STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115491	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Ashburn	441 Industrial Blvd Ashburn, GA 31714

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on record review and staff interview, and review of the facility policy titled, Care Plans, the facility failed to develop a care plan to address an anti-platelet medication prescribed for a stroke for one of five Residents (R)19 and failed to implement care plan interventions for one of four residents R55 related to abuse. The sample size was 31 residents. Findings include: Review of the facilities policy titled, Care Plans, dated 7/27/2023 revealed: Baseline Care Plan- Must include the minimum health care information necessary to properly care for each patient/resident immediately upon their admission, which would address patient/resident specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavior interventions, and assistance with activities of daily living, as necessary. 1. Record review revealed R19 was admitted on [DATE] and had a Brief Interview of Mental Status (BIMS) score of 00 indicating severe cognitive impairment. A primary admitting diagnosis, other cerebral infarction and other diagnoses included but not limited to, stroke, vascular dementia, unspecified severity, with anxiety, and depression, unspecified. Further review of the clinical records revealed the resident was readmitted to the facility under hospice after a brief hospital stay. A Minimum Data Set (MDS) Significant change assessment dated [DATE] revealed section A - reentry from acute care hospital on 3/18/2024, section C - cognitive patterns documented BIMS score 00, section I- stroke. A review of the physician orders dated 4/1/2024 through 4/30/2024 revealed that R19 was ordered to receive clopidogrel tablet 75 mg, an anti-platelet: one tablet by mount once daily with a start date of 3/18/2024 for her diagnosis of cerebral infarction. Review of R19's care plan revealed there was no care plan for a stroke or for the medication, clopidogrel, an anti-platelet. Interview on 5/2/2024 at 9:59 am with Registered Nurse (RN), Case Mix Director (CMD) revealed care plans were done when a new medication was prescribed that could cause complications or if the medicine was something the resident had never been prescribed. CMD revealed that it was her expectations that medications were care planned. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36377 2. R55 was admitted to facility on 2/21/2023 with the following diagnoses of but not limited to moderate intellectual disabilities, dysphagia, and seizures, and delusional disorders. The Minimum Data Set (MDS) assessed a Brief Interview Mental Status Score (BIMS) of seven indicating severe cognitive impairment. Record review of R55's Electronic Medical Record (EMR) documented two incidents of R55 being a victim of sexual abuse by two residents. The Police Report dated 3/27/2024 and 3/20/2024 reported incidents of abuse involving residents in which the facility contacted law enforcement. Record review of R55's care plan revealed no plan of care created to address the sexual abuse incidents involving resident. Interview on 5/2/2024 at 9:45 am, the RN Case Mix Director reported being aware of R55 's incident of exposure to abuse by two male residents in the facility. She confirmed that a care plan was not created for R55 related to abuse to ensure prevention of future abuse. She stated that any nurse/clinical staff could update/create a care plan whether it is a fall or abuse. Interview on 5/2/2024 at 10:15 am, Director of Health Services (DHS) reported that her expectations for her staff to create care plans in a timely manner for abuse victims. Care plans are individualized reported being unaware that R55 was not done in a timely manner. The MDS Manager and Social Service are responsible for ensuring the care plan is completed. The Unit Manager would be responsible for creating the care plan at the time the incident occurred.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on staff interview, record review, and review of the facility policy titled, Physician Narratives, Orders, and Services for Hospice, the facility failed to obtain a physician's order for one of nine residents, resident (R) R19 receiving hospice services. Findings included: Review of facility policy titled, Physician Narratives, Orders, and Services for Hospice dated 11/22/2021 revealed under physician orders: 2. The hospice receives a verbal or written order from a physician to admit the patient to hospice. 5. Documentation of receipt of verbal orders and written orders sent to physician for signature is maintained in the patient's clinical record. Stamped signatures are not accepted. Electronic signatures may be accepted if they meet the criteria established by the MAC. 6. When the signed order is returned it is filed in the patient's clinical record and the unsigned order is removed. 8. Documentation is maintained of all efforts to obtain signed orders from physicians in a timely manner. Record review revealed R19 was admitted on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. A primary admitting diagnosis, other cerebral infarction and other diagnoses included but not limited to, vascular dementia, unspecified severity, with anxiety, and depression, unspecified. A further review of the clinical records revealed R19 was readmitted to the facility under hospice after a brief hospital stay. A Significant change assessment dated [DATE] revealed section A - reentry from acute care hospital on 3/18/2024, section C - cognitive patterns documented BIMS score 00, and section O - special treatment and programs listed hospice care. Review of the comprehensive care plan for R19 revealed plan of care for hospice services that included, problem set-has elected terminal care dated 3/19/2024, goal-death with dignity thru next review 7/11/2024, and interventions- call hospice first about any changes in condition, emergency, questions about care, medication changes or transport and prior to any procedures, monitor signs and symptoms of pain, notify hospice as appropriate and as family agrees, for evaluation for hospice services, meds as ordered, notify MD of any changes, provide comfort measures. Record review revealed the authorization form for hospice services, Medicaid Hospice Election Form dated and signed on 3/18/2024 by R19's family contact, a hospice representative, and the nursing home's Clinical Competency Coordinator (CCC). Hospital discharge orders did not include hospice. The CCC's signature was located on the discharge orders indicating she reviewed the orders. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/2/2024 at 11:25 am with Director of Health Services (DHS) revealed that if a resident were in house and required hospice services, the medical director of the facility would write an order. If the hospital were referring the resident the hospice doctor would write the order. When asked where R19's hospice order was located the DON stated that R19 came back from the hospital with hospice therefore they would not have an order but would review the hospital discharge orders and get back to us. A follow up interview on 5/2/2024 at 12:53 pm DHS revealed that when a resident was sent to the hospital, all standing orders from the facility were discontinued and new orders were completed upon re-entry into the facility. The DON revealed that an order for hospice occurred while R19 was in the hospital and confirmed there would not be an order for hospice written by the facility. The DHS revealed her expectations were that there would be an order written for hospice services, and orders be entered promptly and accurately.