| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115314 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pruitthealth - Austell | 1700 Mulkey Rd<br>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) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579<br><br>Based on observations, staff and resident interviews, and record review, the facility failed to ensure a resident's right to dignity for one of 38 sampled residents (R) (R41). Specifically, R41 was left unclothed and uncovered in the middle of care.<br><br>Findings include:<br><br>Review of the electronic medical record (EMR) for R41 revealed that she was admitted to the facility with diagnoses that included but were not limited to generalized anxiety disorder, depression, and quadruple amputee.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that R41 had a Basic Interview of Mental Status (BIMS) score of 15, indicating intact cognition. Review of Section E (Behavior) revealed that she had no behavior which includes refusal of care. Review of section GG (Functional Abilities and Goals) revealed that she had impairment on both sides of both upper and lower extremities and was total dependence of staff with all activities of daily living (ADLs).<br><br>Observation and interview on 6/12/2024 at 4:55 pm, R41 was observed sitting in her wheelchair, dressed, wearing sunglasses. The resident stated that she felt like she had a target on her back, and it had been ever since she filed a complaint about a Certified Nurses Aid (CNA) neglecting her. She stated that on 2/14/2024 the CNA on duty had come in to render care. She continued by stating that during care, she had asked the CNA if she could come back at around 2:00 pm that afternoon so that she could help her get ready for the Valentines Day party. She then stated that the CNA got angry with her and told R41 that she would try, but that she had other residents to attend to and would not guarantee that she could come back at 2:00 pm. R41 then stated that the CNA got upset with her and threw one of her prosthetic legs at the wall, then left the room with her naked and uncovered.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Pruitthealth - Austell | 1700 Mulkey Rd<br>Austell, GA 30106 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 6/13/2024 at 1:45 pm, R41 stated that the care plan meeting went like she thought it would go. She stated that Social Services offered help if she wanted to transfer to another facility. I still feel like I have a target on my back. It didn't use to be this way, but now since 2/14/2024, it has progressively worsened. She stated that they will come in at 11:00 am to get me up. She stated that there would be several hours between visits. Second Shift usually only came in when I called. She stated that third shift, it depended on who was here. They would come in at the beginning of the shift and then maybe at 6:00 am. She stated that the Nurse Supervisor would come in around 3:30 am or 4:30 am. A lot of times, it took them a long time to get someone in my room to answer the call bell. She then continued by stating at times she had turned on her call light and it took so long that she had gone down to the nurse's station and found nurses just sitting there, with the call light still going off.<br><br>Review of the facility reported incident report that was filed on 2/27/2024 revealed that R41 alleged that a CNA neglected her on 2/14/2024. It was reported to staff on this date that a CNA that was providing care left her in the bed with no clothes on and did not come back to finish the care. There were interviews that were obtained during the investigation that revealed that the resident was left naked and uncovered.<br><br>Interview on 6/13/2024 at 2:43 pm with the Unit Manager, she stated that it was the responsibility of everyone to answer the call lights.<br><br>Interview on 6/13/2024 at 3:05 pm with CNA PP, she stated that R41 had never had any difficult behaviors that she had seen. If she was doing care, R41 would always ask for details so that all her needs were being meet. If she wanted to go to an activity, she would ask her about all the details and would come back and help her to get ready for that activity. She then stated that she had noticed that R41 had isolated herself. She had been upset about an incident that occurred when she turned on her call light and no one answered the light. She stated that she did not turn on the call light very often and if she turned it on, then she really did need something. She continued by stating that R41 was not needy, just particular about what she wanted and when she needed to get her up for the day, she needed to dedicate a full hour to her, because of her condition. And she also knew that she needed two bathroom breaks during the shift after she had been gotten up.<br><br>Interview on 6/13/2024 at 6:30 pm with the Director of Healthcare Services (DHS), she stated that she expected that staff were providing privacy, and at the time of the incident with R41, that she expected that the resident be covered and to go and get another CNA and nurse to finish providing care, and that the CNA did close the curtain. She then stated that it was the responsibility of everyone to answer call lights. She would expect any non-clinical staff to do what they could do after answering the call light and then letting the appropriate person know if it was something that they could not do. If all CNAs were busy, if the nurse was not in the middle of a med pass of something else, I would expect the nurses to answer the call lights and do what was needed, if not, go and get the CNA.<br><br>Interview on 6/13/2024 at 6:32 am with the Administrator, she stated that she expected call lights to be answered and everyone was responsible for doing it. |

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| Pruitthealth - Austell | 1700 Mulkey Rd<br>Austell, GA 30106 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47946<br><br>Based on observations and staff interviews, the facility failed to provide a safe, clean, comfortable, homelike environment for six of 64 rooms on two of four halls. These rooms and hallway contained dirty damaged bathroom ceiling exhaust fan vent covers, dirty damaged Packaged Terminal Air Conditioner (PTAC) units, a bathroom sink with low water pressure, damaged hallway handrails, and pungent odor in the west wing hallways.<br><br>Initial screening observations on 6/11/2024 at 9:00 am in/near room [ROOM NUMBER] revealed a strong, pungent odor near the doorway.<br><br>Initial screening observations on 6/11/2024 at 9:15 am in rooms [ROOM NUMBER] revealed PTAC unit filters were dirty with thick, gray, fluffy substances. Further observations revealed the vent in room [ROOM NUMBER] also had black substances scattered on the upper vents.<br><br>Initial screening observations on 6/11/2024 at 9:40 am in room [ROOM NUMBER] revealed the bathroom sink with low water pressure.<br><br>Initial screening observations on 6/11/2024 at 11:30 am in rooms [ROOM NUMBERS] revealed dirty ceiling exhaust fan vent covers, not secured to the ceiling and hanging above the toilet area.<br><br>Observations on 6/12/2024 at 10:26 am and 6/13/2024 at 10:45 am in rooms [ROOM NUMBER] revealed PTAC unit filters dirty with thick, gray, fluffy substances. Further observations revealed the vent in room [ROOM NUMBER] also had black substances scattered on the upper vents.<br><br>Observations on 6/12/2024 at 10:26 am and 6/13/2024 at 10:45 am in room [ROOM NUMBER] revealed the bathroom sink with low water pressure.<br><br>Observations on 6/12/2024 at 10:26 am and 6/13/2024 at 10:45 am in rooms [ROOM NUMBERS] revealed dirty ceiling exhaust fan vent covers, not secured to the ceiling and hanging above the toilet area.<br><br>Observations on 6/12/2024 at 10:26 am and 6/13/2024 at 10:45 am revealed the handrails between rooms [ROOM NUMBERS] had exposed wood, and the veneer covering was loose on the handrail between rooms [ROOM NUMBERS], and rooms [ROOM NUMBERS].<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview and walking rounds on 6/12/2024 at 10:45 am with the Administrator, Environmental Services Director (ESD) and Maintenance Director (MD) confirmed dirty damaged bathroom ceiling exhaust fan vent covers, dirty damaged (PTAC) units, bathroom sink with low water pressure, and damaged hallway handrails. The ESD revealed the maintenance staff clean the filters monthly and they keep a log of this. He did not want to say if he thought the filters were cleaned in the last month. The Administrator stated they were cleaned, and they just collected a lot of dust because they had been doing a lot of construction work and running electrical cords through the windows. The ESD stated his expectation was for environmental issues to be taken care of as soon as possible. He stated the staff reported issues to maintenance via the maintenance logbook located at each nursing desk and they now have the TELS (maintenance work order system) system that the staff have been acclimating to. He revealed he also oversaw Housekeeping and he stated there were several rooms which they consider to be hot rooms. He stated this means the housekeepers clean those rooms more often. He stated the housekeepers will clean those rooms twice a day on each morning and evening shift. He stated they have been trying a number of cleaning agents to address the strong pungent odors on the west wing halls. The ESD further stated that the bathroom ceiling exhaust fans and hallway handrails needing repair must have just happened because staff are good at reporting issues to him.<br><br>Review of the [NAME] Wing maintenance logbook revealed no issues identified were logged in the last month. The ESD and MD stated they were not aware of any Maintenance policy. The Administrator confirmed the facility do not have a Maintenance or Environmental policy. The Administrator asked the ESD and MD to immediately correct and address the areas of concern in each room. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>49396<br><br>Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Grievances: Healthcare Centers, the facility failed to file a grievance on behalf of one of 38 sampled residents (R) (R47) who had concerns with a roommate.<br><br>Findings include:<br><br>Review of the facility policy titled Grievances: Healthcare Centers revised 11/21/2022 revealed under Scope: This policy applies to all partners employed by the healthcare center, patients, and/or other customers. It revealed under Definitions: A grievance includes, but is not limited to, complaints with respect to care and treatment that has been furnished to a patient, as well as that which has not been furnished, the behavior of staff and of other patients, and other concerns regarding the patient's facility stay. Under Procedures it revealed: 1. In the event a patient expresses a grievance or complaint to a staff member, one or more of the following actions will be taken: If the patient or family member requires assistance with writing the grievance, the staff person receiving the information will assist with completing the appropriate section of the Grievance/Complaint Form: Healthcare Centers.<br><br>Observations and interview during walking rounds on 6/11/2024 at 11:38 am, R47 was seated in his room doorway. R47 expressed concerns about persistent odors coming from his roommate's area, particularly during activities of daily living (ADL) care and wound treatment.<br><br>Observation on 6/12/2024 at 10:15 am, R47 was seated in a wheelchair, still distressed by the odors. R47 confirmed that the smell was affecting his ability to enjoy meals and impacting his quality of life within the facility.<br><br>Interview on 6/12/2024 at 1:10 pm with Certified Medication Aide (CMA) QQ, she stated that R47 had told her a few times about the situation with smells from his roommate's area of the room, and he would not eat his food. She didn't file a grievance, but when she was working on this hall, she tried to honor his wishes.<br><br>Interview on 6/12/2024 at 1:18 pm with Certified Nursing Assistant (CNA) RR, she said that R47 had expressed concerns regarding the smell in the room. She said she tried to be mindful and provide treatment after he had eaten his breakfast, but she didn't think to report it or file a grievance on his behalf. She offered for him to eat in the dining room, but he refused.<br><br>Interview on 6/12/2024 at 1:35 pm with Unit Manager JJ, she stated she was aware of R47's complaint about the smell in his room. They tried to accommodate him by offering him the option of going into the dining room and moving, but he declined. She was asked why she had not filed a grievance, and she stated, I don't think it's that in depth to file a grievance. It's not that serious.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 6/12/2024 at 2:50 pm with Wound Care Nurse EE, when asked about R47 complaining about the smell in the room and not being able to eat his food, she stated that he hadn't said that to her and would try to be more mindful of the situation, but she had just gotten back from vacation and maybe mentioned it to another wound care nurse.<br><br>Review of the Grievance Log revealed no documentation that a grievance was filed on behalf of R47.<br><br>Interview on 6/13/2024 at 8:12 am with the Director of Health Services (DHS) and the Administrator, when asked what the proper protocol was for a resident who was not happy with their roommate and didn't feel comfortable eating in their room due to bad smells, she said the protocol was to write a grievance and try to accommodate the resident by changing rooms or offering another alternative. When asked if R47 had ever complained to her or if the staff had ever reported R47's concerns, the DHS and the Administrator said it was the first time they had heard of it, or they would have addressed it. When asked what the protocol was for facility staff that R47 had informed of his concern, she stated they were supposed to tell their supervisor so they could follow up with a grievance. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579<br><br>Based on observations, resident and staff interviews and record review, the facility failed to provide activities of daily living (ADLs) for two of 38 sampled residents (R) (R 42 and R106). Specifically, showers and assistance with grooming were not provided for R42 and assistance with grooming was not provided for R106.<br><br>Findings include:<br><br>A policy for ADLs and grooming was requested from the facility. Facility representatives stated that they did not have policies for ADLs and grooming.<br><br>1. Review of the electronic medical record (EMR) for resident R42 revealed that she was admitted to the facility with diagnoses that included but were not limited to multiple sclerosis, repeated falls, low back pain, depression, and contractures of right and left ankles.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that R42 had a Basic Interview of Mental Status (BIMS) score of 15, indicating intact cognition. Review of Section E (Behavior) revealed that she was not noted to have behaviors that included refusal of care. Review of Section GG (Functional Abilities and Goals) revealed that she needed substantial/maximal assistance or total dependence of staff for ADLs including showers and grooming. Review of Section H (Bladder and Bowel) revealed that she was always incontinent of bladder and bowel.<br><br>Review of the care plan for R42 revealed that she will not have further deterioration in eating, dressing, toileting, grooming, and maintain personal hygiene. Approaches for this problem include but are not limited to requiring two (2) persons assist with transfers, will have bath as scheduled of her choice, requires maximum assistance with ADLS and transfers with the lift, and staff to provide assistance for eating, dressing, toileting, grooming, and maintaining personal hygiene.<br><br>Observation and interview on 6/11/2024 at 11:10 am of R42 revealed she was noted to have facial hair and was unkempt. There was a strong urine smell noted. R42 stated that she got hurt from the mechanical lift before and she does not like the mechanical lift very much. She then stated that when she tells them that she was afraid of the mechanical lift, the staff thought that she was refusing a shower.<br><br>Observation on 6/12/2024 at 7:00 pm, R42 was lying in bed, wearing the same shirt she was wearing the day before. Her hair was unkept and oily and still had facial hair.<br><br>Observation on 6/13/2024 at 1:26 pm, R42 was noted lying in the bed with a different shirt on, that was covered in food. She stated that she had not had a shower, but she told the Certified Nursing Assistant (CNA) assigned to her today that she wanted one. There was a strong urine smell in the room.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Shower sheets were requested from the facility representatives for R42, and Body Audit Forms were provided. Review of Body Audit Forms for R42 revealed that complete bed baths were given to her on 5/7/2024, 5/10/2024, 5/15/2024, 5/17/2024, 5/20/2024,5/27/2024,5/29/2024, 6/5/2024, and 6/12/2024. Continued review of the Body Audit Forms revealed that there were no documented baths or showers given to R42 on her regular shower days on 4/29/2024, 5/1/2024, 5/3/2024, 5/8/2024, 5/13/2024, 6/7/2024, and 6/10/2024.<br><br>Interview on 6/13/2024 at 2:21 pm with CNA NN, she stated that if a resident refused a shower, then she would report it to the nurse and the Unit Manager. I would then offer them a bed bath. She stated that R42 says that the mehanical lift hurts her and that she does not like the shower chair, so she will give her a bath. If the resident refused, the nurse would be notified and then it would be documented on the shower sheet, and it would be charted not done in the resident's chart. She stated that A bed showers/baths were completed on the first shift and B bed showers/baths were completed on the second shift. She then ended the interview by stating that if there were any ladies with facial hair, she would need to let the Unit Manager know, so that she could get supplies.<br><br>2. Review of the EMR for R106 revealed that she was admitted to the facility with diagnoses that included but were not limited to muscle weakness, unspecified lack of coordination, cognitive communication deficit and age-related osteoporosis without current pathological fracture and dementia.<br><br>Review of the MDS for R106 dated 4/9/2024 revealed that she had a BIMS score of 3, which indicated she is severely cognitively impaired. Review of Section E (Behaviors) revealed that she did not have any behaviors that included no rejection of care. Review of Section GG (Functional Abilities and Goals) revealed that she needed substantial/maximal assistance with toileting, showers, and personal hygiene.<br><br>Observation and interview on 6/11/2024 at 10:55 am with R106, she was sitting in her wheelchair, dressed. She was also observed with long facial hair on her chin. She stated, Yeah, I will be able to tie it as a goatee soon, and she laughed. She then began to cry and asked about her mother.<br><br>Observation on 6/12/2024 at 6:35 pm, R106 was laying in her bed with her eyes closed. She was noted to still have facial hair on her chin.<br><br>Interview on 6/13/2024 at 2:43 pm with the Unit Manager, she stated that typically the CNA asks multiple times if a resident refused a shower. If the resident refused the shower, they are to offer a bed bath. They are then to document that it was offered, and it was refused.<br><br>Interview on 6/13/2024 at 6:30 pm with the Director of Health Services (DHS), she stated that she expected that female residents were groomed, clean, and looked presentable. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47146<br><br>Based on observations, staff and resident interviews, record review, and review of the facility policies titled, Medication Administration: Oral Medications and Occurrences, the facility failed to document administration of pain medication on the electronic Medication Administration Record (eMAR) and follow up on the assessment related to a fall for one of 38 sampled residents (R) (R97), and to re-order / follow up on delivery of pain medications for one of 38 sampled residents (R23), The deficient practice had the potential to place R97 and R23 at risk for medical complications, unmet needs, and a diminished quality of life.<br><br>Findings include:<br><br>Review of the facility policy titled Occurrences revised on 1/11/2024 revealed under the Policy Statement The health care center recognizes that due to the frailty of the patients/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. Under the sub-section titled Medical Attention the policy revealed the licensed nurse will be responsible for providing immediate medical attention including but not limited to check vital signs, provide first aid if indicated, notify the attending physician or designee, informing them of the occurrence and patient/resident condition, implement the physician instructions/orders if indicated, and notify the responsible party. Under the subsection titled Occurrence Documentation revealed in section number two the clinical recorded occurrence documentation will include but not limited to, the date and time the occurrence occurred, where the occurrence happened, if possible the injured person's account of the occurrence, the time the injured person's attending physician was notified as well as the time the physician responded back, if indicated, condition of the injured person at the time the occurrence was reported, and first aid provided to the injured person, including vital signs. Under number six the policy revealed the Director of Health Services will be responsible to review each occurrence for thorough investigation, documenting the investigation in the patient/resident care software occurrence report and appropriate care plan interventions are put in place to decrease risk for repeated occurrences.<br><br>Review of the facility policy titled Medication Administration: Oral Medication last reviewed on 10/17/2023 revealed the Policy was Oral medications are administered in an organized and safe manner. Under the sub-section titled Procedure and Key Points prior to administration of medication number five revealed If a medication is missing or incorrect, nurse is responsible for notifying provider pharmacy and after administration of medications the nurse should according to number 15 Return to medication cart and document medications administered with initials in the appropriate space on the paper medication administration record (MAR). For homes equipped with electronic MAR's (E-MARs), follow the procedure for the particular E-MAR system in use to indicate that the dose was administered and mark the initials of the nurse.<br><br>1. Review of the electronic medical record (EMR) revealed Resident R97 was admitted to the facility with diagnoses including, but not limited to muscle weakness (generalized), unspecified lack of coordination and type 2 diabetes mellitus.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R97's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating R97 was cognitively intact. Section GG, functional status, revealed R97 required partial/moderate assistance with toileting. Section J, health conditions, revealed R97 had been on a scheduled pain mediation regimen in the last five days prior to the assessment and received no PRN (as needed) medications, J1800 (falls since admission or prior assessment) revealed R97 had not had a fall since admission or the prior assessment (which ever was most recent). Section N, medications, revealed R97 was taking an anticoagulant.<br><br>Review of R97's care plan, last updated on 6/7/2024, revealed a goal that stated R97 will not sustain injury related to falling, the approach on 6/7/2024 revealed (staff should) remind R97 to call for assistance when going to the rest room. An approach dated 5/8/2024 revealed (staff should) ensure residents walker remains in reach for transfer support. A problem dated 12/28/2023 revealed R97 had fragile skin and was at risk for bruising, abnormal bleeding or hemorrhage because of anticoagulation use. The approach dated 12/28/2023 revealed R97 will remain free from signs and symptoms of abnormal bleeding, interventions included but not limited to monitor for and report to the physician signs and symptoms of abnormal bleeding and/or hemorrhage.<br><br>Review of the EMR document titled Post Fall Observation dated 6/7/2024 at 6:55 am revealed Registered Nurse (RN) FF documented an unwitnessed fall in bathroom for R97. She documented the description of the fall as lost balance in bathroom, and she was located on the toilet prior to the fall. She documented R97's mental status prior to the fall was alert and oriented. She documented R97's ambulatory status was independent with/without device; fall history in previous 90 days was documented as twice. She documented potential factors that could have contributed to the fall was muscle weakness and measures to prevent further falls was documented as call for assistance.<br><br>Review of the facility document titled Situation, Background, Assessment, Recommendation (SBAR) dated 6/7/2024 and authored by RN FF revealed in the section titled Situation revealed R97 had a fall that was unwitnessed on 6/7/2024, relevant information - resident is becoming weak. The section titled Background revealed R97 was admitted for long term care (LTC), allergies included codeine and simvastatin. Vital signs were documented as blood pressure was 120/60, pulse was 78, respirations were 18, temperature was 97.8, oxygen saturation was 99 percent on room air, and blood glucose level was 100. The section titled Assessment revealed mental status, functional status, behavioral evaluation, respiratory evaluation, cardiovascular evaluation, abdominal/gastrointestinal evaluation, genital urinary/urine evaluation, and neurological evaluation were all marked no changes observed. Symptoms were described as bruises on right hand with skin evaluation marked as no changes observed, pain evaluation was marked yes, and the description/location of pain was documented as right hand, intensity documented as five and other information related to pain was documented as Tylenol two tablets, 325 mgs [milligrams]. Appearance was documented as R97 had minor bruise at right hand and right leg, was cleansed and dressed. Review and notify section was documented as the NP (Nurse Practitioner) was notified on 6/7/2024 at 6:45 am; recommendations of primary clinician was documented as do [NAME] [neuro] (sic) checks, monitor for change in condition, give Tylenol for minor pains, not testing was marked.<br><br>Review of the facility document titled Observation Detail List Report found in R97's EMR dated as 6/7/2024 at 8:00 am revealed the subtitle Morse Fall Scale description was a fall unwitnessed, the morse fall score was 55, indicating R97 was assessed as a high risk for falls.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility document titled Observation Detail List Report found in R97's EMR dated 6/7/2024 at 8:00 am revealed the subtitle as Post Fall Observation which documented description as fall unwitnessed. Location of fall was documented as resident bathroom. Description of fall was documented as lost balance in bathroom. Mental status prior to fall was Alert and Oriented and ambulatory status was independent with/without devices. Footwear documented as socks with skid grip at the time of fall. Fall history was documented as twice in 90 days. Documented R97 was taking antidepressants. Medical care post fall was documented as other - observation. The summarized potential factors that could have contributed to the fall was documented as muscle weakness and plan of care - measures to be taken to prevent further falls was documented as call for assistance.<br><br>Review of the facility document titled Safety Events - Fall Form dated 6/7/2024 at 8:10 am, completed by RN FF, located in R97's EMR revealed the description was unwitnessed fall and the location of the fall was the resident bathroom. The nurse documented the resident was walking just prior to the fall. She documented no pain was observed. Under the section titled Body Observation she documented location of injury as bruise in right hand and right leg and marked other - bruise in right hand and right leg. She documented range of motion was time four without pain/limitations. A neuro check was documented as alert, facial muscle movement was strong, upper left extremity movement/grasps were strong, upper right extremity movement/grasps were strong, lower left extremity movement was strong and lower right extremity movement was strong, left pupil size - 3 millimeters (mm), right pupil size - 3 mm, right eye pupil response/shape was round/brisk, left eye pupil response/shape was round/brisk. Speech was clear - distinct intelligible words. Resident was responding to name, pain, and environment. Mental status was documented as no changes. Possible contributing factors was documented as none of the conditions listed in the section. She documented no restraints/adaptive equipment was in use at the time of the fall. She documented the resident did not experience change in vision, dizziness, discomfort/pain, feeling faint, nausea/vomiting, seizure activity, tinnitus, or tripping prior to fall. The attending physician and resident representative were notified. The evaluation revealed the event was still open.<br><br>Review of the Physician's Orders in R97's EMR for the month of June 2024 revealed an as needed order (PRN) for acetaminophen (OTC-over the counter) 325 milligrams (mg) tablet, administer two tablets every six hours as needed (PRN). The start date was 5/9/2024, the end date was 6/12/2024. There was no Tylenol documented as administered on the eMAR for the month of June 2024.<br><br>A nurse note dated 6/8/2024 at 4:28 am documented fall day two, resident complained of general pain and was given Tylenol 2 tablets 325 mg po as directed by NP, resident verbalized result effective.<br><br>A progress note dated 6/7/2024 at 12:04 revealed weekly PAR (post-acute rehab) meeting held on 6/7/2024 regarding R97's fall described the fall as resident was attempting to sit on toilet in bathroom but missed and set on floor. Resident had noted bruising and on anticoagulant therapy, neuro checks were initiated, a referral to rehab, and care plan was updated.<br><br>A nurse note dated 6/7/2024 at 7:58 am revealed R97 was found on the bathroom floor with bruises on her right hand and right leg. The nurse documented that R97 stated she lost balance when she wanted to sit on the toilet. She denied hitting head on the floor. The nurse documented assessment from head to lower extremities was done, vital signs taken, R97 noted to be on blood thinner and fall was not witnessed. Neuro checks were documented as initiated and the NP, the Director of Health Services (DHS), and the Resident Representative (RP) were notified.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a facility document titled All Falls for Facility with a start date of 12/1/2023 and an end date of 6/12/2023, page six of eight revealed R97 had a fall on 5/8/2024 at 3:50 am and on 6/7/2024 at 8:10 am R97 had an unwitnessed fall in resident bathroom.<br><br>Review of R97 EMR revealed wound care notes were not located in the EMR regarding an evaluation of wound located on R97's right hand.<br><br>Review of a facility document titled Body Audit Form that was filled out by hand, the top of the document had a diagram of the front and back of a body, the nurse marked the right front hand and right front lower leg. The instructions state Please mark location of bruises and/or scars. Generalized skin color was documented as normal. Other instructions stated on body diagram please note: dry skin, flaky/scaly skin, oily skin, etc. The following areas, scalp, face/neck/ears, chest/abdomen, shoulders/back, elbows/arms/hands, sacrum/hips/buttocks, legs/inner knees, ankles, feet/heels/toes/toenails, and other were all marked normal. The document was signed but was not dated.<br><br>An observations and interview with R97 on 6/11/2024 at 12:00 pm, R97 stated she fell on Friday (6/7/2024). Bruising was noted on her right elbow and on the right forearm just below the bend of the arm, wounds were noted to her right thumb and top of right hand, no dressings noted to the wounds. R97 revealed she went to the restroom and fell . During the fall her right thumb was caught in the grab bar. She revealed she was not able to call staff right away, but they found her after just a few minutes. She stated her arm was sore and the nurse gave her Tylenol for her pain, which helped.<br><br>Observations on 6/12/2024 at 9:30 am of R97 sitting up in bed, wound to right thumb and top of hand was not dressed and bruises noted to her right forearm just below the bend of her arm and right elbow.<br><br>Observations on 6/12/2024 at 3:05 pm of R97 sleeping in bed wearing a long-sleeved sweater. The wounds to her right hand were not dressed.<br><br>Interview with RN FF with LPN EE present, RN FF revealed she worked night shift on Saturday night, 6/7/2024 and R97 fell while she was at work that night. RN FF reviewed her note entered in R97's EMR on 6/7/2024 at 7:58 am, she confirmed and verified she was the author of the note, she stated her note documented that R97 was found on the bathroom floor, and she had bruises on her right hand and right leg. She further stated she remembered the fall and stated that once R97 was discovered on the floor she assessed her and stated she was bleeding, so she cleaned her wounds with wound cleanser and dressed her bruises with gauze. She stated she started neuro checks and gave her Tylenol for pain. She stated she called the NP and the family. She stated she notified Wound Nurse GG of the wounds. She stated she documented R97 was bruised and that if skin is bruised you will bleed. She revealed she did not document the dressings she placed on the resident's hand. She stated she did not know how to access wound care assessment notes in the EMR.<br><br>Interview on 6/12/2023 at 3:50 pm with the DHS revealed the nurses document for three days after a resident has a fall. She observed R97's hand after LPN EE placed a dressing on her right hand. She was observed asking R97 if she was having pain and R97 reported she had been having pain since her fall. R97 also reported to the DHS she had asked everyone for pain medication, and she had been given Tylenol for her pain by the nurses which she stated helped her pain. The DHS stated she thought RN FF was confused because wound nurse GG did not work on Fridays and was only a PRN weekend employee. She stated the nurse should have obtained orders from the NP for wound care.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 6/12/2024 at 3:50 pm with the Regional Nurse Consultant confirmed and verified the nurse completed a document titled Body Audit on 6/11/2024 and was signed by RN FF. She stated the form revealed all body systems were marked as normal, but she marked the diagram right hand and right lower leg. She stated she did not know what the marking on the right hand and right lower leg indicated.<br><br>Interview on 6/12/2024 at 5:47 pm with NP HH via telephone, she verified and confirmed she was notified of R97's fall on 6/7/2024 and she remembered the call she received. She stated she was told R97 had bruises. She stated the nurse did not tell her that R97 was bleeding at the time of the fall, nor was she told dressings were applied to the bruises. She stated when a resident has a fall the next provider who is in the facility would visit the resident at their next scheduled visit unless the nurse reports something unusual, abnormal, or critical then the next provider in the facility would evaluate the resident.<br><br>Interview on 6/13/2024 at 2:02 pm with RN Unit Manager JJ, she verified and confirmed that R97 had a PRN order for Tylenol 325 mg, two tablets by mouth, as needed every six hours with a start date of 5/9/2024 and discontinued date of 6/12/2024 on her eMAR. She verified and confirmed no nurse documented on the eMAR that Tylenol 325 mg two tablets by mouth between the dates of 6/1/2024 and 6/11/2024. She confirmed that the process for documentation of PRN medication was for the nurse to document medications administered on the eMAR.<br><br>Interview on 6/14/2024 at 7:12 am with the DHS revealed that if a resident was to receive a PRN medication, then it needed to be at least documented on the eMAR or in a progress note. She then stated that it was good to document on both, but if they only document on one, then to document in a progress note was what she preferred.<br><br>46579<br><br>2. Review of the EMR for R23 revealed that she was admitted to the facility with diagnosis that included but were not limited to fracture of lower end of the femur, displaced comminuted fracture of shaft of left femur and displaced tri-malleolar fracture of left lower leg.<br><br>Review of the admission MDS for R23 dated 4/6/2024 revealed that she had a BIMS score of 15, indicating intact cognition. Review of Section GG (Functional Status) indicated that she had functional limitations of range of motion (ROM) to lower extremities related to impairment on one side. It also revealed that she was dependent on staff for toileting, showering/bathing and personal hygiene. Review of Section H (Bowel and Bladder) revealed that she was always incontinent of bladder and bowel.<br><br>Review of the care plan for R23 revealed that she is at risk for alteration in comfort: Pain r/t [related to] Left Femur, ankle and tibial Fracture, recent surgery. An intervention for this risk was to administer pain medications per physician's orders.<br><br>Observation on 6/11/2024 at 2:45 pm, R23 was sitting up in her bed, dressed, bed in the highest position, and call light within reach.<br><br>Review of medications orders for R23 revealed that she had hydrocodone/acetaminophen 5/325 mg prescribed scheduled every six (6) hours for pain. It was ordered on 4/4/2024 thru 6/10/2024.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the eMAR revealed that R23 was ordered for her pain medication to be received every six hours.<br><br>Review of the April 2024 eMAR revealed that R23 did not receive pain medication for the dates 4/24/2024 at 6:00 pm, 4/25/2024 at 6:00 am, 4/25/2024 at 6:00 pm through 4/26/2024 at 6:00 pm.<br><br>Review of the May 2024 eMAR revealed that R23 did not receive pain medication 5/27/2024 at 6:00 pm through 5/29/2024 at 6:00 pm doses. Review of the progress notes for those missed doses revealed that medication was not available.<br><br>Interview on 6/13/2024 at 2:43 pm with the Unit Manager, she stated that no resident should do without pain medication.<br><br>Interview on 6/13/2024 at 7:12 pm with the DHS, she stated that medications needed to be ordered when the packs get down to a seven-day supply of scheduled controls. She stated that sometimes a prescription was needed and that would allow enough time to get the prescription from the provider to send it to the pharmacy. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579<br><br>Based on observations, resident and staff interviews, and record review, the facility failed to ensure that Activities of Daily Living (ADL) care was provided by using appropriate techniques to prevent accidents for one of 38 sampled residents (R) R23. Specifically, the facility did not have the correct size mechanical lift sling, that resulted in breakage of a strap, which caused R23 to fall to the floor.<br><br>Findings include:<br><br>Review of the electronic medical record (EMR) for R23 revealed that she was admitted to the facility with diagnoses that included but were not limited to fracture of lower end of the femur, displaced comminuted fracture of shaft of left femur and displaced tri-malleolar fracture of left lower leg.<br><br>Review of the admission Minimum Data Set (MDS) dated [DATE] for R 23 revealed that she had a Basic Interview for Mental Status score of 15, indicating intact cognition. Review of Section GG (Functional Abilities and Goals) indicated that she had functional limitations of range of motion (ROM) to lower extremities related to impairment on one side. It also revealed that she was dependent on staff for toileting, showering/bathing and personal hygiene. Review of Section H (Bladder and Bowel) revealed that she was always incontinent of bladder and bowel.<br><br>Review of the care plan for R23 dated 5/9/2024 revealed that she had a recent decline in activities of daily living (ADLs) related to left femur, tibial, ankle fracture and recent surgery. An approach for this decline is that resident needs assistance with transfers. Further review of the care plan revealed that R 23 is at risk for falls related to generalized weakness. Approaches for this risk is to reinforce sling for support, maximum assistance, and assist for toileting and transfers as needed. The care plan also reveals that R23 is at risk for incontinence related complications. Approaches for this risk is for staff to provide incontinent and perineal care after each incontinent episode and to check resident every 2 to 3 hours and as needed for incontinent episodes.<br><br>An observation and interview of R23 on 6/12/2024 at 5:05 pm, she was noted sitting up in her wheelchair. R23 revealed that after her fall from the mechanical lift, she was very leery about the staff using the mechanical lift to get her out of the bed.<br><br>An observation of R23 on 6/12/2024 at 7:00 pm revealed the resident was sitting up in the wheelchair, dressed, and visiting her daughter. R23's daughter, who was also R23's responsible party, was interviewed, and stated that the staff were not tending to her mother's needs and had concerns about her mother. She stated that the facility called her to let her know that her mother (R23) had fallen from the mechanical lift when the staff were attempting to transfer her to the bed from the wheelchair. She stated, How can you fall from a mechanical lift. I think she was dropped.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 6/13/2024 at 2:21 pm with CNA NN, when asked about the incident that occurred with the mechanical lift for R23, she stated that she was the one that worked that day. She stated that when she and another CNA went to get R23 up, before they even started, she thought that it was not the right sling for the resident, but that was all that they had. She then stated that when they got R23 out of the chair to move her to the bed, the strap on the sling broke and R23 fell to the floor.<br><br>Interview on 6/13/2024 at 2:36 pm with CNA OO, she stated that when CNA NN asked for assistance with R23, she went in to assist her. They started to lift the resident out of the wheelchair with the sling that was used to get her out of the bed to the chair earlier. She stated that when they went to lift her up, the strap on the sling popped and broke and R23 fell to the floor. She stated that she felt it was not the correct sling for the resident.<br><br>Interview on 6/13/2024 at 6:30 pm with the Director of Health Services (DHS), she stated that she expected that staff will have two people to assist with mechanical lifts and use the proper equipment.<br><br>Interview on 6/13/2024 at 6:32 pm with the Administrator, she stated that when the incident occurred with the mechanical lift sling, they did a root cause analysis, staff education, skills check off, and ordered all new slings. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>49396<br><br>Based on observations, interviews, record review, and the facility's policy titled, Dish Machine- High Temperature, the facility failed to ensure that the dishwashing machine consistently reached the required operating temperature. The deficient practice had the potential to affect 114 out of 117 residents receiving an oral diet from the kitchen.<br><br>Findings include:<br><br>Review of the facility policy titled Dish Machine-High Temperature reviewed 1/8/2021 revealed under Scope: This policy applies to each facility that uses a high temperature dish machine and to those dietary partners that operate the high temperature dish machine. Under Procedure: An 'name of company' T-Stick, 'name of company' Temperature Indicator Stick, or Water Proof Thermometer will be used to test and verify the internal temperature of a High Temperature Dish Machine is being achieved.<br><br>Review of the manufacturer signage in the kitchen for the dish machine dated 2004 revealed that the temperature of the water should be 120 degrees Fahrenheit (F). Fill the dish machine with hot water (120 F-140 F).<br><br>Observation on 6/11/2024 at 9:28 am, Kitchen Staff TT was observed operating the dishwashing machine. When questioned on the procedure to ensure the machine was prepared for use, Kitchen Staff TT was unsure of the required temperatures and chemical levels, as her primary responsibility had been food scrap removal, not machine operation.<br><br>Interview on 6/11/2024 at 9:30 am with the Dietary Manager (DM), the DM described the dish machine as a temperature-critical device that should operate at 118 degrees Fahrenheit (F) for both washing and rinsing, though observations did not consistently support this claim. The washing and rinsing temperatures during three consecutive cycles were recorded as follows: Cycle 1: Wash at 100 degrees F, Rinse at 102 degrees F.<br><br>Cycle 2: Wash at 100 degrees F, Rinse at 112 degrees F, Cycle 3: Wash at 110 degrees F, Rinse at 118 degrees F.<br><br>Interview on 6/11/2024 at 9:45 am, the Regional corporate representative acknowledged the temperature discrepancies and committed to contacting the dish machine chemical company for technical support. Meanwhile, the facility would switch to disposable dining ware and in-service training would be scheduled for the kitchen staff.<br><br>A review of the Dish Machine Temperature Log dated June 2024:<br><br>On 6/1/2024, the temperature at breakfast was recorded at 118 degrees F for washing.<br><br>On 6/2/2024, the temperature at breakfast was recorded at 118 degrees F for washing and rinsing.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 6/3/2024, the temperature at lunch was recorded at 118 degrees F for washing and rinsing, and supper was recorded at 118 degrees F for rinsing.<br><br>On 6/4/2024, the temperature at breakfast was recorded at 118 degrees F for rinsing; lunch was recorded at 118 degrees F for washing and rinsing; and supper was recorded at 118 degrees F for rinsing.<br><br>On 6/5/2024, the temperature at breakfast, lunch, and supper was recorded as 118 degrees F for washing.<br><br>On 6/6/2024, the temperature at breakfast was recorded at 118 degrees F for rinsing; lunch was recorded at 118 degrees F for washing; and supper was recorded at 118 degrees F for rinsing.<br><br>On 6/7/2024, the temperature at breakfast, lunch, and supper were recorded at 118 F for the wash.<br><br>On 6/8/2024, the temperature for rinsing at lunch and washing at supper was recorded at 118 degrees F.<br><br>On 6/9/2024, the temperature at breakfast was recorded at 118 degrees F for washing; lunch was recorded at 118 degrees F for washing, and supper was recorded at 118 degrees F for washing.<br><br>On 6/10/2024, the temperature at breakfast, lunch, and supper were recorded at 118 degrees F for washing.<br><br>On 6/11/2024, the temperature was not recorded as being checked.<br><br>Interview on 6/12/2024 at 10:00 am with the Dietitian revealed the ongoing efforts to rectify the temperature issue, mentioning a temporary increase in boiler settings that inadvertently raised water temperatures at other points of use within the kitchen. A booster was ordered to stabilize temperatures specifically for the dish machine.<br><br>On 6/13/2024 at 4:06 pm the DM provided evidence of recent staff training on the importance of achieving and verifying correct temperatures in the dishwashing process. This training followed a visit from a dish machine chemical representative who emphasized the need for temperatures to reach at least 120 F during operation cycles. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115314 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pruitthealth - Austell | 1700 Mulkey Rd<br>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 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>46579<br><br>Based on observations, and staff interviews, the facility failed to properly disinfect reusable equipment for five of 38 sampled residents (R) (R35, R9, R87, R109, and R283) during two of five medication administrations, and to properly perform hand hygiene during medication administration by one of five staff. The deficient practice had the potential to spread microorganisms to other residents.<br><br>Findings include:<br><br>Observation of medication administration on 6/12/2024 at 8:19 am of Registered Nurse (RN) KK, she stated that first she needed to check the blood pressure of the resident she was going to prepare the medications for. She removed the electronic blood pressure cuff from the medication cart. She entered the room of R35 and took the blood pressure of the resident. RN KK returned to the medication cart and placed the electronic blood pressure cuff on top of the cart. She then prepared the medications and then administered the medications to R35. After the completion of the medication pass for that resident, she began to prepare the medications for a second resident. She stated that she was going to check the resident blood pressure first, due to the resident was to receive a blood pressure medication. She then took the electronic blood pressure cuff off the medication cart, without disinfecting it, and then entered the room and checked R9's blood pressure. After obtaining the blood pressure, she left the room and placed the blood pressure cuff on the cart. After preparing the medication, she entered the resident's room and administered all medications except for the liquid Keppra. She then left the room, without performing hand hygiene and then went back to the cart and took out the prepared liquid Keppra. She then entered the room to administer the Keppra, and then after the resident took the Keppra and drank some water, as she left the room, she did perform hand hygiene that time. She went back to the medication cart, and then prepared to take the blood pressure of another resident, R87, with the electronic blood pressure cuff that was not disinfected after use. She exited the room, went back to the medication cart, removed an inhaler, entered the room to administer, administered, and then left the room to return the inhaler back to the cart. Hand hygiene was not performed.<br><br>Interview on 6/12/2024 at 9:16 am with RN KK, she stated that the blood pressure cuff should be disinfected after every use. She then ended her interview by confirming that she did not clean the blood pressure cuff in between each use during medication administration observation. She stated that she only performed hand hygiene when she was going from resident to resident.<br><br>Observation of medication administration on 6/12/2024 at 9:23 am of Licensed Practical Nurse (LPN) LL, she started off by obtaining the blood pressure of the resident. She took the electronic blood pressure cuff out of the bottom drawer of the medication cart. She went into the room of the R109 and obtained the blood pressure. She left the room and then placed the cuff on the medication cart, and then prepared the medications for the resident. At 9:32 am, after the administration of the prepared medications, she went to the cart to get ready to prepare medications for her next resident. She took the electronic blood pressure cuff off the top of the cart and entered R283's room. She obtained the blood pressure and then left the room and placed the cuff back on the medication cart.<br><br>Interview on 6/12/2024 at 9:40 am with LPN LL, she stated that she was to disinfect the blood pressure cuff after each use, and she then stated that she had not done that during the observation.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115314 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pruitthealth - Austell | 1700 Mulkey Rd<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 6/12/2024 at 9:11 am with Certified Medication Aid (CMA) QQ, she stated that when providing care, or administrating medications, you are to perform hand hygiene every time you enter and exit a resident's room.<br><br>Interview on 6/13/2024 at 6:30 pm with The Director of Health Services (DHS), she stated that the electronic blood pressure cuff was to be disinfected in between use and expected the nurses and the nursing assistants to disinfect the reusable equipment for the safety of the residents. |