| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 115588 | A. Building<br>B. Wing | 03/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| Pruitthealth - Covington | 4148 Carroll Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
| --- | --- |
| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50880<br><br>Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Medication Administration; General Guidelines, the facility failed to ensure that one of 30 sampled residents (R) (R36) did not have unauthorized and unsecured medications at the bedside. This failure created the potential for medication errors and unauthorized access to medications by other residents.<br><br>Findings include:<br><br>A review of the policy titled, Medication Administration: Guidelines review date 7/22/2024 under the section titled Procedure revealed, 3. Patients/residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. 5. All current medications and dosage schedules, except topicals used for treatments, are listed on the patient/resident's Medication Administration Record (MAR)or within the e-MAR System for facilities using electronic charting of medications. 10. Medications are administered within 60 minutes before or after scheduled time, except for medications ordered to be taken with food and before or after meals, which are administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the healthcare center. 11. After medication administration for facilities using paper MAR, the patient/resident's MAR is initialed by the person administering a medication in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are verified with a full signature in the space provided. After medication administration for facilities utilizing electronic MAR, the patient/resident's e-MAR is electronically signed off. 13. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time, the space provided on the front of the paper MAR for that dosage administration is initialed and circled and for facilities utilizing the e-MAR system the not administered button will be utilized with the appropriate reason given for the not administering medication at scheduled time. An explanatory note is entered is entered on the reverse side of the record provided for PRN indication and general medication notes and for e-MAR the note can be typed into the appropriate space provided within the electronic system. If more than two consecutive doses of a viral medication are withheld or refused, the physician is notified.<br><br>(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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| NAME OF PROVIDER OR SUPPLIER Pruitthealth - Covington | | STREET ADDRESS, CITY, STATE, ZIP CODE 4148 Carroll Street Covington, GA 30015 | |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the electronic medical record (EMR) for R36 revealed diagnosis including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, coronary artery disease, hypertension, diabetes mellitus, aphasia, cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke, hemiplegia or hemiparesis, anxiety disorder, depression, asthma, and chronic obstructive pulmonary disease (COPD).<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of 6 indicating R36 was not cognitively intact.<br><br>Review the EMR revealed, R36 had not been assessed to determine if she was a candidate to self-administer medications.<br><br>Review of the Medication Administration Record (MAR) dated 2/24/2025-2/28/2025 revealed, R36's 9 AM medications included: amlodipine 5 mg (milligram) tablet, aspirin tablet, chewable- 81 mg, buspirone Tablet- 7.5 mg, Colace (docusate sodium) capsule- 100 mg, Diovan HCT (valsartan-hydrochlorothiazide) tablet- 320-12.5 mg, duloxetine capsule, delayed release(DR/EC)- 60 mg, famotidine tablet- 20 mg, gabapentin capsule-400 mg, and metformin tablet- 500 mg; all documented as administered to R36 by the nurse.<br><br>Observation and interview on 2/25/2025 at 10:46 am in R36's room revealed, one plastic medication cup sitting on R36's bedside table containing one pink oblong shaped tablet, one blue and white capsule, one orange capsule, one tan circular shaped tablet, two white circular shaped tablets, and two other odd shaped white tablets for a total of eight pills. R36 revealed, that the nurse had brought the medications and left it there.<br><br>Observation on 2/25/2025 at 11:04 am revealed R36's lying in bed with the plastic medicine cup containing the same eight pills remaining at the bedside.<br><br>Interview on 2/27/2025 at 10:13 am with Registered Nurse (RN) AA revealed that at times, R36 had to be prompted to take medications however it's never a problem. RN AA stated that if any resident refused their medication she would try again within a certain timeframe for example, before the last med pass within an hour. She stated that she would wait and confirm that the resident had ingested all medications before going on to the next resident or room. RN AA revealed, that she was not aware of any residents that had an order for self-administering medications at the facility.<br><br>During an interview on 2/28/2025 at 3:48 pm with the Director of Nursing (DON) revealed, that medications should not be left in a resident's room. DON stated nurses should not leave medications at the bed side during the medication pass and her expectations was for the nurse to observe the residents ingesting the medications prior to leaving the room. DON confirmed that they did not have any residents in the facility that had been assessed to self-administer medications. Surveyor presented DON with the eMar via MatrixCare for review and was asked to verify information listed however, she was unable to provide a clear answer to what the initials/numbers meant.<br><br>(continued on next page) |

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| Pruitthealth - Covington | 4148 Carroll Street<br>Covington, GA 30015 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 2/28/2025 at 4:05 pm with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) CC revealed an explanation to the eMAR (electronic Medication Administration Record) coding. LPN CC pointed out the key near the bottom of the eMAR via MatrixCare and explained that the initials/numbers correspond with nurse that administers the medication to that resident within a two-hour timeframe. She stated that if the nurses code appears in the box that indicate that the medication was given within an hour before or an hour after scheduled time. LPN CC stated that if medication was not given then the nurses code would be in parenthesis. It was observed on the eMAR and confirmed by both DON and LPN CC that on 2/25/2025 the 9:00 am medications were documented as administered to R36 by the nurse. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48338<br><br>Based on observations, staff and resident interviews, the facility failed to provide a safe, clean, comfortable, homelike environment for two out of 35 rooms (room [ROOM NUMBER] and room [ROOM NUMBER]). Specifically, room [ROOM NUMBER] bathroom contained missing tiles on the left side of the toilet, the floor was sticky and malodorous with multiple large spiders and spider webs noted in the corners of the ceiling. In addition, a roach was observed crawling on the wall in room [ROOM NUMBER]. The sample size was 30 residents.<br><br>Findings include:<br><br>1. Observation and interview on 2/25/2025 at 3:36 pm in room [ROOM NUMBER] revealed, multiple spiders and spider webs in the bathroom ceiling and broken tiles around the toilet bowl. The bathroom floor was sticky and malodorous. R52 who resided in room [ROOM NUMBER] revealed, he did not have a problem with rodents or pests, but the spiders had been there for a while.<br><br>Observation on 2/26/2025 at 1:51 pm and at 4:30 pm in room [ROOM NUMBER] revealed, the spiders and spider webs remaining in the ceiling of the bathroom. The bathroom reeked heavily of urine, and the tiles remained missing from the bathroom floor on the left side back of the toilet.<br><br>Observation on 2/28/2025 at 10:40 am in room [ROOM NUMBER] revealed, the spiders and spider webs had been removed from the ceiling. room [ROOM NUMBER] bathroom had been cleaned and did not [NAME] of urine odor; however, the missing tiles had not been replaced on the left side back of the toilet.<br><br>2. Observation on 2/28/2025 at 11:05 am in room [ROOM NUMBER] revealed, a roach crawling on the wall.<br><br>Interview on 2/28/2025 at 11:35 am with the Maintenance Director (MD) revealed, the facility was contracted with [Name of business] for pest control. He stated that they came out monthly and was typically good at coming out for additional services as needed. The MD revealed, if there were additional concerns [Name of business] would leave the suggested recommendations in the pest control book. The MD confirmed the picture shown of the roach in room [ROOM NUMBER] and stated that it was an isolated occurrence because he had not seen any roaches.<br><br>Interview on 3/1/2025 at 10:30 am with the Administrator revealed the documentation for the most recent pest control visit was done on 2/24/2025. The Administrator stated they were contracted with [Name of business] Pest Control and that they came out monthly to spray the facility and as needed.<br><br>A policy for homelike environment was requested but not delivered by the exit. Instead, a goods and services agreement were provided. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50374<br><br>Based on staff interviews and record review, the facility failed to ensure that a psychotropic medication, specifically an opioid medication, was not ordered as needed (PRN) for more than 14 days unless clinically indicated for one of five sampled residents (R) R10 reviewed for the use of unnecessary medications. These deficient practices had the potential to affect the resident's highest practicable mental, physical, and psychosocial well-being.<br><br>Findings include:<br><br>Review of medical records revealed, R10 was admitted to the facility with a diagnosis that included but not limited to, generalized anxiety disorder and chronic pain.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) score of 15 indicating his cognition was intact; Section N (Medication) revealed R10 was taking antipsychotics, hypnotic, and opioid.<br><br>Review of R10's Physicians Orders dated 8/27/2024 revealed oxycodone-acetaminophen (an opioid medication) 10-325 mg (milligram) one tablet by mouth every six hours as needed with no stop date.<br><br>During an interview on 2/28/2025 at 3:32 pm with Licensed Practical Nurse (LPN) EE revealed, that R10 was currently taking oxycodone and that he had been taking it for a long time due to his chronic back pain.<br><br>During an interview on 2/28/2025 at 4:14 pm with the Director of Health Services (DHS) confirmed R10 medical regimen put him at high risk for polypharmacy and stated that the pharmacy and physician monthly consult should be reviewed and evaluated. |