaches noted keep call light in reach at all times. An observation and interview on 12/2/2025 at 12:30 pm with R 117 revealed she was lying on her bed, alert and oriented, watching television. The call light placement on the bed was about six inches out of reach. R 117 confirmed she did not need any assistance at the time, but could not reach the call light if she did need assistance. During an observation on 12/3/2025 at 2:20 pm, R117 was sitting in a reclining position in her wheelchair in her room, watching television. During the interview, R117 was asked if she was able to use her call light to get assistance from staff. R117 demonstrated she was not able to, as the call light was placed on her bed and out of reach. The call light was observed lying in the middle of the bed, at least one foot from R 117. When asked how she gets assistance if she can't use the call light, she stated, I scream out loud even though I know I'm not supposed to do that. During an observation on 12/4/2025 at 10:00 am, certified nursing assistant (CNA) RR was observed providing care for R117. Before leaving the R117's room, CNA RR left the call light on a table at the foot of the bed, out of reach of R117. During an interview with CNA RR at that time, she confirmed that she did not leave the call light within reach for use by the R117, and she returned to R117's room to place the call light within reach. During an interview on 12/4/2025 at 12:15 pm, Nurse Unit Manager NN confirmed that R117 had difficulty activating the nursing call system. Nurse NN confirmed that R117 could benefit from using a more reliable call light device because R117 moves around in the bed, which could easily shift the call light pad, making it difficult to activate it. Nurse NN stated she will report this to the Director of Nursing (DON) so that a breathcall call light device could be ordered for R117. During an interview on 12/4/2025 at 3:30 pm, the DON confirmed that a breathcall call light system was being ordered for R117 to assure she has a reliable means to call for assistance. The DON confirmed he was not aware of R117's inability to activate the call light system using the call pad.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility policy titled Oxygen Administration, the facility failed to ensure oxygen (O2) was administered as ordered for two of 12 residents (R) (R123 and R62) who used oxygen. Specifically, the facility failed to administer oxygen at the correct ordered setting for R123 and failed to ensure oxygen was not administered without a physician's order for R62. These deficient practices placed both residents at increased risk for respiratory complications and adverse clinical outcomes.Findings included:A review of the facility policy titled Oxygen Administration, dated 11/17/2025, revealed under the Procedure section that Oxygen will be administered by licensed personnel only when ordered by the physician, PA, or NP. Further review of this section indicated, under Step 4, that staff are to Regulate liter flow to ordered/desired flow rate.1. A review of the electronic medical record (EMR) revealed R123 was admitted to the facility on [DATE] and pertinent diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, hypertensive heart disease with heart failure, chronic diastolic (congestive) heart failure (CHF), and atrial fibrillation.A review of R123 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14, which indicated R123 was cognitively intact. Section GG, functional status, revealed wheelchair use requiring substantial/max assist with activities of daily living (ADLs). Section O revealed oxygen therapy. A review of R123 care plan dated 11/25/2025 indicated a problem of COPD and CHF. Goals included but not limited to maximizing oxygen levels, maintaining optimal breathing and oxygenation within the limits of COPD. Interventions included, but were not limited to, administering oxygen as ordered, and monitoring oxygen saturation per protocol. A review of the Physician's Order for R123 included but were not limited to: Order dated 8/12/2025 for Oxygen at 2 LPM (Liters Per Minute) via nasal cannula (NC) continuous. An observation and interview on 12/1/2025 at 12:37 pm revealed, R123 was wearing his oxygen via NC and the O2 concentrator (machine that produces oxygen) was running at the setting of 1.5 LPM. An observation on 12/2/2025 at 1:27 pm revealed, R123 was wearing his oxygen via NC and the O2 concentrator was running under 2 LPM. An observation and interview with Licensed Practical Nurse (LPN) II on 12/2/2025 at 3:20 pm confirmed, the O2 concentrator setting was set below 2 LPM, which was the ordered setting. The LPN initially did not observe the concentrator at eye level but corrected the setting once she did. She stated that she had checked the settings earlier that morning and it is the expectation for them to reflect the physician's orders.2. A review of the EMR revealed R62 was admitted to the facility on [DATE] and pertinent diagnoses including but not limited to chronic respiratory failure with hypoxia, COPD, atherosclerotic heart disease of native coronary artery without angina pectoris, and anemia. A review of R62 admission MDS assessment dated [DATE] revealed a BIMS of 15, which indicated R62 was cognitively intact. Section GG, functional status revealed impairment of lower extremity and use of a wheelchair requiring substantial assist with ADLs. Section O revealed oxygen therapy. RA rview of R62 care plan dated 9/17/2025 indicated the care plan did not address any respiratory conditions until 12/2/2025, when it was discovered during the survey that there were no physician orders for oxygen on record. At that time, a problem of COPD was added to the care plan. Goals included but not limited to maintaining optimal breathing and oxygen levels within the constraints of the terminal diagnosis and maximizing oxygen levels over the next 90 days. Interventions included, but were not limited to, administering oxygen as ordered, monitoring oxygen saturation as ordered, allowing ample time for activities of daily living, and notifying the physician of any changes.A review of the Physician's Orders for R62 revealed that there were no orders for oxygen prior to 12/2/2025. On 12/2/2025, an order was added for oxygen at 2 LPM via nasal cannula (NC) continuous.An observation and interview on 12/1/2025 at 12:45 pm revealed, R62 was wearing her oxygen via NC and the O2 concentrator was running at the setting of 2 LPM. An observation on 12/2/2025 at 2:03 pm revealed, R62 was wearing her oxygen via NC and the O2 concentrator was running at the setting of 2 LPM. An observation and interview with LPN II on 12/2/2025 at 2:58 pm confirmed that she was unable to locate any oxygen orders in the EMR despite searching for approximately 20 minutes. When asked what she had referenced earlier that morning when she reported checking the resident's oxygen settings, she stated that she did not know. This raised concern regarding the basis of her assessment in the absence of any physician orders.An interview with the Administrator on 12/4/2025 at 5:15 pm indicated that residents requiring oxygen must have proper physician orders, and nurses are expected to follow these orders. An

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review, staff interviews, and review of the facility's policies titled Medication Administration: General Guidelines, the facility failed to ensure accurate administration of medications for two of 28 medication opportunities observed, resulting in a medication error rate of 7.14%. This deficient practice has the potential to negatively impact residents leading to complications of current health status. The facility census was 97.Findings included:A review of the facility's policies titled Medication Administration: General Guidelines reviewed 7/28/2025 revealed under the Procedure step 2. Medications are administered in accordance with written orders of the attending physician.An observations of medication administration were conducted on 12/3/2025 on two medication carts across two halls (West-A and West-B) with two Registered Nurses (RNs) during three administration times. An observation on 12/3/2025 at 5:30 pm on West-B hall with RN BB, it was observed that R54 had physician orders for Omega-3 (fish oil) 300 mg (120 mg-180 mg)-1,000 mg, two capsules orally twice daily, and Voltaren Arthritis Pain (diclofenac sodium) 1% gel, 2 grams topically to the shoulder and lower back four times daily. The nurse administered only one capsule of fish oil, despite the physician's order for two capsules. The nurse then dispensed the Voltaren gel by squeezing an unmeasured amount into a medication cup, rather than measuring the ordered 2 grams. The nurse applied the gel to the resident's shoulders but did not apply it to the lower back as ordered.An interview on 12/3/2025 at 5:40 pm with RN BB reported that he did not see a specified amount for the Voltaren (diclofenac) gel in the electronic record. This was stated after the surveyor asked what dosage he was referencing, as he had been observed squeezing an unmeasured amount of the gel into a medication cup without using a measuring tool. An interview on 12/4/2025 at 5:15 pm with the Administrator indicated that the facility maintains a zero-tolerance standard for medication errors. She stated that staff are required to follow all physician orders, implement new orders promptly, and notify the physician as indicated.An interview on 12/4/2025 at 5:35 pm with Director of Nursing (DON) indicated that the facility expects a zero medication-error rate to ensure resident safety. He stated that nurses are responsible for reviewing physician orders and administering medications exactly as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, staff interviews, review of manufacturer package inserts, the list titled Expiration Dates for the Following Medications After Opening, and review of the facility policy titled Medication Storage in Healthcare Centers, the facility failed to ensure medications were stored in a safe and secure manner for two of five medication carts (West A and [NAME] B) observed. Specifically, one medication cart contained two expired ophthalmic (eye) drops, one nutritional supplement bottle that was soiled, stored in a bag with a crystallized substance, and had an expiration date that was no longer visible, and a loose unlabeled pill and capsule. In addition, the controlled substance book on that cart contained multiple pages that were torn, loose, and no longer secured within the binder. On a second medication cart, an additional loose unlabeled capsule was found. These deficient practices demonstrate that the facility failed to maintain a safe and secure medication storage system, placing residents at risk of receiving expired, incorrect, or unaccounted-for medications.Findings included:A review of the facility's policy titled Medication Storage in Healthcare Centers, revised 11/11/2025, revealed under the Procedures section Step 3: Nurses . are required to check all medications for deterioration and expiration before administration. Nursing staff . who administer medications are responsible for the cleaning and organization of medication carts and storage areas. Further review of this section revealed Step 12: . ophthalmic and otic preparations . are to be dated (when opened). Except where manufacturer recommendations require a shorter expiration date, . with the exception of latanoprost, will expire according to the manufacturer's expiration date. Further review also revealed Step 13: A daily audit and checklist by a medication/treatment nurse will be completed for all medication carts. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy.A review of the facility's list titled Expiration Dates for the Following Medications After Opening, undated, revealed that for ALL OTHER EYE, EAR, NOSE, INHALERS, the list directs to follow MANUFACTURER EXP (expiration) DATE. A review of the Combigan (brimonidine tartrate/timolol maleate) ophthalmic solution package insert, page 10, section 17, revealed the instruction: Do not use the product after the expiration date marked on the bottle.A review of the Cosopt (dorzolamide hydrochloride-timolol maleate) ophthalmic solution package insert, page 36, under How should I store dorzolamide hydrochloride-timolol maleate ophthalmic solution? revealed the instruction: Do not use your medicine after the expiration date on the bottle.An observation and interview on 12/3/2025 at 10:50 am of the nurse's medication cart with Registered Nurse (RN) FF on West-A hall revealed the following:Controlled Substance Record Book: Multiple pages were torn, loose, and no longer secured within the binder. During inspection, these pages easily fell out, creating a risk for inaccurate or incomplete controlled substance accountability. Active Liquid Protein, Sugar-Free 30 FL Oz bottle: expiration date no longer visible; was soiled, stored in a bag with a crystallized substance.Combigan Sol 0.2/0.5% ophthalmic drops: opened 9/28/2025, expired 11/28/2025.Dorzolamide/Timolol Sol 2-0.5% ophthalmic drops: opened 10/22/2025, expired 11/30/2025.Loose unidentified medications: One tablet and one capsule were found outside of any packaging inside a medication drawer. The nurse was unable to identify the medication or determine which resident(s) they were prescribed to. An observation and interview on 12/3/2025 at 11:59 am of the nurse's medication cart with Licensed Practical Nurse (LPN) JJ in the West-B Back hall revealed the following:Loose unidentified medication: One capsule was found outside of any packaging inside the medication drawer. The nurse immediately reached for it and discarded it into the sharps container. The nurse was unable to identify the medication or determine which resident it was prescribed to. Interview on 12/3/2025 at 11:24 am with RN FF and the Assistant Director of Nursing (ADON) confirmed the presence of expired medications/supplements, loose/unlabeled medications, and unsecured pages in the Controlled Substance Record Book, on the nurse's medication cart. They both explained that expired medications should not be administered, as they may be ineffective. This concern also extends to any supplements for which the expiration date is not visible, as they may also be ineffective. They further noted that the presence of loose, unidentified medications creates a risk that residents may not receive their prescribed medication. Similarly, if pages in the Controlled Substance Record Book are loose, torn, or unsecured, this could result in medications not being administered properly or according to orders. The ADON and RN emphasized that all nurses were responsible for monitoring their medication carts to ensure that medications did not expire. They ADON reported that the expired medications would be discarded, replacement medications would be