STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115393	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Scenic View	205 Peach Orchard Road Baldwin, GA 30511

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record reviews, and review of facility's document titled Dressing a Wound, the facility failed to maintain infection control for two out of nine sampled residents (R) (R39 and R6). Specifically, the facility failed to maintain infection control practices during a wound care procedure for R39 and during medication administration for R6. The deficient practices had the potential to place R39 and R6 at risk of exposure to infection which had the potential to contribute to their decline in health. Findings include:Review of the facility's undated document titled, Dressing a Wound, revealed, Under the document's Description: This checklist identifies the steps needed to dress a wound. It also provide rationales to explain why these steps are performed. The checklist includes, but is not limited to, remove the old dressing while supporting the peri wound. Remove any packing, if applicable if the dressing is adhered to the wound bed moisten it with normal saline to prevent damage to any granulated tissue. Observe the dressing fr any type and amount of drainage and odor. Dispose of the dressing in the trash bag. Perform hand hygiene. Apply clean gloves. Rationale: Prevents transmission of microorganisms.1. Review of medical records revealed R39 was admitted to the facility with the following diagnoses that included but not limited to complete traumatic amputation at left between left hip and knee, pressure ulcer of sacral region, unstageable, local infection of the skin and subcutaneous tissue. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Section C (Cognitive Pattern) revealed, R39 had a Brief Interview for Mental Status (BIMS) score of 12 indicating the resident had little to no cognitive impairment; Section M (Skin Conditions) revealed a stage three pressure ulcer.Review of care plan dated 3/16/2023 revealed, Problem: R39 has a pressure ulcer related to impaired mobility and loss of feeling due to paralysis. Coccyx pressure wound. Goal: R39's ulcer will have no signs and symptoms of infections and/or complications. Approach revealed treatments as ordered, assess the pressure ulcer for stage, size (length, width, depth), presence/absence of granulation tissue and epithelization and condition of surrounding skin. Conduct a systematic skin inspection. Report any signs of any further skin breakdown (sore, tender, red, or broken areas). Keep clean and dry as possible. Minimize skin exposure to moisture. Keep linens clean, dry and wrinkle free as able.Review of R39's physician orders dated 7/30/202025 revealed wound care orders to cleanse ulcer to coccyx with wound cleanser, pat dry, apply lotrisone to peri wound, then calcium alginate and foam dressing once daily and as needed. Observation on 8/6/202025 at 9:15 am with the Licensed Practical Nurse (LPN)/Wound Nurse DD performing wound care for R39 in the resident's room. LPN/Wound Nurse DD donned disposable gown and gloves in hallway. LPN/Wound Nurse DD sanitized the bedside table in the doorway of R39 and covered it with trash bag lining. She removed her gown and gloves, used hand sanitizer and donned clean gown and gloves. LPN/Wound Nurse DD gathered wound care supplies and placed them on covered bedside table. Upon entry to R39 room, she introduced herself to R39 . Certified Nurse Assistant (CNA) AA was present in the room, donned with disposable gown and glove. CNA AA positioned and held R39 on his left side to support during wound care procedure. LPN/Wound Nurse DD removed the soiled dressing and discarded it in the trash can. LPN/Wound Nurse DD then removed the right glove with the soiled gloved left hand. She picked up the wound cleanser, sprayed (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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