

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Pruitthealth - Fort Oglethorpe		STREET ADDRESS, CITY, STATE, ZIP CODE 1067 Battlefield Parkway Fort Oglethorpe, GA 30742	

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>28270</p> <p>Based on review of the facility's surveillance video, staff interview, record review, and review of the facility's policy titled, Prevention of Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to ensure one (Resident (R)62) was free from sexual abuse by R50 out of a sample of 32 residents. This had the potential for further sexual abuse for the resident and other residents by R50.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, reviewed 12/07/22, indicated, It is the policy . to actively preserve each patient's right to be free from . sexual.abuse.Sexual abuse is non-consensual sexual contact of any type with a resident</p> <p>Review of the Resident Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed R62 was admitted to the facility with a diagnosis of dementia and Alzheimer's.</p> <p>Review of R62's quarterly Minimum Data Set (MDS) located under the RAI tab of the EMR with an Assessment Reference Date (ARD) of 03/19/24 indicated a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was not cognitively intact.</p> <p>Review of the Resident Face Sheet revealed R50 was admitted to the facility with a diagnosis of dementia, psychotic disturbance, and high-risk heterosexual behavior.</p> <p>Review of R62's quarterly MDS located under the RAI tab of the EMR with an ARD of 05/13/24 indicated a BIMS score of five out of 15, which indicated the resident had severe cognitive impairment.</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>Review of R50's Care Plan located under the RAI tab of the EMR initiated on 03/02/20 revealed R50 had his hand inside a female resident's shirt as well as staff reported he had been entering female resident rooms without permission from residents initiated on 01/09/23. Interventions include . Observe for sexually inappropriate behavior, remove from situation and report as indicated. (Initiated on 04/12/21) Redirect him from other resident's room. (Initiated on 02/05/21) Remove from situation when the attention is unwanted. Psych consult. Redirect when he is sexually inappropriate with other staff/residents. (Initiated on 03/16/20). Approach: R50 has been approved for psych services. R50 sees the psych NP and the psychotherapist. (Initiated on 03/03/20) Provide a room when he requests private time. Redirect when he is inappropriate with others. Chart behaviors each shift and as needed (Initiated on 03/02/20).</p> <p>Further review of R50's Care Plan revealed on 06/14/24 a Care Plan was initiated for R50 having had inappropriate sexual behaviors toward female residents. The interventions included observe for effectiveness of medication, report any misconduct to administrator immediately, redirect him from female company when being inappropriate, and medication as ordered.</p> <p>Review of the facility's 5-Day Follow-up Investigation Report, provided by the facility, dated 06/14/24, revealed Licensed Practical Nurse (LPN)1 notified the Administrator on 06/10/24 at 5:48 PM that R50 was groping R62. Further review of the facility's investigation revealed no residents or additional staff members were interviewed following the review of the surveillance cameras.</p> <p>Record review of R50's Social Services Note, located under the Progress Notes tab of the EMR, dated 06/13/24, that stated R50 was seen by psych services. There was no documentation that the resident received psych services until 07/01/24. Further documentation located under the Progress Notes tab revealed on 06/13/24 the Interdisciplinary Team (IDT) held a behavior management meeting, and the resident was prescribed medication to reduce sexual desires.</p> <p>Review of an additional facility's 5-Day Follow-up Investigation Report, dated 07/03/24, provided by the facility, revealed on 07/01/24 at 10:30 AM Certified Nursing Assistant (CNA)1 informed the Administrator that she witnessed resident R50 grabbing R62's breast. Further review of the facility's investigation revealed additional staff members were interviewed following the review of the surveillance cameras.</p> <p>Review of the facility's surveillance video along with the Administrator on 09/11/24 at 10:28 AM revealed on 06/10/24 both residents were sitting in front of the nursing station. R50 was seen reaching over and touching R62's legs and thigh area. During the surveillance two family members walked by and then two staff (identified as LPNs) witnessed the incident and brought R50 back to his room while allowing R62 to bring themselves back to their room. During the 07/01/24 incident, R50 and R62 were seen rolling in their wheelchair in front of the nursing station. R50 is then seen rubbing on R62's chest area. There were two staff members approximately two doors down from the residents. After approximately three minutes, CNA1 is then observed approaching the residents, saying something to the residents and proceeded to leave the residents and goes into another resident's room. The residents then rolled down the hallway and the video stopped.</p> <p>(continued on next page)</p>		

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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 with Administrator on 09/11/24 at 10:28 AM, the Administrator stated during the 06/10/24 and 07/01/24 incidents staff should have removed both residents from the area as well. The Administrator confirmed staff did not follow the abuse policy as well as the resident care plan to separate the residents to ensure the residents were safe. The Administrator also confirmed they did not interview any additional staff to ensure they were not a victim of inappropriate touch. There have been no further incidents with R50 and R62, or any other resident.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>28270</p> <p>Based on observation, staff interview, record review, and review of the facility's policy titled, Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to complete a thorough investigation for two incidents of resident to resident sexual abuse for one (Resident (R) 62) by R50 out of three residents reviewed for abuse out of 32 residents reviewed in the sample. This failure had the potential for unknown other incidents of sexual abuse for R62 or any other residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, reviewed 12/07/22, indicated, 1. The Administrator of the provider is responsible for assuring that an accurate and timely investigation is completed. If there is an occurrence of or allegation involving patient abuse (including injuries of unknown source), neglect, exploitation, mistreatment or misappropriation of patient property, the following investigation and reporting procedures will be followed: . Documentation of the investigation should include, but not be limited to, the following:</p> <p>Details of the alleged incident and injury.</p> <p>Signed statements from pertinent parties;</p> <p>Cognitive status of victim(s) and patient(s) who are witnesses (e.g., whether they are alert, oriented, and able to answer questions appropriately, which could help in determining whether the witness is credible and able to testify).</p> <p>Review of the facility's 5-Day Follow-up Investigation Report, provided by the facility, dated 06/14/24, revealed Licensed Practical Nurse (LPN)1 notified the Administrator on 06/10/24 at 5:48 PM that R50 was groping R62.</p> <p>Further review of the facility's investigation revealed no residents or additional staff members were interviewed following the review of the surveillance cameras.</p> <p>Review of the facility's 5-Day Follow-up Investigation Report, dated 07/03/24, provided by the facility, revealed on 07/01/24 at 10:30 AM CNA1 informed the Administrator that she witnessed resident R50 grabbing R62's breast. Further review of the facility's investigation revealed additional staff members were interviewed following the review of the surveillance cameras. There was no evidence that any residents or R50's family was interviewed to ensure a thorough investigation had been completed.</p> <p>Interview with Administrator on 09/11/24 at 10:28 AM stated during the 06/10/24 and 07/01/24 incidents between R62 and R50, they did not interview any additional staff, residents, or the family that was present in the video to ensure they were not a victim of inappropriate touch or to obtain additional witness statements.</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Cross Reference F600)		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013</p> <p>Based on resident and staff interviews and record review, the facility failed to provide a written notice of a transfer to the resident and/or resident's Responsible Party (RP) for three of three residents (Resident (R) 80, R32, and R73) reviewed for hospitalization out of a sample of 32 residents. This had the potential for the resident and or RP not knowing where and why a resident was transferred.</p> <p>Findings include:</p> <p>1. Review of the Resident Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab documented R80 was admitted to the facility on [DATE] and had a diagnosis of dementia.</p> <p>Review of the Progress Note found in the EMR under the Progress Note tab dated 05/16/24 documented the physician was notified that R80 had an elevated axillary temperature of 102.3 degrees Fahrenheit (F), his right elbow had increased swelling, was red, hot, very painful, and he was transferred to the hospital.</p> <p>There was no documentation in the EMR that R80 or the RP were notified of the transfer to the hospital in writing.</p> <p>During an interview on 09/10/24 at 6:55 AM, the Director of Health Services (DHS) said although R80's family member was notified by telephone of R80's transfer to the hospital, she was not aware she had to send written notices to families/RP related to a resident's transfer to the hospital and therefore, a written notice was not sent to R80's RP or other residents that have been transferred to the hospital. The DHS said the facility did not have a policy that addressed the requirement for the responsible person to be notified via a written notice regarding the reason and date of a resident's transfer to the hospital. The DHS said she confirmed with the corporate office that a written notice to a resident's responsible person or family member related to a resident's transfer to the hospital was required.</p> <p>31562</p> <p>2. Review of the Resident Face Sheet located in the EMR under the Face Sheet tab documented R32 was admitted to the facility on [DATE] and had a diagnosis of chronic kidney disease and unspecified fracture of the end of left femur.</p> <p>Review of the Progress Note found in the EMR under the Progress Note tab dated 07/12/24 documented the physician was notified that R32 had experienced a fall with a head laceration. and received orders for the resident to be transferred to the hospital.</p> <p>There was no documentation in the EMR indicating R32 and/or the RP were notified of the transfer to the hospital in writing.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with R32 on 09/11/24 at 10:49 AM revealed she was sent to the emergency room with a packet of papers, but she was not sure what was in the packet, and she was never required to sign any paperwork regarding transfer/discharge.</p> <p>During an interview with the DHS on 09/11/24 at 1:30 PM, she indicated the resident was sent to the emergency room with a packet which included information regarding the bed hold policy, but nothing was sent related to a written notice to the family regarding transfer/discharge. She also verified the facility did not have a policy regarding a requirement for the RP to be notified via a written notice regarding the reason and date of a resident's transfer to the hospital.</p> <p>39857</p> <p>3. Review of R73's Face Sheet from the (EMR) Face Sheet tab showed a facility admitted [DATE].</p> <p>Review of R73's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/09/24 showed a Brief Interview for Mental Status (BIMS) score of 99, indicative of being cognitively impaired.</p> <p>Review of R73's EMR Progress Notes tab showed a late entry note on 07/06/24 at 2:30 AM for 07/05/24 at 3:30 AM that revealed R73 was observed lying on his left side beside his bed, and appeared to have slid out of bed. There was no apparent injury, and he was assisted back to bed. Resident left the facility at 8:40 AM with emergency medical services, (EMS) due to seizure like activities.</p> <p>Review of R73's Progress Notes did not show evidence of the provision of a written notice of transfer provided to R73 and his RP.</p> <p>Upon request for evidence of the written notice of transfer provision, the facility was unable to provide a transfer notice from the facility to the emergency room .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46319</p> <p>Based on observations, staff interviews, and review of the facility's policies titled, Receiving and Storage of Food and Supplies and Hand Washing, the facility failed to ensure food stored in the kitchen was labeled, dated, and not expired. Additionally, staff failed to perform adequate hand hygiene when leaving and returning to food preparation area after touching the lid of trash can. This had the potential to increase the spread of foodborne illness and infection for 108 out of 109 residents that received meals from the kitchen.</p> <p>Findings include:</p> <p>Review of facility policy titled, Receiving and Storage of Food and Supplies dated [DATE]. Under the section labeled Guidelines: 1. The DM or trained designee is accountable for receiving and storage of food .7. Supplies already on shelves shall be moved forward and the latest date supplies placed on the back of shelves . 12. Date all stock with current delivery date.</p> <p>Review of the facility policy titled, Hand Washing dated [DATE] revealed, To prevent spreading bacteria, the dietary staff must wash their hands properly .before and after handling food .after handling unclean items such as trash. Guidelines: 1 .6. Dry hands with paper towels. Discard the paper towels in a foot operated trash can .</p> <p>During the initial observation of the kitchen with the DM (Dietary Manager) on [DATE] at 8:40 AM, there were six unopened 16-ounce containers of poultry seasoning located on a shelf in the dry good storage area that had an expiration date of ,d+[DATE]. A transparent plastic bag containing two frozen pizzas, without a received date, open date, or expiration date were located in the walk-in freezer. There was one opened case of sliced ham and one opened case of beef roast both showing a received date of [DATE] that had no open date, located in the walk-in cooler.</p> <p>During an observation and interview on [DATE], Cook1 removed the six unopened 16-ounce containers of poultry seasoning, stating these should have been thrown away a long time ago.</p> <p>During an interview on [DATE] at 7:30 AM, the DM stated that the expired items and those not dated when opened should be disposed of because they could cause residents to become sick.</p> <p>During an observation on [DATE] at 11:30 AM, Cook1 was observed preparing pureed beets and turkey pot pie. Cook1 placed the container on the table and performed hand hygiene. After performing hand hygiene Cook1 returned to the prep area, grabbed the lid to the trash can with a barehand and placed the paper towel into the trash can. [NAME] 1 then continued to prepare the pot pie without hand hygiene. Cook1 confirmed they touched the trash can when they threw away the paper towel and did not perform hand hygiene before preparing the pot pie.</p> <p>During an interview on [DATE] at 11:50 AM, the DM confirmed dietary staff should wash their hands.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013</p> <p>Based on observations, record review, resident and staff interviews, the facility failed to offer residents hand hygiene prior to meals for five of five residents observed (Residents (R)24, R68, R99, R105, and R37) out of a total sample of 32 residents. This had the potential for the risk of transmission of infections.</p> <p>Findings include:</p> <p>1. Review of Resident Face Sheet found in the Electronic Medical Record (EMR) under the Face Sheet tab documented R24 was admitted to the facility on [DATE] with diagnosis of dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) found in the EMR under the RAI tab with an assessment reference date (ARD) of 08/05/24 documented R24 had a Brief Interview of Mental Status (BIMS) score of nine out of 15, which indicated moderately impaired cognition, required set up by staff for eating, and was dependent on staff for hygiene, which included hand washing.</p> <p>During an observation on 09/09/24, at 1:00 PM, revealed R24 was sitting in his chair in his room. A staff member assisted R24 with his tray, and did not offer to assist him with hand hygiene.</p> <p>During an interview with R24 on 09/09/24 at 1:02 PM, R24 said although he would like to wash his hands before meals, the staff never helped him with hand washing.</p> <p>2. Review of the Resident Face Sheet found in the EMR under the Face Sheet tab documented R68 was admitted to the facility on [DATE] with diagnosis of type 2 diabetes.</p> <p>Review of the quarterly MDS found in the EMR under the RAI tab with an ARD of 06/19/24, documented R68 had a BIMS score of 14 out of 15, which indicated intact cognition, was independent with eating, and required moderate assistance with hygiene.</p> <p>During an observation on 09/09/24, at 1:09 PM, R68 was in his room sitting in his bed. A staff member set up R68's tray, and did not offer to assist him with hand hygiene.</p> <p>During an interview on 09/09/24 at 1:10 PM, R68 said he was bed bound and not able to get out of bed to wash his hands at the sink. He said although he would like to wash his hands before meals, the staff never offered to assist him with hand washing.</p> <p>3. Review of the Resident Face Sheet found in the EMR under the Face Sheet tab documented R99 was admitted to the facility on [DATE].</p> <p>Review of the quarterly MDS found in the EMR under the RAI tab with an ARD of 06/05/24 documented R99 had a BIMS score of five out of 15, which indicated severely impaired cognition, required set up for eating, and supervision/touch for hygiene.</p> <p>During an observation on 09/09/24, at 1:08 PM, R99 was sitting in her chair in her room. A staff member assisted R99 with her tray and did not offer to assist her with hand hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of the Resident Face Sheet found in the EMR under the Face Sheet tab documented R105 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes.</p> <p>Review of the quarterly MDS found in the EMR under the RAI tab with an ARD of 08/28/24, documented R105 had a BIMS score of 13 out of 15, which indicated intact cognition, required set up for eating, and maximum assistance with hygiene.</p> <p>During an observation on 09/09/24, at 1:04 PM, R105 was sitting in her chair in her room. A staff member set up R105's tray, and did not offer to assist her with hand hygiene.</p> <p>During an interview on 09/09/24 at 1:06 PM, R105 said the staff never offered to assist her to wash her hands before meals.</p> <p>5. Review of the Resident Face Sheet found in the EMR under the Face Sheet tab documented R37 was admitted to the facility on [DATE] with a diagnosis of blindness.</p> <p>Review of the quarterly MDS found in the EMR under the RAI tab with an ARD of 06/24/24, documented R37 had a BIMS score of nine out of 15, which indicated moderately impaired cognition, required set up for eating, and moderate assistance with hygiene.</p> <p>During an observation on 09/10/24, at 1:01 PM, a staff member set up R37's meal tray and did not offer to assist her with hand hygiene.</p> <p>During an interview on 09/09/24 at 1:06 PM, R37 said the staff never helped her wash her hands before meals.</p> <p>During an interview on 09/10/24 at 1:22 PM, Licensed Practical Nurse (LPN) 4 said sometimes the staff assisted residents to clean their hands before meals with hand sanitizer or a wet face cloth with soap. LPN4 said on 09/10/24, she set up R37's lunch tray and did not assist her with washing her hands.</p> <p>During an interview on 09/10/24 at 1:25 PM, Certified Nurse Aide (CNA)7 said she never assisted residents who ate their meals on the unit with hand washing prior to assisting them with their meals, unless their hands were soiled.</p> <p>During an interview on 09/10/24 at 1:28 PM, CNA6 said she did not assist residents with hand sanitation prior to meals on 09/11/24 and on other days she was assigned to the facility. She said they did not have hand wipes and did not have enough time to clean each residents' hands with face cloths or bring them to the sink to wash their hands.</p> <p>During an interview on 09/11/24 at 1:05 PM, the Infection Control Preventionist (IP) said although the staff used wipes in the dining room to provide hand sanitation to the residents prior to meals, she said the wipes were not used for residents on the units. She said hand sanitation was to be provided to residents prior to meals to prevent the potential for residents developing infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/10/24 at 3:30 PM, the Director of Health Services (DHS) said although the facility did not have a specific policy related to resident hand hygiene prior to meals, the expectation was that the staff would ensure all residents had the opportunity to wash their hands or be assisted by the staff to wash their hands prior to each meal to prevent residents from potentially acquiring an infection.</p>		