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. 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 (continued on next page)

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 0656 Level of Harm - Actual harm Residents Affected - Few	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 1:35ˆpm 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. 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 (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 0656 Level of Harm - Actual harm Residents Affected - Few	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 0689 Level of Harm - 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 observations, staff and resident interviews, record review, and review of the facility policies titled Occurrences, Gait (Transfer) Belts, and Assistance with Transfers, the facility failed to follow established transfer procedures when assisting one of 42 sampled residents (R) (R62). 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 facility policy titled Occurrences reviewed 11/17/2025, revealed under the policy statement that The healthcare 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 or care. Further review of the Assisting Occurrence Victim section revealed Do not move the victim until he/she has been examined by a licensed nurse for possible injuries. Only move the injured person out of harm's way, to a treatment area or bed after a licensed nurse has evaluated them.A review of facility policy titled Gait (Transfer) Belts reviewed 3/6/2025, revealed under the policy statement that A gait belt will be utilized with patients/residents who require assistance with transfers and ambulation. To promote safety from injury for both patients/residents and nursing staff.A review of facility policy titled Assistance with Transfers, issued September 2012, revealed the following procedures: step 8: Be sure you have a good footing, stand with legs apart, bend your knees, keep arms and back in proper alignment. Step 9: Use your arms to support the resident and legs to stabilize and support, not your back. Step 11: Be sure you have a firm and secure, but gentle grip before moving the resident. Avoid using fingertips or grabbing limbs with your hand. Step 13: To avoid injury to yourself or the resident, be sure to get help if the person is too heavy for you alone.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.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. On 12/5/2025, the care plan was updated to include a new problem of abrasion to the right knee related to a fall earlier that day. Short-term goals included healing of the abrasion without complications by 12/31/2025. Interventions included handling the resident with care during direct care and monitoring for signs of localized infection (swelling, redness, pain, tenderness, heat, purulent drainage, or loss of function) every shift. The fall risk interventions were also updated to indicate one-person assist with one-person standby.A review of the Physician Orders for R62 included, but was not limited to:Order dated 9/25/2025 for AP and Lateral X-ray of the right knee due to tibial fracture and pain; special instructions: wheelchair bound.Order dated 12/5/2025 for wound care related to a right knee abrasion from the fall: cleanse with normal saline, pat dry, apply Xeroform, cover with protective dressing, 3x/week and PRN.Order dated 12/5/2025 for X-ray of the right knee due to fracture.Observation and interview on 12/5/2025 at 12:10 pm with R62 revealed a 3x3 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 Certified Nursing Assistant (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.A review of R62's vital signs indicated the resident weighed 205.2 lbs. (pounds) on admission.A review of R62 physical therapy evaluation and plan of treatment dated 9/18/2025 indicated that R62 was referred for skilled physical therapy following a right tibial fracture, generalized weakness, and decreased functional mobility. Precautions included non-weight-bearing on the right leg, right knee injury, and fall risk. Therapy focused on improving lower extremity strength, bed mobility, transfers, and wheelchair skills to support a safe return home. The patient actively participated, demonstrated good rehabilitation potential, and responded well to interventions, with primary barriers being medical conditions and weight-bearing restrictions.A review of R62's physical therapy note dated 12/4/2025 indicated that R62 received skilled physical therapy for bilateral lower extremities. Precautions included non-weight-bearing on the right leg, right knee injury, and fall risk. The resident actively participated, with no barriers or contraindications identified. Pain management was addressed by nursing.A review of R62's progress note dated 12/5/2025 at 12:17 pm indicated that the 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 1:35ˆpm 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.An interview on 12/5/2025 at 12:25 pm with both Physical Therapist (PT) SS and Therapy Outcome Coordinator VV revealed they both oversee and participate in R62's therapy plan of care. They stated R62 is non-weight-bearing and unable to transfer safely without staff assistance. They reported it is their expectation that nursing staff, including CNAs, use a gait belt when assisting with transfers, and that therapy had provided training on gait belt use. They stated that, at a minimum, staff should provide hands-on physical contact when assisting R62. They reported they were not informed that R62 had sustained a fall and expressed concern regarding the possible impact on her recovery.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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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.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. He stated staff should ensure the bed height is appropriate, assist the resident to sit up, position the wheelchair correctly, use proper body mechanics, and provide the level of assistance indicated in the care plan to ensure resident safety. An interview on 12/5/2025 at 1:42 pm, the Regional Nurse Consultant revealed that CNAs should ask residents if they want assistance with transfers, and if assistance is accepted, support the resident's weak side, position the chair correctly, and provide help as needed. She stated that refusals should be reported to the nurse and witnessed. She stated the CNA should not have allowed the resident to transfer without assistance and that she would have provided hands-on help throughout the transfer.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, resident interviews, record review, and review of the facility's policies titled Care Plans, the facility failed to coordinate a quarterly care plan conference for one of 47 sampled residents (R) (R21).Findings included:A review of the facility's policy titled Care Plans, dated/revised 10/21/2025, revealed that during all care plan meetings other than the admission Comprehensive Care Plan that was conducted during a Post admission Care Conference, care plan meetings including IDT (Interdisciplinary Team), patient/resident, and/or patient/resident representative attendance should be documented in the Care Conference Notes. Comprehensive care plans should be reviewed not less than quarterly according to the OBRA MDS (Omnibus Budget Reconciliation Act Minimum Data Set) schedule, following completion of the assessment.A review of R21's electronic medical record (EMR) revealed R21 was admitted to the facility on [DATE], and pertinent diagnoses included, but were not limited to epilepsy, muscle weakness, and cognitive communication deficit.A review of R21's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicates R21 was cognitively intact. A review of R21's EMR revealed no documentation of a care plan conference, including a care plan conference upon admission.An interview on 12/3/2025 at 11:51 am with R21 revealed that she does not remember having a care plan conference meeting since she moved into the facility. She stated that her family may have been involved.A phone interview on 12/3/2025 at 12:10 pm with the family of R21 revealed that a care plan meeting was held when R21 was admitted to the facility, and that was the only one. Since admission, he has had to initiate calls with the Unit Manager to discuss R21's care, and he would have to get lucky getting someone on the phone. R21's family expressed concerns regarding communication with the facility and stated that he has not received an invitation for a formal care plan conference meeting. An interview on 12/4/2025 at 12:06 pm with the Social Services Director (SSD) revealed she has been working at the facility for three months. She stated that long-term residents have quarterly care plan conferences, and the MDS nurse will give her a schedule to know which quarterly meetings are needed. Family and residents are informed a month prior to the care plan conference that the resident is due for a quarterly meeting, and the facility will also mail out a letter as a reminder. When asked about R21's care plan conferences, the SSD stated that R21 would have had a care plan conference in July 2025, which would have been the initial one completed at admission. The SSD confirmed that R21 was due for a quarterly care plan conference in October, but she does not see that it was completed. The SSD further confirmed that the only care plan conference that was completed was the initial one on admission. The SSD further stated that care plan conferences are important to keep the resident and family updated to assess any changes that have been going on with the resident, changes the family and resident would want to include, and address any concerns the resident or family may have.An interview on 12/5/2025 at 10:38 am with the Administrator revealed that she expects the care plan conferences to be done timely on admission, upon change of condition, quarterly, and annually.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, resident and staff interviews, and facility policy titled Patient/Resident Rights, Accommodation of Needs, the facility failed to ensure the call light provided was appropriate for the physical condition of one of 47 sampled residents (R) (R117). The facility was unable to ensure that R117 could obtain help when needed using the call light provided. This failure placed R117 at risk of accident, injury, and/or unmet needs related to an inability to use the call light system provided to call for staff assistance. Findings included:A review of the facility's policy titled Patient/Resident Rights, Accommodation of Needs revealed that, unless indicated in the care plan, each patient/resident, when in their room or in bed, must have the call light placed within reach at all times, regardless of staff assessment of the patient/resident's ability to use it. When the patient/resident is in bed, the call bell should be fastened to the side rail he/she is facing. When out of bed, the call bell is to be draped across the bed so it is accessible from a wheelchair or bedside chair.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, teaching reinforced on the use of call light for assistance.An observation and interview on 12/1/2025 at 12:42 pm revealed R117 was alert and oriented, lying in her bed. The resident was observed to be a quadruple amputee. She stated that she has been a resident at the facility for almost ten years, and since she has no arms, it is a challenge to push the call light to request staff assistance. A round call light pad in the bed was observed.An observation and interview on 12/2/2025 at 12:30 pm with R117 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. R117 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 R117. 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 11:28 am, the Therapy Outcome Coordinator revealed that it is routine for the therapy staff to evaluate all residents for needs and abilities. She confirmed that R117 uses a flat round call light pad for use to call for assistance. She confirmed that she was not aware that R117 could not use the call light pad. 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 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this to the Director of Nursing (DON) so that a breathcall call light device could be ordered for R117. (A Breathcall call light is a pneumatic nurse call device for residents with limited motor skills, activated by a gentle puff of air into a disposable straw/filter, not pressing a button, making it easy to use when movement is difficult. It features a flexible gooseneck with a clamp for mounting and connects to the existing nurse call system, providing a lifeline for those who can't operate standard call cords.)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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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. **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 Physician Orders, the facility failed to ensure timely coordination and follow-up of physician/Nurse Practitioner (NP) recommendations for one of 47 sampled residents (R) (R9). Specifically, the facility failed to schedule or track urology specialist appointments, failed to document completed visits or follow-up outcomes, and failed to act on prior NP recommendations. These deficient practices resulted in prolonged pain, delayed evaluation and treatment of ongoing urinary symptoms, and lack of oversight of the resident's urologic care, placing the resident at risk for worsening complications.Findings included: A review of the facility policy titled Physician Orders, reviewed 2/3/2025, revealed under the section Verbal and Telephone Orders, Step 1: All verbal and telephone orders will be immediately transcribed in the medical record by the licensed professional taking the order. Further review of this section indicated under Step 3: The licensed professional will sign and date the order, will indicate the name of the physician giving the order, and will document ?read back' as proof of verification of orders.A review of the electronic medical record (EMR) revealed that R9 was admitted to the facility on [DATE] with pertinent diagnoses including, but not limited to, urinary tract infection, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, neuromuscular dysfunction of the bladder, other specified disorders of the bladder, and dysuria. R9 also has type 2 diabetes mellitus, which increases the risk of urinary infections and chronic Foley catheter dependence as documented under his bladder-related diagnoses. A review of R9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Section GG (functional status) revealed that R9 required extensive assistance to total dependence for activities of daily living (ADL) care. A review of Section H (bowel and bladder) revealed that the resident had an indwelling urinary catheter in place during the assessment period and was not on any bladder toileting program. The resident was always incontinent of bowel.A review of R9's care plan, initiated 05/28/2025 and last revised 10/27/2025, indicated multiple problems, including risk for urinary tract infection (UTI) due to a chronic indwelling catheter, neuromuscular bladder dysfunction, and stool incontinence. Goals included, but were not limited to, preventing complications associated with catheter use, maintaining urinary comfort, and preventing infections. Interventions included, but were not limited to, coordinating follow-up with specialists, including urology. A review of the Physician's Orders for R9 included, but was not limited to:Order dated 6/13/2025 for urology consult for neurogenic bladder/BPH with chronic Foley (catheter to drain urine from the bladder).A review of R9's EMR revealed an open-ended urology referral order from June 2025. Documentation regarding follow-up was inconsistent and incomplete. A printout of abnormal urine analysis (UA) results dated 11/13/2025 included a handwritten note dated 11/20/2025, which indicated the need for a urology appointment; but had no initials or signature identifying the author, and staff were unable to determine who wrote it. No subsequent orders or documentation were found in the EMR confirming that follow-up with the urologist had been scheduled or completed, or that the resident or their representative had been notified of the need for the follow-up. There were also no uploaded documents or visit notes verifying that R9 had attended any urology appointments.An observation and interview on 12/1/2025 at 12:20 pm revealed that R9 was waiting to be taken to the emergency room (ER) due to a UTI. He stated that he could feel the infection and pointed to his pubic area to indicate where he was feeling pain. R9 was seated in a reclining wheelchair with a Foley catheter in place, but tubing was visible with dark blood present.During an interview on 12/2/2025 at 1:23 pm, R9 reported that he had been in pain for about a month. An observation and interview on 12/3/2025 at 3:55 pm with R9 revealed he was lying in bed and continued to experience discomfort. He recalled seeing the urologist the previous month, but could not recall the date.An interview on 12/4/2025 at 3:55 pm with R9's wife via telephone she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expressed continued frustration regarding poor communication at the facility and noted that the facility was responsible for arranging transportation for R9 to medical appointments. She stated she planned to visit the facility that evening to speak with the Director of Nursing (DON) to address communication concerns and ensure that follow-up appointments were managed appropriately. An interview on 12/2/2025 at 4:32 pm with NP HH via telephone emphasized the importance of follow-up with a urologist as previously recommended.An interview on 12/4/2025 at 3:46 pm with the Urology Center revealed that a staff member from the facility contacted their practice to schedule an appointment for R9, and it is scheduled for 12/17/2025. Further stated that R9 was seen on 10/7/2025 for leakage of the catheter and had a CT and labs, and again on 11/4/2025 for Blood in urine and urinary retention, and a Cystoscopy (procedure to view the inside of your bladder and urethra with a scope) was done. They have been trying to get R9 to return to the practice for a follow-up to discuss the results of the cystoscopy since 11/17/2025, with no success. They have been calling and calling with no answer. An interview on 12/4/2025 at 4:33 pm with the Assistant Director of Nursing (ADON) revealed that all nurses on the floor are responsible for following up on NP recommendations and writing orders for specialist visits. She confirmed the open-ended urology referral from June 2025 and acknowledged that records of R9 visits on 10/7/2025 and 11/4/2025 were missing from the EMR. An interview on 12/4/2025 at 5:15 pm with the facility Administrator revealed that staff were expected to follow through on physician-ordered referrals and ensure appointments are scheduled and completed. She emphasized that failure to follow up may result in delayed care. She stated that the responsible staff must ensure all follow-up is completed and that any issues should be discussed during IDT (Interdisciplinary Team) meetings, and families should be notified. An interview on 12/4/2025 at 5:35 pm with the DON revealed that the facility is responsible for ensuring residents are appropriately scheduled for referrals and specialist appointments. Nurses, unit managers, or the nurse receiving the order may initiate physician consultations and follow up on results. Nursing staff are expected to track outcomes of specialist visits, including any required follow-up. Even if a resident returns without information from the physician/specialist visit, it remains the responsibility of the nurses to contact the provider to obtain documentation of what occurred during the visit and any recommendations or follow-up needed. Failure to properly schedule or follow up on appointments could result in declines in the resident's health and negatively impact overall care.

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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. **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 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview with the Director of Nursing (DON) on 12/4/2025 at 5:35 pm indicated that every resident receiving oxygen must have a physician order, and oxygen must be administered and monitored according to the frequency specified in the order, which may be every shift. If a resident is admitted with existing oxygen orders, these must be transcribed accurately, and care must reflect the physician's instructions. If a resident is receiving oxygen without an order, the physician must be notified. Failure to follow orders could result in adverse outcomes, such as shortness of breath, depending on the resident's diagnosis.

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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. 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 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(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 ordered per current orders, and the loose pages in the Controlled Substance Record Book would be secured after being uploaded into the medical records system.An interview on 12/3/2025 at 12:10 pm with LPN JJ and the ADON confirmed the presence of loose, unlabeled medication on the nurse's medication cart. LPN JJ stated that this could result in a resident not receiving their prescribed medication. She further noted that education was required for staff, and it was the responsibility of the nurse to notify management of such findings. An interview on 12/4/2025 at 5:15 pm with the Administrator revealed the facility's expectations regarding medication management and accuracy. She stated that nursing staff were responsible for ensuring that expired medications were not present, medication carts remained clean and free of loose pills, and carts were cleaned at the end of each shift. She further emphasized that controlled substance logs must remain intact, without rips or tears, to ensure proper documentation and accountability.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **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 Diagnostic and Laboratory Services: Procedure for Processing, the facility failed to notify the physician/ Nurse Practitioner (NP) of abnormal laboratory results for one of 47 sampled residents (R) (R9). This deficient practice had the potential to cause delayed assessment and treatment of abnormal clinical conditions.Findings included:A review of the facility policy titled Diagnostic and Laboratory Services: Procedure for Processing revised 1/3/2024 revealed under the section Laboratory Results and Communication with the Provider and Responsible Party Step 4: The licensed nurse is responsible for communicating patient/resident laboratory results to the provider as: Outside of Normal Limits: When test results are outside of normal limits, the licensed nurse will notify the resident's provider of the laboratory results and document the notification in the clinical record. Further review of this section indicated under Step 5: The licensed nurse will communicate laboratory test results to the patient/resident and/or responsible party at the time a new provider order is received related to the test results. The licensed nurse will document the notification in the clinical record.A review of the electronic medical record (EMR) revealed that R9 was admitted to the facility on [DATE] with pertinent diagnoses including, but not limited to, urinary tract infection, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, neuromuscular dysfunction of the bladder, other specified disorders of the bladder, and dysuria. R9 also has type 2 diabetes mellitus, which increases the risk of urinary infections and chronic Foley catheter dependence as documented under his bladder-related diagnoses. A review of R9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Section GG, functional status, revealed that R9 required extensive assistance to total dependence for activities of daily living (ADL) care. Review of Section H revealed that the resident had an indwelling urinary catheter in place during the assessment period and was not on any bladder toileting program. The resident was always incontinent of bowel.A review of R9's care plan, initiated 5/28/2025 and last revised 10/27/2025, indicated multiple problems, including risk for urinary tract infection due to chronic indwelling catheter, neuromuscular bladder dysfunction, and stool incontinence, as well as risk for dehydration related to history of urinary tract infection (UTI), diabetes, and metabolic encephalopathy. Goals included, but were not limited to, preventing complications associated with catheter use, maintaining urinary comfort, preventing infections, and ensuring hydration and nutritional stability. Interventions included performing lab tests as ordered.A review of the Physician's Orders for R9 included, but was not limited to:Order dated 5/27/2025 for an indwelling urinary catheter #20 French (FR), 10 Cubic Centimeters (cc) bulb.Order dated 5/27/2025 for catheter: neurogenic bladderOrder dated 5/27/2025 for catheter care every shift.Order dated 5/27/2025 for catheter care PRN (as needed) for leakage, obstruction, or dislodgement.Order dated 5/27/2025 to monitor and record intake and output every shift, noting urine characteristics and lab specimen submission.Order dated 5/27/2025 for Foley catheter monthly change on the 26th.Order dated 12/2/2025 for urinalysis with reflex to culture/sensitivity.A review of R9's urinalysis (UA) results dated 11/13/2025, finalized 11/18/2025, revealed abnormal results that reflected a culture, showing Greater than 2 organisms recovered, none predominant. The printout included a handwritten note dated 11/20/2025, with no initials or signature identifying the author, and the staff were unable to determine who wrote it or how to track the author. The note read: Over 2 strains, which indicates contamination, would have to see the urology soon, and they will know what/if they want to treat. A review of R9's UA results dated 12/2/2025 revealed abnormal results with a handwritten note dated 12/3/2025, again with no identifying initials or signature, stating: NP Notified, No New Orders, Sensitivity Pending. A review of R9's EMR did not contain documentation showing that the physician (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or Nurse Practitioner (NP) was notified of the abnormal urine culture results from 11/13/2025 or the abnormal urinalysis results from 12/2/2025. There was no documentation showing that the resident or responsible party was notified of the abnormal laboratory results as required by policy. Two handwritten notes on the printed lab reports were unsigned and unidentifiable, and no provider response or follow-up orders were documented.An observation and interview on 12/1/2025 at 12:20 pm revealed that R9 was waiting to be taken to the emergency room (ER) due to a Urinary Tract Infection (UTI). He stated that he could feel the infection and pointed to his pubic area to indicate where he was feeling pain. R9 was seated in a reclining wheelchair with a Foley catheter in place, but tubing was visible with dark blood present.An observation and interview on 12/2/2025 at 1:23 pm with R9 reported that he had been in pain for about a month. He stated that his wife told him he did not need to go to the hospital and mentioned that she would be visiting him today and could provide more details about his condition. An interview on 12/2/2025 at 3:38 pm with R9's wife via telephone revealed that she visited R9 on 11/30/2025 and observed blood in his catheter tubing. She informed the nurse, who stated that a UA would be ordered. She was aware that R9 was in pain and believed he had a UTI, noting his history of UTIs since the Foley catheter insertion in May 2024. She expressed frustration with the lack of urgency and poor communication at the facility, noting that she was unaware that R9 had seen the NP/physician on 11/12/2025 and that a UA had been ordered at that time as well. An observation and interview on 12/3/2025 at 3:55 pm with R9 revealed he was lying in bed and continued to experience discomfort. He recalled seeing the urologist the previous month. An interview on 12/4/2025 at 3:55 pm with R9's wife via telephone to inform her of the scheduled follow-up appointment with the urologist for R9 on 12/17/2025. She expressed continued frustration regarding poor communication at the facility and noted that the facility was responsible for arranging transportation for R9 to medical appointments. She stated she planned to visit the facility that evening to speak with the Director of Nursing (DON) to address communication concerns and ensure that follow-up appointments were managed appropriately. Interview on 12/1/2025 at 12:26 pm with Licensed Practical Nurse (LPN) UU revealed that he could not find any orders in the system related to a UA and stated that he would be contacting the NP and obtain an order for a UA.An interview on 12/2/2025 at 2:58 pm with Licensed Practical Nurse (LPN) II revealed she was unsure how to check laboratory results in the system. She attempted to look for R9 results but was unable to locate any laboratory information.An interview on 12/2/2025 at 4:02 pm with the DON, who had been standing at the nurse's station during the interview with LPN II, explained the lab process, including notification of the family, collection, and processing by the [NAME] Health laboratory. He stated that it is the responsibility of both the Unit Manager and ADON to review results and track abnormal labs using the Lab Book. Further stated that for Critical results, the lab will contact the DON or Regional Consultant. Follow-up for abnormal results involved notifying the NP and resident families.An interview on 12/2/2025 at 4:32 pm with NP HH via telephone revealed that he and the physician evaluated R9 on 11/12/2025 and ordered a urinalysis for complaints of dysuria (pain/discomfort with urination). He stated he was not notified of the abnormal urinalysis and culture results from 11/13/2025, which he identified as the facility's responsibility to report. He noted that, looking at the results now, they appeared contaminated and stated that had he been notified of the abnormal findings, he would have ordered a repeat urinalysis as the appropriate next course of action; however, no follow-up testing was ordered or communicated to him.An interview on 12/4/2025 at 4:33 pm with the Assistant Director of Nursing (ADON) revealed that she and the Unit Manager were both responsible for reviewing abnormal laboratory results and ensuring that the NP was notified. She stated she had not been aware of the abnormal UA results dated 11/13/2025 until surveyors brought them to her attention, and could not explain why the NP had not been notified. She added that she held ultimate responsibility for ensuring abnormal laboratory results were reviewed and acted upon.An interview on 12/4/2025 at 5:15 pm with the Administrator revealed her expectation was that staff notify providers of abnormal laboratory findings. She stated that failure to do so could result in delays in treatment.

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

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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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observations, record review and staff interviews, the facility failed to ensure required privacy curtains were in place for one of 47 samples residents (R) (R118). This had the potential to put residents at risk for exposure during care due to the absence of privacy curtains.Findings included:The facility did not have a privacy policy.A review of the electronic medical record (EMR) for R118 revealed an admission date of 12/31/2023 with diagnoses including vascular dementia, moderate Alzheimer's disease, chronic kidney disease, hypertension, lack of coordination, anemia, and generalized weakness.A review of R118's quarterly Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition.A review of the physician's orders for R118, dated 7/2/2024, revealed orders for incontinent care, as needed.A review of R118's care plan, revised on 10/24/2025, revealed the resident was care-planned for Activities of Daily Living (ADL) care decline related to COVID-19, Alzheimer's, dementia, hypertension, peripheral vascular disease (PVD), and anemia due to cognitive impairment and functional decline. Additionally, R118 is care planned to be at risk for skin breakdown/pressure ulcer development related to weakness, bowel and bladder incontinence, and dementia. Interventions include providing incontinence care.An observation and interview conducted on 12/1/2025 at 12:10 pm in R118's room revealed the resident was seated in a wheelchair in his room. The resident stated he was confused about what he was supposed to be doing that day and did not recall what he had eaten. Observation of the room revealed the resident's private curtain was missing; no curtain was present.An observation conducted on 12/3/2025 at 1:00 pm and 12/4/2025 at 9:31 am in R118's room revealed that the privacy curtain was missing.An interview and observation conducted on 12/4/2025 at 10:22 am with Certified Nursing Assistant (CNA) AA revealed that she had worked at the facility for four years. She described her usual process when responding to a call light as knocking on the door, introducing herself, asking what the resident needs, gathering supplies, closing the door, pulling the privacy curtain, explaining the care she will provide, performing hand hygiene, donning gloves, and beginning care. When asked whether she observed a privacy curtain in the resident's room, she stated she did not. CNA AA reported that the previous day was the first time she noticed the resident did not have a privacy curtain. She acknowledged she did not notify anyone about the missing curtain, stating she assumed the curtain had been removed for cleaning. She further stated she did not report it on the day of the interview because she was unsure how long laundry takes to return the curtains. She explained this was not her usual hall, and she rotates between halls. CNA AA stated a potential negative outcome of not having a privacy curtain was that someone could enter the room without knocking, leaving the resident exposed. She stated she typically performed the resident's brief changes in the bathroom.An interview conducted on 12/4/2025 at 10:36 am with Registered Nurse (RN) BB revealed that the process for providing personal care includes knocking, introducing oneself, explaining the care to be provided regardless of the resident's cognitive status, and honoring the resident's right to refuse. If the resident agrees, staff then close the door and pull the privacy curtain. The nurse stated that privacy is very important. Observation of the resident's room was completed with the nurse, who confirmed the resident did not have a privacy curtain. He reported that no CNA had notified him of the missing curtain. He identified a possible negative outcome as a violation of resident privacy if someone were to enter the room while care was being provided. RN BB stated his expectation is that staff notify him when privacy curtains are missing.An interview conducted on 12/5/2025 at 10:14 am with the Director of Health Services (DHS) revealed that all resident rooms were required to have privacy curtains. The DHS stated staff were expected to notify appropriate personnel when curtains are missing so they can be replaced. The DHS identified the potential negative outcome as a loss of resident privacy.An interview conducted on 12/5/2025 at 10:17 am with the Regional Consultant confirmed that all rooms are required to have privacy curtains. The Regional Consultant stated that the potential negative outcome for a missing privacy curtain is a lack (continued on next page)

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	115314	A. Building B. Wing	12/05/2025

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of privacy for the resident.An interview conducted on 12/5/2025 at 10:21 am with the Administrator revealed that every resident is expected to have a privacy curtain in place. The Administrator stated the expectation is that staff notify management when privacy curtains are missing. The Administrator identified the potential negative outcome as a resident not receiving visual privacy.