STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115473	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Lithonia, LLC	2816 Evans Mill Road Lithonia, GA 30058

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and review of the facility's policies titled, Foodborne Illness and Labeling, Dating, and Storage facility failed to adequately uphold food safety practices, which could lead to potential foodborne illnesses. Opened food products in the walk-in refrigerator were not appropriately labeled, dated, and discarded. The deficient practices had the potential to place 135 residents who received an oral diet from the kitchen at risk of contracting a foodborne illness. Findings Include:Review of facility's policy titled, Foodborne Illnesses reviewed dated 01/8/2021, revealed in Procedure 2. Foods will be used before the expiration date, use by date, and sell by date, indicated on the food item. Foods not used prior to the expiration date, use by date, best by date, or sell by date must be discarded. 3. It is the responsibility of the Dietary Manager to see that dietary employees practice safe and sanitary methods when preparing foods to prevent cross contamination and the spread of bacteria. 7. Meats will be thawed and cooked to appropriate internal temperature to prevent foodborne illnesses. Thaw meat under refrigeration at or below 41 degrees Fahrenheit in a drip proof container or submerged in a solid bottom pan under cold running water.Review of facility's policy titled, Labeling, Dating, and Storage review dated 11/12025, in Procedure section 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.During the initial tour on 03/17/2026 at 8:49 am, revealed in the kitchen walk-in cooler/refrigerator (19) 1 oz. single packs of sour cream, which have an expiration date of 01/12/2026. Additionally, there were (10) half-pint cartons of milk with an expiration date of 03/15/2026. Ongoing observation of the kitchen indicated that in the separate double sink designated solely for washing and preparing vegetables/produce, as well as thawing meat, there was a large silver bowl containing meat, which the cook SS identified as pork chops, submerged in water.Observation and Interview on 03/17/2026, at 9:13 AM, conducted during the breakfast meal tray pass and the distribution of carts to the floor revealed expired milk present on both the prepared tray and the cart. Dietary Aid (DA) RR confirmed that she was tasked with ensuring the accuracy of the meal trays. Dietary Aid RR stated that she had not received any training regarding storage, labeling, and dating.Observation on 03/17/2026, at 9:19 AM, revealed the presence of one half pint of expired milk, with the expiration date 03/15/2026, on breakfast tray for resident(R)91.The record review for R91 revealed a comprehensive Minimum Data Set (MDS) dated [DATE] and a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. A review of R91of the care plan initiated on 02/21/2026 revealed problem: At risk for altered nutritional status. Approach: Observe intake. Provide diet as prescribed/ordered.Observation on 03/17/2026, at 9:22 AM, revealed that breakfast meal tray for R139 contained one half pint of milk that had expiration date 03/15/2026.The record review for R139 revealed a quarterly Minimum Data Set (MDS) dated [DATE] and a Brief Interview for Mental Status (BIMS) score of 12, indicating no cognitive impairment. A review of R139 of the care plan initiated on 02/5/2026 revealed problem: Resident requires a therapeutic diet. Approach: Diet: as ordered.Follow up tour of the kitchen revealed for the three-compartment sink used (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for dishwashing revealed and checked by DM on 03/18/2026 at 1:36 PM, sanitizing solution strips with expiration date 10/1/2027, with no results. Retest completed on 03/19/2026, at 8:50 AM, revealed no solution disbursing from sanitizer, no results.Interview on 03/19/2026 at 8:53 AM, with cook MM disclosed that he had washed the morning dishes and discovered that the sanitizer machine was not working. [NAME] MM explained he manually poured the sanitizer solution into the water. [NAME] MM acknowledged that he did not test the sanitizer concentration nor did he measure the volume of the solution. Interview on0 3/19/2026 at 9:03 AM, with Dietary Aid NN revealed that on the morning of 03/17/ 2026, the kitchen was in disarray because the previous night, all meal tickets had not been printed, and there was no key available to access the kitchen that morning due to the cook who possessed the key calling off. DA NN explained that she had to stop with working on the meal tray line, to print tickets and then provide assistance in the dining room; so, she had DA RR to check the tickets.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, staff interviews, and review of the facility policy titled, Waste Disposal: Dietary Services, the facility failed to ensure the outdoor garbage and refuse area was free of litter by being maintained in a sanitary manner. Findings include:Review of the facility policy titled Waste Disposal: Dietary Services reviewed dated 10/20/2025 revealed under Procedure: 6. Dumpster lids, doors, and plugs should be kept closed at all times. 7. Dumpster and surrounding areas should be kept clean and free of debris. During the initial observation of the dumpster on 03/18/2026 at 11:58 AM the Dietary Manager (DM)PP confirmed the presence of two dumpsters. The dumpster adjacent to the brick wall; left door was observed to be completely open, overflowing with clear trash bags protruding from the left door. Observation indicated the presence of one compressed empty box, purple gloves, remnants of straws, and several white surgical face masks surrounding the two dumpsters. Interview on 03/18/2026, at 11:59 AM was conducted with the DM PP, who acknowledged the presence of trash and debris around the dumpster. The dumpster located near the brick wall door left open. DM PP confirmed the responsibility for the dumpster was with the kitchen. DM PP confirmed that the dumpster was open.Observation on 03/18/2026, at 3:00 PM revealed two dumpsters and the dumpster adjacent to the brick wall left door was observed mid-open, overflowing with clear trash bags and purples gloves protruding on to the ground. Observation indicated the presence of one compressed empty box, purple gloves, remnants of straws, and several white surgical face masks surrounding the two dumpsters. Interview on 03/19/2026 at 9:53 AM with Register Dietitian OO confirmed she was uncertain regarding who was responsible for maintaining the dumpster. However, she confirmed that any individuals who place trash in the dumpster should ensure that it is free of debris and that the doors are closed.Interview on 03/19/2026 at 11:38 AM with Maintenance Director confirmed that his department is tasked with the upkeep of the dumpsters. He noted that the facility operates continuously, 24 hours a day, and that the night shift had been notified of their responsibilities.

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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** Based on observations, record review, staff interviews, and review of the facility's policy titled Oxygen Administration, the facility failed to ensure respiratory equipment was maintained in a clean and sanitary manner by not cleaning the oxygen concentrator filter for one resident (R) (R69) out of 12 residents on respiratory care. This deficient practice had the potential to cause ineffective oxygen delivery, respiratory complications, and increased risk of infection.Findings include:Record review of facility's policy titled Oxygen Administration, reviewed on 11/17/2025, revealed the Policy Statement included, It is the policy of [NAME] Health Hospice and Healthcare Centers/Veterans Homes to provide oxygen safely and accurately to appropriate patients/residents. The policy further revealed The large external, black filter should be washed with soap and water once each week and PRN [as needed]. Dry with towel and reinsert. Clean exterior of concentrators weekly and between each patient/resident use with bactericidal surface cleaner.Record review of the electronic health record (EHR) revealed R69 was admitted on [DATE] with diagnoses including but not limited to chronic respiratory failure with hypoxia, dementia, shortness of breath, and dependence on supplemental oxygen.Record review of the Annual Minimum Data Set (MDS) for R69, dated 09/22/2025, revealed that Section C (Cognitive Patterns) documented that the Brief Interview for Mental Status (BIMS) was not performed. The MDS further revealed R69 was dependent on staff for all activities of daily living and received oxygen therapy and hospice services.Record review of physician orders for R69, dated 12/16/2025, revealed an active order for oxygen at 3 liters per minute via nasal cannula continuously, with additional orders to change respiratory circuit/supplies weekly and monitor pulse oximetry as needed.Record review of the care plan, last revised on 12/18/2025, for R69 revealed an active problem for oxygen use with interventions to administer oxygen as ordered, monitor oxygen saturation, position for optimal breathing, and observe for signs of hypoxia.Observations conducted on 03/17/2026 at 12:02 PM, 03/18/2026 at 9:11 AM, and 03/18/2026 at 12:57 PM revealed the oxygen concentrator filter had grey, fuzzy debris present.Interview conducted on 03/19/2026 at 9:10 AM with Licensed Practical Nurse (LPN) BB stated that the Maintenance Director was responsible for cleaning the concentrator filter. LPN BB observed the concentrator filter and stated she saw visible dust on the filter.Interview conducted on 03/19/2026 at 9:21 AM with the Maintenance Director revealed Certified Nursing Assistants (CNAs) were expected to notify the Maintenance Department when the oxygen concentrator filters were dirty, and then he would proceed to clean them. The Maintenance Director observed the concentrator filter and stated he saw visible debris.Interview conducted on 03/19/2026 at 9:22 AM with the Director of Nursing (DON) revealed that she was not aware of who was responsible for cleaning the filters and was not aware of the process. The DON observed the concentrator filter and stated she saw visible dust. The DON stated that expectations were to follow policy in maintaining filters.Interview conducted on 03/19/2026 at 12:52 PM with the Administrator revealed she was unsure how often the filters were cleaned and stated an outside company serviced the equipment monthly. The Administrator stated that staff were expected to report concerns.

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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. Based on observations, staff interviews, and review of the facility's policy titled Medication Storage in Healthcare Centers, the facility failed to ensure that medications and biologicals were stored securely on one of eight hallways. This deficient practice had the potential to place the residents and staff at risk of having unauthorized access to medications. Findings include:A review of the facility's policy titled Medication Storage in Health Care Centers, revised March 12, 2026, revealed that medications and biologicals are stored safely, securely, and properly following the manufacturer's recommendation or those of the supplier. The medication supply is accessible only to licensed nursing personnel, certified medication aides, and pharmacy personnel. Observation on 03/18/2026 at 6:10 AM revealed that a medication cart on the G Hall Corridor was unlocked, unattended, and out of direct sight of a nurse. Observation revealed the cart remained unlocked and unattended for three to five minutes. In an interview on 03/18/2026 at 6:15 AM, Registered Nurse (RN) DD confirmed the medication cart was unlocked and unattended, and stated the cart should be locked. RN DD further stated a consequence of leaving the medication storage cart unlocked was that a resident or unauthorized staff could gain access to medications. In an interview on 03/18/2026 at 6:18 AM, Certified Medical Assistant (CMA) EE revealed that she stepped away from the medication cart for a moment to get ice.