

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Pruitthealth - Crestwood, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Pendleton Place 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45811</p> <p>Based on observations, interviews, record reviews, and a review of the policy titled, Abuse Identification the facility failed to maintain an environment that was free from sexual abuse by another resident for one of three residents (R1) sampled for abuse.</p> <p>Findings include:</p> <p>Review of the policy titled Abuse Identification, last reviewed on 1/11/2024 revealed the following: Policy Statement 3. Patients/residents in a Health Care Center should not be subjected to abuse or neglect by anyone (including but not limited to: staff, other patients/residents, consultants, volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals).</p> <p>Review of the medical record for R1 revealed diagnosis that included but was not limited to unspecified dementia, unspecified severity, with psychotic disturbance, cerebral infarction. Review of the Admission Minimum Data Set (MDS) dated [DATE] with a Brief Interview for Mental Status (BIMS) score that was not indicated</p> <p>Review of Progress Notes dated 4/11/2024 revealed R53 was sexually inappropriate towards a female resident. He was rubbing her in inappropriate places.</p> <p>Review of Progress Notes dated 4/13/2024 indicated inappropriate sexual behavior was noted towards another resident by R53.</p> <p>Review of Progress Notes dated 4/21/2024 indicated, male resident entered R1's room and was seen by staff inappropriately touching her breast. Facility administrator and DON notified.</p> <p>During an interview on 4/25/2024 at 3:15 pm with Registered Nurse (RN) AA it was revealed R1 was admitted to the facility with only the clothes she had on and clothing had to be utilized from the Lost and Found items. It is reported that R1 pulled up her shirt exposing her breast. R53 is reported as seeing R1 exposing herself and he began to follow her. RN AA further reported that R1 has not exposed herself since that initial incident because her family brought her clothing in the next day. RN AA also reported there was an incident in which R53 was observed rubbing on R1's legs when they were sitting outside. R53 was told not to touch R1.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/25/2024 at 3:15 pm with Licensed Practical Nurse (LPN) BB it was revealed, R1 frequently walked and R53 would follow her. LPN BB further reported that staff would monitor R53's behavior by making sure he was not near R1.</p> <p>During an interview on 4/25/2024 at 4:15 pm with Certified Nursing Assistant (CNA) CC it was revealed R53 was in R1's room sitting on the side of the bed touching her breast. CNA CC reported that she told R53 to stop touching R1 and to get out of the room. R53 then walked out of the room and went to stand near the back door.</p> <p>During an interview on 4/25/2024 at 3:40 pm with RN DD, it was revealed R53 exhibited inappropriate behavior towards R1. It was explained that R53 reached for R1 and pulled her to his chest, her shoulder was touching his chest. RN DD reported that she separated the two residents and R53 went outside.</p> <p>During an interview on 4/25/2024 at 4:45 pm with the Social Service Director (SSD), it was revealed that R53 was sent out to a psychiatric facility because of his inappropriate sexual behavior toward R1 on 4/21/2024.</p> <p>During an interview on 4/25/2024 at 5:00 pm with LPN EE it was revealed on 4/21/2024 she was called to the room of R1 and the staff in the room told her R53 was observed touching R1's breast. When LPN EE got to the room, R53 was no longer touching R1 but remained in the room.</p> <p>During an interview on 4/25/2024 at 5:15 pm with the Administrator she revealed she was notified on 4/21/2024 of inappropriate sexual behavior exhibited by R53 towards R1. She reported that she instructed staff to provide 15-minute checks of R53 until he could be transferred out of the facility the next day.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>45811</p> <p>Based on observations, interviews, record reviews, and review of the policy titled, Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property the facility failed to timely report an allegation of sexual abuse to the State Agency (SA) for one resident of three residents (R1) sampled for abuse.</p> <p>Findings include:</p> <p>Review of the policy titled Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, last reviewed 1/11/2024, under the Policy Statement: It is the policy of (named facility) and its affiliated entities (collectively, the Organization) to comply with all applicable federal and state requirements regarding the reporting of patient abuse, neglect, exploitation, mistreatment, and misappropriation of property. Under the Procedures section: Any allegation, suspicion, or identified occurrence is identified involving, patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of an unknown source, should be immediately reported to the Administrator of the provider entity. In accordance with applicable laws and regulations, the Administrator or his or her designee should notify the appropriate state agency (or agencies), the patient's attending physician, and the patient's designated representative of any allegation or incident described above and of the pending investigation.</p> <p>Review of the medical record for R1 revealed, a Brief Interview for Mental Status (BIMS) score was not indicated. R1 diagnosis included unspecified dementia, unspecified severity, with psychotic disturbance, and cerebral infarction.</p> <p>Review of Progress Notes dated 4/11/2024 revealed R53 was sexually inappropriate towards a female resident. He was rubbing her in inappropriate places.</p> <p>Review of Progress Notes dated 4/13/2024 indicated inappropriate sexual behavior, by R53, was noted towards another resident.</p> <p>Review of Progress Notes dated 4/21/2024 indicated, R53 resident entered R1's room and was seen by staff inappropriately touching her breast. Facility administrator and DON notified.</p> <p>There was no evidence to support that the incidents on 4/11/2024 and 4/13/2024 were reported to the SA.</p> <p>During an interview on 4/25/2024 at 4:45 pm with the Social Service Director (SSD), it was revealed that R53 was sent out to a psychiatric facility because of his inappropriate sexual behavior toward R1 on 4/21/2024. She did not know about any allegation of sexual abuse documented by the staff on 4/11/2024.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/25/2024 at 5:15 pm with the Administrator she revealed she was notified on 4/21/2024 of inappropriate sexual behavior exhibited by R53 towards R1. She stated that staff were then instructed to provide 15-minute checks of R53 until he could be transferred out of the facility the next day.</p> <p>During a post survey interview on 5/9/2024 at 9:29 am, the Administrator reported that she was not aware of any incidents between R53 and R1 before 4/21/2024. The Administrator further stated that the supervisor should have reported any incidents to her, and the staff who witnessed any incidents should have reported them to their supervisor.</p>