STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115325	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Washington	112 Hospital Drive Washington, GA 30673

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50878 Based on observations and staff interview, the facility failed to ensure the Packaged Terminal Air Conditioners (PTAC) were maintained to provide a clean and comfortable environment for 11 of 31 resident rooms (Rooms 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21). Findings include: Observation of the filtration system in the PTAC on 11/17/2024 at 2:27 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Upon pulling out the filter, debris was also noted down inside the PTAC unit where the filter was housed. Observation of the filtration system in the PTAC on 11/17/2024 at 2:36 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Upon pulling out the filter, debris was also noted down inside the PTAC unit where the filter was housed. Observation of the filtration system in the PTAC on 11/17/2024 at 2:55 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Upon pulling out the filter, debris was also noted down inside the PTAC unit where the filter was housed. Observation of the filtration system in the PTAC on 11/17/2024 at 3:12 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Observation of the filtration system in the PTAC on 11/17/2024 at 3:22 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Upon pulling out the filter, debris was also noted down inside the PTAC unit where the filter was housed. Observation of the filtration system in the PTAC on 11/17/2024 at 3:43 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Upon pulling out the filter, debris was also noted down inside the PTAC unit where the filter was housed. Observation of the filtration system in the PTAC on 11/17/2024 at 3:55 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Upon pulling out the filter, debris was also noted down inside the PTAC unit where the filter was housed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the filtration system in the PTAC on 11/17/2024 at 4:14 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Upon pulling out the filter, debris was also noted down inside the PTAC unit where the filter was housed. Observation of the filtration system in the PTAC on 11/17/2024 at 4:30 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Upon pulling out the filter, debris was also noted down inside the PTAC unit where the filter was housed. Observation of the filtration system in the PTAC on 11/17/2024 at 2:27 pm in room [ROOM NUMBER] revealed a fuzzy, grayish brown substance in and on the filter surface. Upon pulling out the filter, debris was also noted down inside the PTAC unit where the filter was housed. Interview on 11/20/2024 at 11:05 am with the Maintenance Manager revealed, that the TELS (a web-based platform/service records) Building Management System has a reminder and check off for these to be done quarterly. He stated that he has told management that he feels cleaning should be done more often especially with the construction and painting currently taking place in the facility. The Maintenance Manager stated that all filters were cleaned this week after concerns were identified by surveyors.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46579 Based on observations, staff interviews, record review, and review of facility's policy titled Care Plans, the facility failed to follow a care plan for one of two residents (R) R42 reviewed for oxygen. Findings include: Review of the facility's policy titled Care Plans with dated 7/27/2023 under the section titled Definitions revealed, Person-Centered Care Focus is on the patient/resident as the center of control. Supports each resident in making his or her own choices. Includes making an effort to understand what each patient/resident is communicating, verbally and nonverbally, to identify what is important to each resident with regards to daily routines and preferred activities and having and understanding of the resident's life before coming to reside in the health care center. Under the section titled Admission Comprehensive Plan of Care revealed, number four The care plan approach serves as instructions for the patient/resident's care and provides continuity of care by all partners. Review of R42's Electronic Medical Record (EMR) revealed, she admitted with diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease (COPD), acute respiratory failure, and chronic pulmonary embolism. Review of R42's care plan revealed resident removes nasal canula, adjust settings and turns concentrator off with approaches that included but not limited to regularly check to see if tubing is properly worn with approach start date of 8/26/2024 and administer medication as ordered with approach start date of 7/15/2024; resident has episodes of shortness of breath and ineffective air exchange related to emphysema/COPD with approaches that included but not limited to administer oxygen at 2 (two) L/min (liters per minute) via nasal cannula, monitor and report signs of respiratory distress, monitor/document respiratory status every shift. (See Medication Administration Record), respiratory therapy: ipratropium-albuterol solution for nebulization; 0.5 mg (milligram)-3 mg (2.5 mg base)/3 mL (milliliters); amount: one vial with approach start date of 6/12/2024; resident has impaired gas exchange related to COPD, COPD exacerbation, and acute respiratory failure with approaches that included but not limited to administer oxygen at 2L/min via nasal cannula PRN (as needed), monitor oxygen saturation via pulse oximetry per protocol and prn, monitor/document respiratory status for changes, and provide respiratory care: nebulizer tx (treatment) per MD (medical doctor) order q (every) 12 hours, record response and time of length of time of treatment with approach start date of 6/1/2024. Review of R42's Medication Administration Record (MAR) dated 11/1/2024 through 11/20/2024 revealed, orders to monitor vital signs weekly on Wednesdays (3-11pm) once a day on Wednesday to administer oxygen at 2 LPM via nasal cannula as needed for shortness' of breath r/t (related to) COPD, check pulse ox check PRN as needed, and administer ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg (2.5 mg base)/3 mL three times a day however there was no documentation on the MAR for monitoring respiratory status every shift, monitoring oxygen saturation or documentation of response and length of time for treatments. Observation on 11/17/2024 at 3:17 pm revealed, R42 receiving oxygen at 5 LPM via nasal cannula. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/17/2024 at 5:04 pm revealed, R42 receiving oxygen at 5 LPM via nasal cannula. Observation on 11/17/2024 at 5:10 pm with Licensed Practical Nurse (LPN) DD, who was asked to R42's room confirmed the oxygen setting was at 5 LPM. Interview on 11/20/2024 at 1:50 pm with Registered Nurse (RN) EE revealed that he knew when R42 needed oxygen by checking her pulse oximetry and from signs and symptoms. He revealed that R42 did not have history of adjusting the flow rate. He revealed that he should be checking the flow rate to verify that it was correct every shift. He then stated that if a resident that receives a breathing treatment, they were supposed to be checking the vital signs before treatment and after treatment. He stated that it should be documented on the medication administration record (MAR) and/ or under the vital signs tab. He confirmed that they had not been documenting. Interview on 11/20/2024 at 1:59 pm with the Director of Health Services (DHS) revealed, breathing treatments documentation should include vital signs 15 minutes before treatment, 15 minutes post treatment and the duration of the treatment. She stated that the oxygen flow rate should be checked frequently at a regular basis, because she really does need her oxygen. Cross Reference F695

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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** 46579 Based on observations, staff interviews, record review, and review of the facility's policy titled Oxygen Administration, the facility failed to ensure oxygen was administered, provide documentation of monitoring for respiratory status, and to record oxygen saturation and nebulization treatments as ordered for one of two residents (R) R42 reviewed for oxygen. The deficient practice had the potential to affect R42's quality of life. Findings include: Review of the facility's policy titled Oxygen Administration dated 8/2/2023 Policy Statement revealed, It is the policy of [Name] to provide oxygen safely and accurately to appropriate patients/residents. Under the section titled Procedure revealed, number four Regulate liter flow to ordered/desired flow rate; number six, Monitor patient/resident's vital signs as warranted by patient/resident's condition and physician's orders. Review of the Electronic Medical Record (EMR) for R42 revealed, she admitted with diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease (COPD), acute respiratory failure, and chronic pulmonary embolism. Review of the Medication Administration Record (MAR) for R42's dated 11/1/2024 through 11/20/2024 revealed, orders to monitor vital signs weekly on Wednesdays (3-11pm) once a day on Wednesday to administer oxygen at 2 LPM (liters per minute) via nasal cannula as needed for shortness' of breath r/t (related to) COPD, check pulse ox check PRN (as needed), and administer ipratropium-albuterol solution for nebulization; 0.5 mg (milligram)-3 mg (2.5 mg base)/3 mL (milliliter) three times a day however there was no documentation on the MAR for monitoring respiratory status every shift, monitoring oxygen saturation or documentation of response and length of time for treatments. Observation on 11/17/2024 at 3:17 pm revealed, R42 oxygen flow rate at 5 LPM via nasal cannula. Observation on 11/17/2024 at 5:04 pm revealed, R42 oxygen flow rate at 5 LPM via nasal cannula. Observation on 11/17/2024 at 5:10 pm with Licensed Practical Nurse (LPN) DD, who was asked to R42's room confirmed the oxygen flow rate was at 5 LPM. Interview on 11/20/2024 at 1:50 pm with Registered Nurse (RN) EE revealed that he knew when R42 needed oxygen by checking her pulse oximetry and from signs and symptoms. He revealed that R42 did not have history of adjusting the flow rate. He revealed that he should be checking the flow rate to verify that it was correct every shift. He then stated that if a resident that receives a breathing treatment, they were supposed to be checking the vital signs before treatment and after treatment. He stated that it should be documented on the medication administration record (MAR) and/ or under the vital signs tab. He confirmed that they had not been documenting. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/20/2024 at 1:59 pm with the Director of Health Services (DHS) revealed, breathing treatments documentation should include vital signs 15 minutes before treatment, 15 minutes post treatment and the duration of the treatment. She stated that the oxygen flow rate should be checked frequently at a regular basis, because she really does need her oxygen. Cross Reference F656

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38154 Based on observation, staff interview, record review, and review of the facility's policy titled Cleaning Schedule Policy, the facility failed to maintain the ice machine in a clean, sanitary manner. The deficient practice had the potential to cause illness to 43 out of 45 residents who consumed an oral diet. Findings include: Review of the facility's policy titled Cleaning Schedule Policy dated 9/29/2022 under the Policy Statement revealed, It is the policy of [Name] that the Dietary Manager prepares a list of all cleaning tasks and posts them in the Dietary Department. It is the Dietary Manager's responsibility to develop and enforce the cleaning schedules and to monitor the completion of assigned cleaning tasks to promote a sanitary environment. Review of the facility's Ice Machine Cleaning Schedule Form revealed the unit should be cleaned monthly and indicated that it had been cleaned on 10/4/2024. Review of the facility's Direct Supply TELS (a web-based platform/service records) Work History Report indicated the ice machine was cleaned on 10/4/2024. During an observation on 11/17/2024 at 1:16 pm of the kitchen with the Dietary Manager (DM) revealed, the ice machine in the dining room next to the kitchen. Observation of the interior side of the ice machine revealed a black substance at both hinges of the lid. Interview with the DM stated the Maintenance Director (MD) was responsible for cleaning the ice machine, but she was not sure how often the unit should be cleaned or the last time it was cleaned. Observation and interview on 11/17/2024 at 1:45 pm with the MD, confirmed the black film on the interior side of the ice machine. He stated he cleaned the unit monthly and as needed and that he last cleaned it a couple of weeks ago. The MD revealed he should look inside the unit more frequently to make sure it remained free of the filmy substance. Observation and interview on 11/17/2024 at 3:30 pm with the DM revealed, the unit was cleaned and that she would help monitor the unit more frequently for cleanliness.