STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115377	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Valdosta, LLC	2501 North Ashley Street Valdosta, GA 31602

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 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. 34318 Based on observations, staff interviews and review of the facility policy titled, Medication Administration: Guideline, the facility failed to ensure that six residents (R6, R7, R11, R12, R13, R14) of 14 sampled residents' medications were not pre-set on one of four medication carts. Findings included, Review of the facility policy Medication Administration: Guidelines. Policy Statement: Medication are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do only after they have familiarized themselves with the medication. Procedure: 4. Medications are administered at the time they are prepared. Medications are not pre-poured/pre-set/pre-crushed. Only one patient/resident's medications are prepared and administered at a time. During observations on 3/5/2024 at 12:21 pm, on the North Hall far end medication cart were two nurses Licensed Practical Nurse (LPN) AA and LPN BB. When the medication cart drawer was opened, there were several unlabeled plastic cups with medication in them. The medication had been removed from the pharmacy delivery package pouches. During the observation on 3/5/2024 at 12:21 pm, the Licensed Practical Nurse (LPN) AA was asked how she know which medication cups goes with what resident. She revealed that she had put the pills in the cup and placed the pills in the slot with the resident's other medications that was not scheduled. An observation on 3/5/2024 at 12:24 pm observed LPN AA and LPN BB entered the Resident 14 (R14) room with unlabeled plastic cups removed from the medication cart drawer. LPN BB check R14 gastrostomy tube for placement. LPN AA flushed the peg with cold water and then attempted to pour a crush white pill through the tube. The cold water and the white pill caused a blockage in the tubing. After using a declogger in the tubing, the liquid medications were administered through the tubing without any difficulties. (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: 115377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER: Pruitthealth - Valdosta, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2501 North Ashley Street, Valdosta, GA 31602	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 3/5/2024 at 12:49 pm, observed LPN AA give Resident #6 the pre-set medication from the medication cart. An observation on 3/5/2024 at 12:41 pm, observed LPN AA give Resident 7 the pre-set medication from the medication cart. An observation on 3/5/2024 at 12:45 pm, observed LPN AA give Resident 11 the pre-set medication from the medication cart. An observation on 3/5/2024 at 12:46 pm, observed LPN AA give Resident 12 the pre-set medication from the medication cart. An observation on 3/5/2024 at 12:47 pm observed LPN AA give Resident 13 the pre-set medication from the medication cart. An interview on 3/6/2024 at 4:20 pm, the Director of Health Services (DHS) revealed that nurses should not be pre-setting up medications as this is a safety issue. An interview on 3/6/2024 at 4:38 pm, the Administrator revealed that nurses should never pre-set up medications, as this is a safety hazard.