STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Covington	4148 Carroll Street Covington, GA 30015

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45849 Based on staff interviews, record review, and review of the facility's policy titled, Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to report an allegation of abuse to the State Survey Agency within two hours for one of four Residents (R) (R2) reviewed for abuse. Findings include: Review of the facility's policy titled, Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, dated 7/29/2019, indicated, 1. Any allegation, suspicion, or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of an unknown source, should be immediately reported to the Administrator of the provider entity. 2. In accordance with applicable laws and regulations, the Administrator or his or her designee should notify the appropriate state agency (or agencies), the patient's attending physician, and the patient's designated representative of any allegation or incident described above and of the pending investigation. The state survey agency and the state agency for adult protective services should be notified in accordance with state law through established procedures of any allegations of abuse, neglect, exploitation or mistreatment, including injuries of an unknown source and misappropriation of patient property, within 2 hours after the allegation is made if the events upon which the allegation is based involve abuse or result in serious bodily injury, and not later than 24 hours if the events upon which the allegation is based do not involve abuse and do not result in serious bodily injury. Review of R2's Resident Face Sheet revealed diagnoses that included but not limited to, metabolic encephalopathy (a brain disorder resulting from other organ system failures), diabetes mellitus with diabetic kidney complication, end stage renal disease, pain in left shoulder, and vascular dementia. Review of R2's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/2023, revealed Section C:Cognitve Patterns, a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment; Section GG: Functional Abilities and Goals revealed, functional limitations in range of motion on one side of their upper and lower extremities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's Care Plan revealed a problem area initiated on 4/1/2023, that indicated R2 had frequent complaints of pain to their left shoulder. The Care Plan was updated on 11/15/2023 that indicated R2 had a left shoulder dislocation. R2's Care Plan also included a problem area, initiated on 4/1/2023, that indicated R2 had experienced a decline in their ability to perform activities of daily living (ADLs) related to a recent hospitalization secondary to metabolic encephalopathy, acute respiratory failure, acute cardiovascular accident (CVA, a stroke) with left-sided weakness, and dementia. An intervention started on 4/1/2023 directed staff to provide physical assistance with ADL care needs. Review of R2's Progress Notes revealed the following entries: - a note, dated 11/4/2023 at 2:37 pm, that indicated R2 complained of pain to their left shoulder blade. The note indicated that the resident rated their pain an 8 on a scale of 0-10, with 10 being the worst possible pain. The note indicated that the resident was given an as needed (PRN) pain medication; - a note, dated 11/5/2023 at 10:04 am, that indicated R2's left hand was swollen and was warm to the touch. The note indicated that R2 denied numbness but reported pain when touched. The note indicated that a PRN pain medication was given, and the resident's physician was notified of the resident's condition; - a note entered by Nurse Practitioner (NP) #17, dated 11/6/2023 at 11:55 am, that indicated R2 was evaluated for complaints of pain to left hand and arm; and - a note, dated 11/6/2023 at 2:00 pm, that indicated that the resident's left upper extremity and hand were swollen. The note indicated that a pain medication was given, and NP #17 evaluated the resident and ordered an ultrasound of the left upper extremity. Review of R2's Patient Report for the left upper extremity venous doppler ultrasound, dated 11/6/2023, revealed no evidence of a deep vein thrombosis or a superficial vein thrombosis. The report revealed R2 had a patent (open) dialysis shunt to their left arm. Review of R2's Progress Notes revealed a note entered by NP #17, dated 11/8/2023 at 1:00 pm, that indicated the resident was re-evaluated, and the resident reported their hand still hurt. Review of R2's Progress Notes revealed a note, dated 11/10/2023 at 2:55 pm, that indicated the resident had Slight swelling to their left upper arm. The note indicated the resident was unable to move their shoulder. Review of R2's Progress notes revealed a note, dated 11/11/2023 at 3:23 pm, that indicated the x-ray results were received and revealed an Acute anterior dislocation. Review of R2's Facility Incident Report Form, dated 11/14/2023, indicated the facility notified the state survey agency of an abuse allegation on 11/14/2023 at 10:51 am, six days after receiving the allegation from R2's family. The form indicated, This is an ALLEGED mishandling by the resident's [family member]. Resident has a dislocated shoulder. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/2024 at 4:12 pm, the Director of Health Services (DHS) stated that R2 was admitted to the facility with chronic pain. The DHS stated R2 started to complain of more pain to their shoulder, and on 11/10/2023, the resident's family called and alleged R2 had a displaced shoulder and alleged facility staff caused it. She stated that she called the dialysis provider, who said they had sent the resident to a vascular doctor. She stated that she called the vascular doctor, who reported that the resident's shunt had been displaced, and the shunt needed to be pushed back in. The DHS stated she then contacted NP #17 and got an order for an x-ray. Further interview with the DHS revealed, if she received a complaint of staff being rough, she would report it to the Administrator, suspend the staff member, speak to the resident, complete a head-to-toe assessment, and it should be reported to the state within two hours. The DHS further stated if a resident had an injury and they did not know how the injury occurred, she would report it to the Administrator and report it to the state. The DHS stated that while they were working to identify the cause of R2's arm pain, the resident's family called on 11/10/2023 and alleged the resident had a dislocated shoulder, caused by facility staff. The DHS said that despite discussions with the dialysis provider and vascular doctor, the family member continued to accuse facility staff of causing the injury. The DHS revealed after the family member made the allegation, it should have been reported to the state survey agency within two hours. During an interview on 7/16/2024 at 4:37 pm, the Administrator confirmed R2's family made the allegation on 11/10/2023, but the facility did not submit the initial report to the state survey agency until 11/14/2023. The Administrator stated the allegation should have been reported to the state on 11/10/2023.