

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/30/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>115588                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>04/09/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Pruitthealth - Covington                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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 0641<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded to reflect a significant weight loss for one of five residents (R) (R46) reviewed for nutrition. This had the potential to result in unmet care needs due to the facility not recognizing weight loss and the need for interventions. Findings include: Record review revealed that resident (R)46 was admitted to the facility with the diagnosis included, but limited to encephalopathy, pneumonia, severe sepsis with septic shock, malignant neoplasm of oropharynx. Record review revealed that Resident R46 experienced a significant, unplanned downward weight trend. R46's weight decreased from 151.4 pounds on 10/01/2025 to 141.0 pounds on 01/02/2026, representing a 10.4-pound (6.9%) weight loss over approximately three months. This weight loss meets the criteria for significant weight change. Review of dietary progress notes from 01/12/2026 revealed: Resident's weight is trending down. varied intake of meals noted receiving ensure 1 carton BID (two times a day). Recommend liberalize diet by d/c (discharge) NAS (no added salt); continue with Regular. Review of the Quarterly MDS dated [DATE], Section K0300 (Weight Loss), indicated the resident was coded as: 1 - Yes, on physician-prescribed weight-loss regimen. Further record review did not identify evidence that the resident was on a physician-prescribed weight-loss regimen with the goal of intentional weight reduction. Interview with MDS Coordinator on 04/9/2026 at 11:12 AM confirmed that for R46's quarterly MDS dated [DATE], Section K0300 (Weight Loss) was coded as 1 - Yes, on physician-prescribed weight-loss regimen. The MDS Coordinator stated this coding was based on the resident receiving diuretic medication, which she considered a prescribed weight-loss regimen. Further review of the medical record revealed that R46 had been prescribed diuretic medication since 09/2/2022. Interview with the Director of Health Services (DHS) on 04/9/2026 at 12:12 PM confirmed inaccurate MDS coding for R46 and revealed that no care plan revisions had been made to address the R46's significant downward weight trend. Cross-Reference F656</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<br>REPRESENTATIVE'S SIGNATURE | TITLE                   | (X6) DATE                                                              |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                      | Event ID:<br><br>115588 | Facility ID:<br><br>115588<br><br>If continuation sheet<br>Page 1 of 5 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>115588                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>04/09/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Pruithhealth - Covington                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                         |                                                 |
| <p>F 0656</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interviews, and review of the policy titled Care Plan, revision date 10/21/2025, the facility failed to develop and to implement a care plan to address significant weight loss for one of five residents reviewed for nutrition. This had the potential to result in unmet care needs due to the facility not recognizing weight loss and the need for interventions. Findings include: Review of the facility policy titled Care Plan revealed: Care Plan Review and Update: 4. Care plans will be updated by nurses, Case Mix Directors (CMD), or any other interdisciplinary team member so that the care plan will reflect the patient/resident's needs at any given moment. Record review revealed that Resident R46 was admitted to the facility with diagnoses including, but not limited to, encephalopathy, pneumonia, severe sepsis with septic shock, and malignant neoplasm of the oropharynx. Record review revealed that R46 experienced a significant downward weight trend. R26 weight decreased from 151.4 pounds on 10/01/2025 to 141.0 pounds on 01/02/2026, representing a 10.4-pound (6.9%) weight loss over approximately three months. Review of dietary progress notes revealed: On 1/12/2026: Resident's weight is trending down. Varied intake of meals noted. Receiving Ensure 1 carton BID. Recommend liberalize diet by discontinuing NAS (no added salt); continue with regular diet. On 3/23/2026: Resident's weight is trending down. Intake of meals varies. Resident is receiving a liberal regular diet. Recommend double eggs at breakfast, monitor weight per protocol, and f/u prn (follow up as needed). Review of the care plan for R46 revealed no evidence that R46 significant weight loss was addressed. The care plan lacked interventions, goals, and/or revisions related to the identified downward weight trend. Review of the Quarterly Minimum Data Set (MDS) dated [DATE], Section K0300 (Weight Loss), indicated the resident was coded as: 1 - Yes, on physician-prescribed weight-loss regimen. Further record review failed to identify evidence that the resident was on a physician-prescribed weight-loss regimen intended for intentional weight reduction. Interview with the MDS Coordinator on 04/9/2026 at 11:12 AM confirmed that Section K0300 was coded as 1 - Yes. The MDS Coordinator stated the coding was based on the resident receiving diuretic medication. Further interview revealed that the Interdisciplinary Team (IDT) is responsible for development and updates of care plans. Interview with the Director of Health Services (DHS) on 04/9/2026 at 12:12 PM revealed there were no care plan updates related to R46's downward weight trend. The DHS stated that nursing staff and/or the MDS Coordinator are responsible for updating care plans.</p> |                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>115588                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>04/09/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Pruitthealth - Covington                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, policy review and interviews, the facility failed to ensure safe smoking for one of one resident (R) reviewed for smoking. The sample size was 47. Findings include: Review of the facility policy titled Smoke Free Policy with a revised date of 02/10/2026, revealed the policy statement to be as of January 1, 2015, smoking is not allowed on the Healthcare center premises by visitors, partners or patients/residents. Smoking will only be allowed in outdoor designated areas for those residents grandfathered in prior to January 1, 2015. Assessment and Care Planning section, 2. Each patient/resident will be assessed, utilizing the Smoking Observation Form, by a licensed nurse upon admission, re-admission, and/or with a Significant Change. An admission Smoking Care Plan shall be developed by the Licensed Nurse on the admission Interim Care Plan Form. 3. An assessment is completed at least quarterly thereafter only if the answer to either of the first two (2) questions indicate the resident either smokes or has a history of smoking. After completion of the assessment, the care planning team shall review and utilized the assessment when developing the resident's care plan. 8. Patients/residents will be assessed for risk/hazards prior to smoking in designated area and shall be supervised as necessary based on the Smoking Observation Form. 9. When the patient/resident is identified as an unsupervised smoker, the Administrator must be notified immediately. Review of the electronic health record for R12 revealed R12 was admitted to the facility on [DATE] with diagnosis of but not limited to acute respiratory failure, unspecified dementia, chronic kidney disease, glaucoma moderate intellectual disabilities. The resident's most recent Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) was coded as 13, which indicated no cognitive impairment. Review of the last completed smoking observation Form for R12, dated 05/23/2023, revealed Question one Does the resident smoke? Yes column is checked. Question two: Does the residents have a past history of smoking? Yes column is checked. Review of admission Observation Form for R12 dated 09/17/2025, after a return from the hospital, revealed R12: current every day smoker. Based on review of R12's baseline care plan and current comprehensive care plan provided, documentation was found for smoking; subsequently interventions and goals were found. Observation on 04/07/2026 at 10:18 AM, R12 was observed smoking in the designated smoking area, along with one nursing assistant outside with him. He was wearing a smoking apron and appeared to be smoking safely. Observation of R12 on 04/09/2026 at 8:08 AM revealed R12 was waiting at back door to go out to designated smoking area. The Maintenance Director (MD) came and provided the resident with smoking materials to the resident and unlocked door and led resident to smoking area. R12 was observed to have a smoking apron. Interview on 04/09/2026 at 10:38 AM with Minimum Data Set (MDS) coordinator, revealed the nurses on the floor are responsible for filling out the Smoking observation form when assessments are due. Interview on 04/09/2026 at 1:35 PM with the director of nurses (DON) confirmed that R12 was last assessed for smoking on 09/17/2025 as indicated on admission Observation during R12 return from the hospital. She also confirmed that an assessment was overdue and should be completed quarterly. She stated that she expects that the nurse assigned to R12's hall/unit will fill out the smoking observation form when indicated by matrixcare system.</p> |                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>115588                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>04/09/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Pruitthealth - Covington                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         |                                                 |
| <p>F 0695</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, staff and resident interviews, record review, and review of the facility policies titled Oxygen Administration, the facility failed to obtain an oxygen order for one resident (R) out of 14 sampled residents that were on continuous oxygen. This deficient practice had the potential to cause hospitalization related to the resident potentially not being on a therapeutic oxygen setting. Findings include: Review of the policy titled Oxygen Administration revised 8/2/2023 and reviewed on 11/17/2025 policy statement revealed it is the policy of Pruitthealth Hospice and Healthcare Centers/Veteran Homes to provide oxygen safely and accurately to appropriate patients/residents. The scope states this policy is for nurses and respiratory therapists. The procedure section revealed oxygen will be administered by licensed personnel only when ordered by the physician, PA or NP. The physician order may be written PRN for comfort/dyspnea or may specify the number of liters, method of administration and length of time the oxygen is to be administered. Oxygen ordered PRN for comfort/dyspnea will be based upon the physician/licensed nurse assessment of the patient/resident's condition including oxygen saturation levels, respiratory rate, effort used by patient/resident to breath, shortness of breath present, and respiratory distress. Review of the electronic medical record (EMR) revealed R 62 was admitted to the facility on [DATE] and pertinent diagnoses including but was not limited to chronic systolic (congestive) heart failure (Primary), urinary tract infection, site not specific, and Type 2 diabetes mellitus with diabetic neuropathy. Review of R62 admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of four, which indicates R62 has severe cognitive impairment. Section GG, functional status, revealed R62 is dependent with toileting hygiene, lower body dressing, and footwear. Section O revealed continuous oxygen therapy on admission. Review of R62 care plan dated 03/10/2026 indicated a problem of shortness of breath. Goals included but not limited to, resident will not exhibit signs of respiratory distress (restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds) through next review Interventions included but not limited to administer oxygen as indicated, observe oxygen precautions, keep room cool and free of irritants and provide calm environment free of stimuli to reduce/prevent anxiety. Review of the Physician's Orders for R62 did not reveal an order for oxygen therapy. An observation on 04/7/2026 at 11:51 AM revealed R62 is sitting in manual wheelchair in the hall outside her room. R62 is receiving oxygen via nasal canula per oxygen tank secured to back of wheelchair. An interview on 04/7/2026 at 1:41 PM with R62 resident representative (RR) revealed that R62 was walking prior to having a lung biopsy. Something happened during the biopsy and led to her mom decline in condition. She states she has been on oxygen since her biopsy and was admitted to the facility on oxygen. An observation on 04/8/2026 at 4:20 PM revealed R62 is sitting up in manual wheelchair inside her room. Her husband is at her bedside and states that the resident is on oxygen at all times since she has been sick. R62 is receiving oxygen at 3L. No distress noted. An observation on 04/9/2026 at 1:45 PM resident is sitting outside of room in manual wheelchair. R62 does not have on her oxygen tubing. Oxygen tank is low and the setting is 2L. 04/9/2026 at 2:06 PM the nurse comes and checks the oxygen tank. On 04/9/2026 at 2:08 PM the nurse returns and exchanges the tank as well as place the oxygen tubing in the resident's nose. An interview on 04/9/2026 at 1:51 PM with certified nursing assistant (CNA) DD revealed R62 wears oxygen continuous although she sometimes removes it. The CNA's check the tanks periodically to ensure the tanks are not empty. If the tank is low, the nurse is notified. An interview on 04/9/2026 2:34 PM with the registered nurse (RN) LL revealed that R62 wears oxygen at all times. She also stated that R62 was admitted on oxygen. The CNAs will notify the nurse if the tank is low and the nurse will change the tank. An interview on 04/9/2026 at 2:44 PM with the Director of Nursing (DON) revealed the nurse should look at the electronic medical record (eMAR) to determine the oxygen rate. She also confirmed that anytime a<br/>(continued on next page)</p> |                                                                                         |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/30/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>115588                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                | (X3) DATE SURVEY<br>COMPLETED<br><br>04/09/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Pruitthealth - Covington                                                                       |                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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 0695<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | resident is on oxygen the resident should have an order. She states that the nurses are responsible for putting in orders for new admits. An interview on 03/9/2026 at 3:10 PM with the administrator states that nurses are responsible for admission orders. The orders should be done at the time of admission to include any other admission documents per the admission process. |                                                                                         |                                                 |