STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115600	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Lanier	2451 Peachtree Industrial Blvd Buford, GA 30518

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33363 Based on observations, staff interviews, and review of the facility policy titled, Infection Control - Housekeeping Services, the facility failed to maintain a clean and homelike environment for residents in 12 of 49 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]). This deficient practice had the potential to place residents at risk for living in an unsanitary and unsafe living environment and a potential for diminished quality of life. Findings include: Review of the facility policy titled, Infection Control - Housekeeping Services, revised 10/16/2023, revealed Policy Statement: It is the policy of this facility to ensure housekeeping services will be performed on a routine and consistent basis to ensure an orderly, sanitary, and comfortable environment. The section titled Routine Cleaning of Horizontal Surfaces stated 1. In patient/resident care areas, cleaning of non-carpeted floors and other horizontal surfaces will be performed daily and more frequently if spillage or visible soiling occurs. Observations on 6/17/2024 from 10:50 am to 11:59 am revealed the following: room [ROOM NUMBER] - The window screen had holes in it, the window blind was broken, trash was on the floor, the bathroom door had scrapes, and a small painted panel on the door. room [ROOM NUMBER] - There was a basin under the sink filled with approximately two inches of water and pipes dripped slowly under the sink into the basin, there were scrapes on the bathroom door with a small painted panel on the door, the bathroom door frame had gouges into the wood and was missing paint. room [ROOM NUMBER] - A cable outlet box was pulled out from the wall one-fourth to one-half an inch, gray duct tape held a sponge-like material on the window edges, the bathroom door had scrapes and rusted areas, and paint was peeling off the wall by the sink. room [ROOM NUMBER] - The window screen was pulled away from the window, two unlabeled urinals were hanging from the handrail by the commode, which was a bathroom used by residents from two rooms, the bathroom door had scrapes and dents in it, and paint was peeling on the wall by the sink. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] - Dirt and debris were observed behind the entry door and along the floor edges in the bathroom, the wall had scrapes, only one of two lightbulbs worked in the bathroom, and scrapes were seen on the bathroom doors. room [ROOM NUMBER] - Dirt was observed along the edges of the floor, the walls had scrapes, the front part of the air conditioner had dirt on it and was pulled loose from the right side, trash was on the floor, the bathroom door had scrapes, and the wall/floor molding was separating from the wall. room [ROOM NUMBER] - A dark brown substance was observed on the closet drawers, there was dirt on the floor along the wall edges, red color stains were observed on the air conditioner's wood-encased box, different floor patterns/color tiles were in the room, the bathroom had a brown substance on the seat of the stool riser down the stool, and large area of brown discoloration was observed on the floor by the stool, caulking was missing from around the stool, a brown substance was on the toilet paper roll, and the sink was loose from the wall. room [ROOM NUMBER] - The bathroom had trash on the floor, only one of two lightbulbs worked in the bathroom, the bathroom was missing flooring and the flooring was rolled and raised, three boards were observed stacked on top of each other along the bathroom wall, and the trash can had a three by four inch piece missing. room [ROOM NUMBER] - The vinyl molding was separated from the wall, the bathroom door frame was scraped and the paint was peeling, the privacy curtain was pulled together and held in place with disposable gloves, no window screen was on the window, tile was missing from the windowsill, lights were not working in the bathroom, and there was a buildup of a brown/rust colored debris along the bathroom door frame. room [ROOM NUMBER] - The air conditioner edges had a brown color on them, there were different patterns/color tiles on the floor, chipped and missing floor tiles were observed, a buildup of dirt was along the edges of the wall, the paint had peeled and was hanging down in the bathroom, there was no toilet paper holder, the wall paint had peeled and was missing around the sink, only one of two light bulbs worked in the bathroom and white tape held up the black television cords. room [ROOM NUMBER] - The bathroom door had gouges and missing paint, wood was missing along the door edges, four different floor tiles were in the room, only one of two bathroom lights worked, and the light on the ceiling in the middle of the room had missing paint around it. room [ROOM NUMBER] - The bathroom doors had gouges and missing facing, the bathroom door frame was missing wood and had scrapes, dirt and debris were seen on the floor behind the room door, caulking was missing around the toilet, no toilet paper holder was in place, the bathroom ceiling paint had peeled and was hanging down, and different patterns/color floor tiles were observed in the room. During an interview with Housekeeper OO, the housekeeper in charge while the Housekeeping Director was on vacation, on 6/18/2024 at 12:41 pm, she stated each housekeeper had their own hall that they were responsible for. Housekeeper OO stated at the present time, they only had two housekeeping carts so they shared with each other.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33363 Based on observations, interviews, record reviews, and review of facility policy titled, Medication Administration: Enteral Tubes, the facility failed to ensure that care and services were provided according to accepted standards of practice for two of seven residents (R) (R6 and R9) reviewed for medication administration. Specifically, the facility failed to administer R6 medications in a timely manner; and failed to follow procedure for enteral medication administration for R9. Findings include: Review of the facility policy titled, Medication Administration: Enteral Tubes dated revised 1/12/2024 revealed, Procedure & [and] Key Points: 8. Flush the tube with 15 ml [milliliters] water or per physician's order. 9. Remix the medication. Place the first medication into the syringe. After medication has been given, flush with 5 [five] ml of water or per physician orders then place the next medication into the syringe (then repeat for each medication given). 10. Allow medication to flow down the tube via gravity. Give gentle boosts with the plunger (approximately 1 [one] inch down) if the medication will not flow by gravity. Repeat if necessary. Do not push medications through the tube. 1. Review of the closed record of R6 revealed an admitted [DATE] at 6:38 pm from the hospital with diagnoses which included, malignant neoplasm of brain, glioblastoma multiforme, insomnia, hypercholesterolemia, major depressive disorder, gastro esophageal disorder, and history of hepatitis B. Review of Resident R6's physician orders included the following medication orders: Dabigatran etexilate (treat and prevent blood clots), 150 milligrams (mg) two times a day scheduled for 9:00 am and 5:00 pm, Dexamethasone (steroid) two mg two times a day scheduled for 9:00 am and 5:00 pm, Famotidine (used to treat acid in the stomach) 20 mg two times a day scheduled for 9:00 am and 9:00 pm, levetiracetam, (used to prevent seizures) 500 mg every 12 hours scheduled for 9:00 am, and 9:00 pm, Mirtazapine (antidepressant) 15 mg at bedtime scheduled for 9:00 pm, Trazodone (antidepressant, helps with sleep) 100 mg at bedtime scheduled for 9:00 pm. Review of R6's Medication Administration Record (MAR) for 12/2022 revealed the resident did not receive their dexamethasone until 12/3/2024 at 5:00 pm, did not receive the famotidine, levetiracetam, mirtazapine or trazodone until 12/3/2024 at 9:00 pm, and did not receive the dabigatran etexilate until 12/4/2024 at 9:00 am. In an interview with Unit Manager GG on 6/18/2024 at 9:30 am, she stated the staff enter the medication orders in the computer and they directly go to the pharmacy to be filled. The pharmacy delivered every evening, and they utilized an on-call pharmacy to get medications from also. The nurses could also obtain medications from the Emergency Medication Cabinet System. Review of the facility provided list of contents of the Emergency Medication Cabinet, put in place on 12/2022, revealed the cabinet contained: famotidine, levetiracetam, mirtazapine, and trazodone, all medications R6 was prescribed. Further review revealed staff did not utilize the Emergency Medication Cabinet to administer the residents' medications ordered by the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Health Services (DHS) on 6/18/2024 at 1:31 pm, she stated the nurses could enter medication orders into the computer up to 5:30 pm and still receive the medication from the pharmacy that same evening. DHS stated if the medication was not delivered the staff could then use the emergency supply of medications until the resident's medication came in. 2. Review of R9's Physician Orders revealed the order dated 3/13/2024 for baclofen (muscle relaxant) 10 mg via the gastroesophageal (g-tube) three per day. Further review of the Physician orders revealed an order dated 3/13/2024 to flush the g-tube with 15 milliliters (mls) of water before and after medications and five mls between each medication. Observation during the medication pass on 6/18/2024 at 12:12 pm for R9 revealed Registered Nurse (RN) NN crushed Baclofen, 10 mg and added five ml of water. RN NN turned off the g-tube feeding. She then checked placement by instilling five ml of air and listening to the abdomen and then checked for residual. RN NN poured the Baclofen into the syringe, without flushing the tubing with the ordered water first. The Baclofen did not flow down the tubing and the RN NN used the piston of the syringe to push the medication down the tubing. RN NN followed with a 15 ml water flush. During an interview with RN NN on 6/18/2024 at 12:19 pm, she stated the nurse should flush with 15 ml of water prior to giving medication through the g-tube and confirmed she did not flush the g-tube prior to giving the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33363 Based on observations, staff interviews, record review, and review of facility policy titled Enhanced Barrier Precaution (EBP), the facility failed to follow infection control practices during direct contact care for one of 11 residents (R) (R9) on Enhanced Barrier Precautions (EBP) during incontinent care and the administration of medications through a gastrostomy tube (G-tube) (a tube surgically inserted through the skin into the stomach to deliver nutrition, hydration, and medication). These failures had the potential to expose residents to infections due to cross-contamination. Findings included: Review of the facility policy title, Enhanced Barrier Precaution (EBP), dated 4/30/2024, revealed 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE [personal protection equipment] is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. The policy further stated, 4. High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: any skin opening requiring a dressing. Review of R9's clinical record revealed diagnoses included pneumonia, vascular dementia, quadriplegia, cerebral infarction, and major depressive disorder. Review of R9's quarterly Minimum Data Set (MDS), dated [DATE], revealed section GG (Functional Abilities and Goals) documented R9 was dependent on staff for ADLs, section H (Bowel and Bladder) documented R9 was always incontinent of bowel and bladder, section K (Swallowing/Nutritional Status) documented R9 had a feeding tube and received 51 percent or more of total calorie intake and 501 cubic centimeter or more per day by the feeding tube. Review of the care plan dated 4/11/2024 revealed the resident was on EBP due to having a G-tube, with an intervention to wear a gown and gloves during close-contact care. The care plan further revealed the resident had urinary incontinence, with an intervention for staff to anticipate and provide incontinence care as needed. Review of the Physician's Orders dated 4/9/2024 revealed an order for enhanced barrier precautions, with special instructions to wear a gown in addition to gloves during close contact care. Observation on 6/18/2024 at 9:54 am. revealed Certified Nursing Assistant (CNA) PP provided incontinence care for R9 while providing a bed bath. Observation revealed the resident was lying on her back and the CNA unfastened the brief and used a cloth with soap and water to clean between the legs and the frontal area. Further observation revealed that CNA PP did not change the position of the wipe with each swipe. CNA PP then turned the resident to their left side and cleaned between the buttocks without changing the position of the wipe with each swipe. Additional observation revealed CNA PP wore a mask and gloves but did not wear a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation during G-tube medication administration for R9 on 6/18/2024 at 12:12 pm revealed Registered Nurse (RN) HH wore a mask and gloves but did not wear a gown. In an interview with RN HH on 6/18/2024 at 12:19 pm, she stated she should have worn a gown when administering G-tube medications. In an interview with the Director of Health Services (DHS) on 6/18/2024 at 1:31 pm, she stated the staff should wear a gown and gloves when working with a resident on EBP and should change the position of the cloth with each wipe during incontinence care. In an interview with CNA RR on 6/19/2024 at 9:53 am, she stated when providing incontinence care the staff should clean front to back and change the position of the wipe/cloth with each swipe.