STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115608	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Ocilla	209 West Hudson Street Ocilla, GA 31774

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to provide supervision to prevent accidents for one of one resident (Resident (R) R1) reviewed for accidents out of a total sample of 3. This failure caused actual harm on 06/26/25 when Certified Nursing Assistant (CNA) AA served R1 a hot soup on a Styrofoam bowl and left the room with R1 attempting to pull the bowl closer when the bowl fell on R1's sternum and R1 sustained a second degree burn on her chest and was hospitalized .Findings include:Review of R 1's admission Record, located in the electronic medical record (EMR), revealed R1 was admitted to the facility on [DATE] with diagnoses that included but not limited to muscle weakness (generalized), unspecified abnormalities of gait and mobility, other reduced mobility, Muscle weakness (generalized), and difficulty in walking.Review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/23/2025 revealed R1 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderate cognitive impairment. It was recorded that R1 under section GG-under Eating /Oral hygiene/ Upper body dressing requires Setup or clean-up assistance,Review of R1 Progress Note dated 6/26/2025 at 5:58 pm indicated Resident requested soup for dinner. CNA fixed her some chicken soup. Soup was placed on the bedside table by CNA which advised resident soup was hot. NursingFurther review of R1's Progress Note dated 6/26/2025 at 06:00 pm [Recorded as Late Entry on 6/27/2025 11:23 am] revealed CNA heard resident yell for help. When CNA entered the room, the soup bowl noted to be on floor. The resident states she pulled soup to her and started feeding herself. The soup fell off bedside table on to resident sternum/Abd area. NP notified new order given. Nursing Review of Progress Note dated 6/26/2025 at 6:35 pm revealed Emergency Medical Service (EMS) here to take the resident to the emergency room (ER). Review of Facility Wound Summary Report for R1 indicated a burn on 6/26/2025 at 6 pm located in the mid-chest area with an initial size of 5x5 centimeters (cm). Review of R1's entire clinical record failed to indicate an assessment to determine the resident's ability to handle hot liquids had been completed for the resident prior to 6/26/2025.Review of hospital record revealed R1 was admitted to the local hospital on 6/26/2025 due to second degree burn after spilling hot soup while she was drinking it. During an observation and interview on 7/2/2025 at 1:05 pm with R1, she revealed that she requested soup from Certified Nursing Assistant (CNA), CNA AA because she did not like what was on the dinner tray. R1 stated that CNA AA brought the soup in a Styrofoam bowl and sat the soup on a bedside table across the bed. R1 stated that she tried to move the soup, and the bowl fell on her chest and hands. R1 stated that she pushed the bowl off her chest to the floor and started screaming for help. She stated that the soup was very hot. R1 further stated that CNA AA responded within five minutes and reported that she could not do anything because she has to call the nurse, which she did.During an interview on 7/2/2025 at 1:28 pm with Licensed Practical Nurse (LPN) CC she revealed that she was on call on the night of the incident. She stated that she received a call from LPN BB that R1 sustained a burn. She stated that she notified the Administrator and informed her of the burn incident for R1.During an interview on 7/2/2025 at 2:48 pm LPN BB revealed that she was at the nursing station when the CNA AA informed her that R1's soup fell on her chest. She stated that she went to R1's room and R1 informed her that the soup was on her bedside table and as she tried to pull the soup closer to her the bowl fell and landed on her chest. LPN BB stated that she notified the physician and LPN CC who was the nurse on call, and the family was notified. She stated that the physician gave her orders for Silvadene and later an order to send R1 to the hospitalDuring a telephone interview on 7/2/2025 at 7:35 pm with CNA AA she revealed that she served R1 her dinner tray and she did not like what was on the tray. She stated that R1 requested soup. She stated that R1 was in bed Head of the Bed (HOB) elevated at 45-degree angle, and legs slightly elevated. She stated that she warmed the soup for a minute in a Styrofoam bowl in the microwave. CNA AA stated that the soup was not steaming because she held the bowl in her hand. It was further reported that she gave R1 some crackers per R1 request to soak them in the soup and placed the bowl on the bedside table with a towel across R1's chest. CNA AA stated that she then went to another resident's room across from R1's room to assist that resident. While in the other resident's room CNA AA reported that she heard R1 calling her name. Upon returning to R1's room CNA AA reported observing the bowl was on the floor and the towel was no longer on the R1's chest. She stated that R1 told her that she was burned, and that is when she called the nurse to the room to evaluate R1. During an interview on 7/3/2025 at 1:41 pm with Minimum Data Status (MDS) Coordinator who revealed the