STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115391	A. Building B. Wing	09/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Eastside	2795 Finney Circle Macon, GA 31217

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 33548 Based on record review, staff interviews, and review of the facility policy titled Nutritional Screening and Assessments/Food Preferences, the facility failed to ensure the Registered Dietitian completed an annual nutritional assessment for one of 30 sampled residents (R) (R53). The deficient practice had the potential to place R53 at risk of unmet nutritional needs. Findings include: A review of the facility policy titled Nutritional Screening and Assessments/Food Preferences, revised 3/28/2024, revealed the Nutrition Assessment will be completed at a minimum of annually for each patient/resident. A review of the medical record revealed R53's diagnoses included, but were not limited to, Alzheimer's disease, dysphagia, feeding difficulties, and stage 3 pressure ulcer. A review of R53's Physician Orders revealed a diet order for regular mechanical soft, no red sauce. A review of the medical record revealed the last nutritional assessment completed by the Registered Dietitian was 6/23/2023. In an interview on 9/22/2024 at 12:05 pm, the facility's Corporate Nurse Consultant (CNC) confirmed the last nutrition assessment completed by the Registered Dietitian was in June 2023. The CNC revealed that the facility has recently transitioned to a new Dietitian, and R53's annual nutritional assessment was likely missed. In an interview on 9/22/2024 at 1:05 pm, the Administrator revealed the facility had a new Dietitian who had only been with them for one month. The Administrator revealed the previous Registered Dietitian should have completed an annual nutritional assessment for R53. The Administrator further stated the Dietitian was expected to complete nutritional assessments on residents at admission and at least annually.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 35180 Based on observations, staff interviews, record review, and review of the facility policy titled Oxygen Administration, the facility failed to ensure respiratory equipment was maintained in a sanitary manner for three of 10 residents (R) who received oxygen (R64, R54, and R29). The deficient practice had the potential to place R64, R54, and R29 at an increased risk of respiratory complications and infection. Findings include: A review of the facility policy titled Oxygen Administration, revised 8/3/2023, revealed the internal filters would be changed by a contracted company, and the exteriors of the concentrators would be cleaned weekly. 1. A review of R64's Quarterly Minimum Data Set (MDS) dated [DATE] revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 15 (indicating little to no cognitive impairment) and section O (Special Treatments and Programs) documented R64 received oxygen. A review of R64's medical record revealed an order dated 12/26/2023 for oxygen at 3 liters per minute (LPM) via nasal cannula continuous. An observation of R64's oxygen concentrator on 9/20/2024 at 9:17 am and 9/21/2024 at 9:05 am revealed the interior filter, exterior of the concentrator, and air intake cover were covered with visible dust and debris. During an observation of R64's oxygen concentrator on 9/21/2024 at 9:29 am, the Administrator and Infection Control Preventionist (ICP) verified the interior filter, exterior of the concentrator, and air intake cover were covered with visible dust and debris. During an interview on 9/20/2024 at 9:20 am, R64 revealed that a staff member would usually change the filters and clean the concentrator weekly. However, it had been at least 30 days since she had seen staff change the filter or clean the oxygen concentrator. 2. A review of R54's Quarterly MDS dated [DATE] revealed section O (Special Treatments and Programs) documented that R54 received oxygen. A review of R54's medical record revealed an order dated 10/21/2023 for oxygen at 2 LPM via nasal cannula continuous. An observation of R54's oxygen concentrator on 9/20/2024 at 9:17 am and 9/21/2024 at 9:05 am revealed the exterior air intake cover/vent was covered with visible dust and debris. During an observation of R54's oxygen concentrator on 9/21/2024 at 9:29 am, the Administrator and (ICP) verified the exterior air intake cover/vent was covered with visible dust and debris. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of R54's oxygen concentrator on 9/22/2024 at 9:22 am revealed the exterior air intake cover/vent continued to be covered with visible dust and debris. 3. A review of R29's Annual MDS dated [DATE] revealed section O (Special Treatments and Programs) documented that R29 received oxygen. A review of R29's medical record revealed an order dated 8/1/2024 for oxygen at 2 LPM via nasal cannula as needed. An observation of R29's oxygen concentrator on 9/20/2024 at 9:22 am and 9/21/2024 at 9:18 am revealed the exterior air intake cover/vent was covered with visible dust and debris. During an observation of R29's oxygen concentrator on 9/21/2024 at 9:32 am, the Administrator and ICP verified the oxygen concentrator air intake cover was covered with visible dust and debris. An observation of R29's oxygen concentrator on 9/22/2024 at 9:01 am revealed the oxygen concentrator air intake cover continued to be covered with visible dust and debris. During an interview with the ICP on 9/21/2024 at 9:29 am, she stated that ensuring the oxygen concentrators and oxygen filters were clean fell under infection control, but she did not know how often the filters and concentrators needed to be cleaned. The ICP acknowledged R64's, R54's, and R29's oxygen concentrator air intake cover and R64's oxygen filter were covered with visible dust and debris and should have been cleaned. During an interview with the Administrator on 9/21/2024 at 9:30 am, she stated it was her expectation for the oxygen filters and concentrators to be cleaned per the manufacturer's instructions and facility policy, and when observed to be visibly dirty. The Administrator acknowledged R64's, R54's, and R29's oxygen concentrator air intake cover and R64's oxygen filter were covered with visible dust and debris and should have been cleaned.

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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. 33548 Based on observations, staff interviews, and review of the facility policies titled Foodborne Illnesses, Labeling, Dating, and Storage, Pot/Pan Washing and Sanitation, and Food Temperatures, the facility failed to thaw meat properly to prevent a foodborne illness, failed to clean a floor fan to prevent food contamination, failed to label and date opened food items, failed to discard leftover foods by the use by date, failed to demonstrate the proper usage of the three-compartment sink to prevent foodborne illness, and failed to properly maintain all food items on the steam table above 135 degrees Fahrenheit (F) to prevent bacteria growth. The deficient practices had the potential to place 78 residents who received an oral diet from the kitchen at risk of contracting a foodborne illness. The facility census was 79. Findings include: 1. A review of the facility policy titled Foodborne Illnesses, reviewed 1/8/2021, revealed the Procedure section included .7. Meats will be thawed and cooked to appropriate internal temperature to prevent foodborne illnesses. Thaw meats under refrigeration at or below 41 degrees Fahrenheit in a drip-proof container or submerged in a solid bottom pan under cold running water. Observation on 9/20/2024 at 8:27 am of the food preparation sink revealed the water faucet was running a stream of water into a large rectangle steam table pan filled with pork chops. The pork chops were piled high in the pan, and only half of them were completely submerged in water. In an interview on 9/20/2024 at 8:27 am, the Assistant Dietary Manager (ADM) confirmed the pork chops were in the process of being thawed and confirmed that not all of the pork chops were submerged in water. The ADM was unable to state the reason behind completely submerging food items in water when thawing. 2. A review of the facility policy titled Labeling, Dating, and Storage, reviewed 11/11/2022, revealed the Procedure section included 1. Food and beverage items will have an identifying label as well as a received date and opened date, as applicable, for items prepared onsite, a use by date will also be indicated. Observation on 9/20/2024 at 8:35 am of the dry storage area revealed a large, tall, white plastic container containing rainbow pasta with no label or date. Continued observation revealed a large, tall, clear plastic container containing egg noodles with no label or date. Further observation revealed an opened 48-ounce jar of grape jelly with no open date. In an interview on 9/20/2024 at 8:35 am, the ADM confirmed that both large plastic containers containing pasta had no labels or dates, and the opened jar of grape jelly had no open date. The ADM revealed that dietary staff should have dated any food item that was opened and stored. Observation on 9/20/2024 at 8:40 am of the two-door reach-in refrigerator, located in a back room of the kitchen, revealed a square clear plastic container labeled Ravioli prep date 9/14 and discard date 9/18. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 9/20/2024 at 8:40 am, the ADM confirmed that the clear plastic container of food was labeled with a discard date of 9/18. The ADM revealed that she had been off of work and, since returning, had not had the opportunity to go through the refrigerator. The ADM revealed that dietary staff should have reviewed leftover food items in her absence and discard if needed. 3. Observation on 9/20/2024 at 9:15 am of the large floor fan in the kitchen by the fryer revealed the fan housing had a layer of dust and lint. The fan was turned on, and the airflow was directed into the food preparation area. Observation on 9/21/2024 at 12:40 pm of the large floor fan in the kitchen revealed it continued to have a layer of dust and lint. A large rectangular steam table pan containing flour was on the top of a cart, and the cart was next to the fryer. The airflow from the fan was directly in the path of the pan containing flour and in the food preparation area. Observation on 9/22/2024 at 9:40 am of the large floor fan in the kitchen revealed it continued to have a layer of dust and lint. The airflow from the fan was directed into the food preparation area, where the dietary staff was prepping food for the lunch meal. In an interview on 9/22/2024 at 9:40 am, the ADM confirmed the large floor fan in the kitchen had a layer of dust and lint build-up and that the fan was blowing directly into the food preparation area. The ADM stated that due to the heat in the kitchen the fan helps keep staff cool. The ADM revealed that dietary staff have assigned cleaning tasks, and the fan was to be cleaned once a week. The ADM further revealed that she does expect dietary staff to clean the fan when dust and lint are noted. 4. A review of the facility policy titled Pot/Pan Washing and Sanitation, reviewed 11/16/2020, revealed the Procedures section included Chemical Sanitizers: Items need to be immersed for 60 seconds in the Quaternary. Review of the chemical sanitizing Product Specification Document revealed to expose all surfaces to the sanitizing solution for a period of not less than one minute. Observation on 9/21/2024 at 11:30 am of Dietary [NAME] AA washing the food processor bowl, lid, and blade revealed she washed the dishware items with soapy water, rinsed, swished the items in the sanitizing solution for two seconds, then placed the items on the drying rack. In an interview on 9/21/2024 at 11:30 am, Dietary [NAME] AA confirmed the dishes she cleaned were only in the sanitizing solution a few seconds before being placed on the drying rack. Dietary [NAME] AA revealed that she had not been trained on how long dishware items needed to be submerged in the sanitizing solution. She further confirmed that the poster titled Pot & Pan Procedure, which hung on the wall over the 3-compartment sink, stated to submerge in the sanitizing sink for one minute. In an interview on 9/21/2024 at 11:35 am, the ADM revealed the facility uses a quaternary sanitizer solution for the three-compartment sink. The ADM revealed she could not recall when the last in-service was conducted using the three-compartment sink. She further stated that she expected the dietary staff to have dish items in the sanitizing solution for at least one minute. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. A review of the facility policy titled Food Temperatures, revised 2/24/2023, revealed the Procedure section included 1. All hot foods served from the steam table must be held at or above 135 degrees. Steam table temperatures were completed on 9/21/2024 at 12:35 pm with Dietary [NAME] AA assisting and using the facility's calibrated food thermometer. Observation revealed the steamed beets had a temperature of 126 degrees Fahrenheit (F). In an interview on 9/21/2024 at 12:35 pm, Dietary [NAME] AA confirmed the beets had a temperature of 126 degrees F. In an interview on 9/21/2024 at 12:35 pm, Dietary Aide BB, who was assisting Dietary [NAME] AA, revealed that foods on the steam table should be at 135 degrees F or hotter. In an interview on 9/21/2024 at 12:45 pm, the Dietary Manager (DM) revealed that she expects dietary staff to have food items on the steam table at least maintained at 135 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914 Based on observation, staff interviews, record review, and review of the facility policies titled Infection Control Precautions for Dressing Change, Clean Procedures, and Using the Treatment Cart and Infection Prevention-Hand Hygiene, the facility failed to ensure infection control practices were followed during wound care for one of two residents (R) (R28) reviewed for wound care. The deficient practice had the potential to increase the probability of R28 contracting an infection in his current wound. Findings include: A review of the facility's undated policy titled Infection Control Precautions for Dressing Change, Clean Procedures, and Using the Treatment Cart revealed the Procedure section included 15. Wash your hands (or use an alcohol cleaner) after removing and discarding the existing dressing. A review of the facility policy titled Infection Prevention-Hand Hygiene, dated 8/22/2024, revealed the Procedures section included D. Indications Requiring Hand Wash or Hand Rub 5. After contact with blood, body fluids or excretions, mucous membranes, non-in-tact skin, and wound dressings. 6. When hands move from a contaminated body site to a clean body site during resident care. A review of the medical record revealed that R28's diagnoses included but were not limited to venous insufficiency (chronic) (peripheral) and cutaneous abscess. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 13 (indicating little to no cognitive impairment) and section M (Skin Conditions) documented R28 had one unstable deep tissue injury with applications of ointments/medications. A review of the Physician Order Report revealed an order dated 7/15/2024 of Clean left heel with normal saline and pat dry. Apply skin prep to surrounding skin and apply AMD [Antimicrobial Foam Dressing] foam. Cover with foam dressing. Once a day PRN [as needed]. Wound care observation on 9/21/2024 at 3:18 pm revealed Skin Integrity Coordinator (SIC) Licensed Practical Nurse (LPN) knocked on R28's door and asked for permission to complete wound treatment to left heel with surveyor observation. After permission was granted, the nurse proceeded to gather supplies. SIC LPN cleaned and sanitized R28's bedside table with germicidal bleach wipes and allowed it to air dry. She then covered the table with a clean trash bag before placing gathered supplies on the table. SIC LPN donned a plastic gown, sanitized hands, and applied clean gloves. R28 was repositioned to the left side, and the old bandage was removed and placed in a trash bag resting on the resident's bed. SIC LPN removed her gloves and donned clean gloves without washing or sanitizing her hands between the glove change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 9/21/2024 at 3:30 pm, SIC LPN revealed she received training for wound care from the wound care company that is contracted with the facility. She acknowledged that she did not wash or sanitize her hands during wound care and revealed that during the training she received, it was disclosed that it was not necessary to sanitize or wash your hands between glove changes during wound care. In an interview on 9/22/2024 at 8:19 am, the Director of Health Services (DHS) revealed that during wound care, the nurse should be performing hand hygiene between glove changes for infection control purposes. She stated the expectation was for all nursing staff to know when it is appropriate to wash and sanitize hands, and an in-service would be conducted.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35180 Based on observations, staff interviews, and resident interviews, the facility failed to ensure a functioning call system for one of 30 sampled residents (R) (R39). This failure placed R39 at risk of accident, injury, and/or unmet needs related to an inability to call for staff assistance. Findings include: A review of R39's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed section C Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 10 (indicating moderate cognitive impairment), and section GG (Functional Abilities and Goals) documented no upper extremity impairment. Observations of R39's call light on 9/20/2024 at 9:51 am and 9/21/2024 at 8:57 am revealed the call light was not working. When the call light was unplugged from the wall, the call light was triggered outside the room, but when the call light was plugged in, and the call light was depressed, the call light did not trigger outside the resident's room. An interview with R39 on 9/20/2024 at 9:56 am revealed he was unaware the call light was not working, and he had no idea when it had stopped working. He stated he could not remember when the staff had last checked his call light. An observation of R39's call light with the Administrator and Assistant Maintenance Director (AMD) on 9/21/2024 at 9:37 am revealed the call light was not working. The Administrator and AMD acknowledged that when the call light was unplugged from the wall, the call light triggered outside the room, but when the call light was plugged in, and the call light was depressed, the call light did not trigger outside the resident's room. During an interview with the ADM on 9/21/2024 at 9:38 am, he said he checked the resident's call lights every other day but had not checked R39's call light recently because he had been busy with different tasks. He could not remember the last time he had checked the call light in R39's room. During an interview with the Administrator on 9/21/2024 at 9:39 am, she stated the resident's call lights were supposed to be checked regularly and fixed or replaced if they were found to be non-functioning. She said R39's light should have been checked, fixed, or replaced. The Administrator further stated the facility had no policy or written procedure indicating who was responsible for monitoring the call light system or how the system would be assessed for functional ability.