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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115616 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/06/2025 |
| NAME OF PROVIDER OR SUPPLIER Pruitthealth - Franklin | | STREET ADDRESS, CITY, STATE, ZIP CODE 360 South River Road Franklin, GA 30217 | |

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

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| <p>F 0656</p> <p>Level of Harm - Minimal harm 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>44757</p> <p>Based on record review and review of the facility policy titled, Care Plans, the facility failed to develop a care plan for one of 35 sampled residents (R) (R14) to include physical therapy discharge recommendations.</p> <p>Findings include:</p> <p>A review of the facility policy titled, Care plans revealed under Care Plan Review and Update . 2. Updates to the care plans should be made with any changes in condition at the time the change in condition occurred. For MatrixCare users, all updates are made electronically.</p> <p>Review of R14 care plan dated 12/26/2024 indicated a problem of R14 at risk for falling R/T Cerebral Palsey(sic)/impaired mobility. Goals include R14 will remain free from injury. Approach(s) include keep call light in reach while in bed, observe changes in resident's condition that may warrant increased supervision, observe frquently (sic) when OOB in chair (sic). There was nothing found in the care plan regarding Physical Therapy's (PT) recommendations.</p> <p>Review of the PT discharge evaluation dated 8/21/2019 documented the following, GOAL MET - on 8/21/2019. The patient tolerates upright sitting in personal custom tilt manual wheelchair maintaining proper midline body alignment for 180 minutes or greater daily without negative skin changes. The following documented discharge plans and instructions, Discharge planned for this patient. Recommendations discussed with Nursing caregivers include continued OOB (out of bed) daily to pt's (patient's) personal seating/positioning system tilt manual w/c (wheelchair) with checks every hour for any seating needs and for tilting w/c to various angles for pressure reliefs.</p> <p>Cross reference to F688</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44757</p> <p>Based on observations, staff interviews, record review, and review of the facility policy titled, Restorative Nursing Program, the facility failed to ensure one of 35 sampled residents (R) (R14) did not have a reduction in range of motion due to the facility not providing custom equipment post discharge from physical therapy services.</p> <p>Findings include:</p> <p>A review of the facility policy titled Restorative Nursing Program revised 11/4/2021 documented under Policy, It is the policy of this healthcare center to provide restorative nursing which actively focuses on achieving and maintain optimal physical, mental and psychological functioning and well-being of patient/resident.</p> <p>Review of the electronic medical record (EMR) revealed R14 was admitted to the facility with diagnoses including but not limited to cerebral palsy (primary admission contracture, left wrist, contracture, left hand, contracture, right hand, contracture, right wrist, abnormal posture, pain, unspecified, and muscle weakness (generalized).</p> <p>Review of R14's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicates R14 was unable to finish the assessment due to being unable to respond. Section GG, functional status, revealed R14 was dependent on staff due to upper extremities impairment on both sides, lower extremities impairment on one side and benefits from the use of a wheelchair (manual). R14 is dependent on staff in all areas.</p> <p>Review of R14's care plan dated 12/26/2024 indicated a problem of requires total assist with ADL's (activities of daily living) R/T (related to) Cerebral Palsey (sic). Goals included but not limited to [R14] will be kept clean/dry with neat appearance. Approach included but not limited to 1/4 side rails for turning and positioning, 2 person assist (sic) with mechanical lift, Call light within reach while in bed, NPO receives Tube feeding, Total care needed with ADL's, uses geri-chair when OOB (out of bed). (Activities) Problem of has limited participation in activities r/t impaired mobility/speech. Goal R14 will participate in activities of his liking. Approach(s) of assit (sic) resident to activities when he is OOB, provide setting in which activities are preferred own room, day room, likes to watch cartoons, visit in room [ROOM NUMBER]:1 when resident is not oob. Problem of R14 at risk for falling R/T Cerebral Palsey (sic)/impaired mobility. Goal includes R14 will remain free from injury. Approach(s) include keep call light in reach while in bed, observe changes in resident's condition that may warrant increased supervision, observe frquently (sic) when OOB in chiar (sic).</p> <p>Review of the physical therapy discharge evaluation dated 8/21/2019 documented the following, GOAL MET - on 8/21/2019. The patient tolerates upright sitting in personal custom tilt manual wheelchair maintaining proper midline body alignment for 180 minutes or greater daily without negative skin changes. The following documented discharge plans and instructions, Discharge planned for this patient. Recommendations discussed with Nursing caregivers include continued OOB daily to pt's personal seating/positioning system tilt manual w/c (wheelchair) with checks every hour for any seating needs and for tilting w/c to various angles for pressure reliefs.</p> <p>(continued on next page)</p> | | |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observation on 3/4/2025 at 2:32 pm of R14 in his room in the bed revealed he had a cushion that was on the side dresser near the bed. There was no w/c in room at the time.</p> <p>Observation on 3/5/2025 at 11:30 am, observed R14 in their room, in bed watching tv. Observed no w/c in the room.</p> <p>Observation on 3/6/2025 at 1:53 pm, observed R14 in their room, in bed sleeping. Observed no w/c in the room.</p> <p>Interview on 3/6/2025 at 10:30 am with Certified Nursing Assistant (CNA) FF revealed she made sure to check on R14 at least every hour to every hour and a half to make sure he was dry and that his feeding was going. She revealed he did have a wedge, but he did not get up and get in his chair unless he was going to the doctor or the shower.</p> <p>Interview on 3/6/2025 at 1:49 pm with CNA FF revealed R14's w/c was in his closet.</p> <p>Observation on 3/6/2025 at 1:53 pm revealed a manual [facility name] w/c in R14's closet.</p> <p>Interview on 3/6/2025 at 11:33 am with Licensed Practical Nurse (LPN) DD revealed R14 did not get out of bed,</p> <p>but there was no particular reason why at the moment. LPN DD went on to reveal R14 got out of bed to get a shower and that was it. At 1:42 pm LPN DD revealed she did not know where R14's w/c was.</p> <p>Interview on 3/6/2024 at 12:09 pm with CNA II and CNA JJ revealed they were restorative CNA's, and therapy would assign to them what they needed to do daily. The therapist would then show them what to do that was resident specific. The CNA's revealed R14 did not do anything with therapy because he was not on restorative, but he had soft splints for his hands.</p> <p>Interview on 3/6/2025 at 12:15 pm with the Physical Therapist (PT) KK revealed she had worked with R14 regarding positioning so he could safely transfer to the geri-chair (medical recliner) and or shower as well as getting out of bed. She further revealed even though R14 was discharged from physical therapy, the recommendations were implemented immediately and expected to be put in place indefinitely unless a licensed nurse deemed the recommendations to be inappropriate or the recommendations caused harm, at which point the licensed nurse would recommend the resident get an assessment for services again.</p> <p>Interview on 3/6/2025 at 1:32 pm with LPN Unit Manager (AA) revealed R14 did not have a w/c but if they got him up they would get him up in his geri-chair. She revealed she had never seen a w/c for him and that the geri-chair was not in the room and they were not sure where the geri-chair was.</p> <p>Interview on 3/6/2025 at 2:33 pm with the Administrator and DON interview revealed they were unaware of the w/c and revealed R14 did not have a tilt w/c but has had one in the past when he was smaller, but he outgrew it. The DON was not sure if R14 was using that (custom) w/c at that time. The DON further revealed there was no way for R14 to be in the w/c due to his hip.</p> <p>(continued on next page)</p> | | |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on 3/6/2025 at 4:00 pm with the DON revealed he was able to go into the system and print out documents where R14 did go back to therapy for an OT (occupational therapy) referral where there were no other recommendations at that time.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>50940</p> <p>Based on observations, record review, staff interviews, and review of the facility's policies titled, Handwashing/Hand Hygiene and Enhanced Barrier Precaution (EBP), the facility failed to comply with infection control protocols for three of 25 sampled residents (R) (R38, R34, and R2) by inconsistently practicing hand hygiene and not using personal protective equipment (PPE) as required. The deficient practice had the potential to expose residents to harmful pathogens, increasing the risk of infection and compromising their overall health and safety.</p> <p>Findings include:</p> <p>Review of the facility policy titled Handwashing/Hand Hygiene revised 10/15/2024 revealed under the Policy section D. Indications requiring Hand Wash or Hand Rub. 1. Before and after contact with the resident . 6. When hands move from a contaminated-body site to a clean -body site during resident care. G. Other Aspects of Hand Hygiene. 4. Perform hand hygiene and change gloves during resident care if moving from contaminated body site to a clean body site.</p> <p>Review of the facility policy titled Enhanced Barrier Precaution (EBP) revised 4/3/2024 revealed under the Policy section, 2. Initiation of Enhanced Barrier Precaution: . b. An order for enhanced barrier precautions will be obtained for residents with any of the following: . i. indwelling medical devices (.urinary catheters .) . 3. Implementation of Enhanced Barrier Precautions: . b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . 4. High-contact resident care activities include: . b. bathing . d. providing hygiene . f. changing briefs or assisting with toileting. G. device care or use: .urinary catheters .</p> <p>1. An observation of catheter care for R38 was conducted on 3/5/2025 at 2:36 pm by Certified Nursing Assistant (CNA) BB revealed the CNA introduced herself to the resident, explained the procedure, performed hand hygiene, but did not use PPE (a gown) for the care. Privacy was ensured before she gathered the necessary supplies and assisted the resident into a comfortable position. The CNA filled a basin with warm water and had the resident check the water temperature by placing their hand in the basin. The CNA emptied the full catheter drainage bag into a urinal and then disposed of the urine by flushing it down the toilet. After completing this task, she removed her gloves but did not perform hand hygiene before donning (putting on) a new pair of gloves. She then continued with the catheter care as follows: She placed a protective barrier under the resident's buttocks, used the first washcloth with soap and water to carefully clean around the catheter insertion site where it exits the penis. Using a new, clean section of the washcloth for each stroke, she cleaned the catheter tubing from the insertion site downward toward the drainage bag, ensuring there were no kinks and that the tubing remained at a lower level than the bladder. CNA BB used another clean, moistened washcloth with soap to gently clean the penis and scrotum, ensuring proper hygiene. She used a new washcloth to thoroughly rinse the catheter tubing and the cleaned area, avoiding any soap residue. She dried the catheter tubing and surrounding area with a clean, dry cloth, ensuring no moisture remained. Then CNA BB changed the resident's brief, repositioned them for comfort, and sanitized her hands before leaving the room.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview immediately after the procedure, the surveyor asked CNA BB whether she should have worn a gown during catheter care and sanitized her hands after disposing of the urine and changing gloves. She acknowledged the oversight, agreeing it was a fair observation, and admitted that she had failed to wear a gown for a resident on EBP)and should have re-washed her hands after removing her gloves and before putting on a new pair during the procedure.</p> <p>In an interview on 3/5/2025 at 1:50 pm with the Director of Health Services (DHS), he stated that his expectation was for staff to perform hand hygiene immediately after removing gloves and before donning a new pair.</p> <p>In an interview on 3/6/2025 at 2:45 pm with the DHS, he also revealed his expectation for staff was to follow the facility policies and procedure when using PPE for high-contact care of residents on EBP.</p> <p>2. A. During an observation of a medication pass on 3/6/2025 at 8:40 am for R34, Licensed Practical Nurse (LPN) CC approached the medication cart, logged into her laptop, and began preparing medications without sanitizing her hands. After preparing the medications, she proceeded to the resident's room and administered them. However, she again failed to sanitize her hands upon entering the room, doing so only upon leaving.</p> <p>When interviewed immediately following the medication pass, the surveyor asked LPN CC why she had not sanitized her hands before beginning the task and upon entering the room. LPN CC admitted that she was nervous and had forgotten to do so.</p> <p>In an interview on 3/5/2025 at 1:50 pm with the DHS, he stated he expected staff to follow their policies and sanitize their hands before and after each resident interaction.</p> <p>2. B. The surveyor observed a medication pass on 3/5/2025 at 5:00 pm for R2 by LPN DD. R2 received medications via a percutaneous endoscopic gastrostomy (PEG) tube and was on EBP precautions for that. The nurse was observed preparing the resident's medications. Upon entering the room, the nurse donned a gown and performed hand hygiene. The PEG site was clean with a clean gauze pad placed underneath. The nurse confirmed PEG tube placement by auscultation (listening with a stethoscope) and checked the residual volume, which measured 10 mL milliliters). LPN DD administered R2's medications per the doctor's orders, one by one, flushing with water before and after each medication administration. After completing the PEG tube medication administration, the nurse changed gloves but did not perform hand hygiene before donning a new pair for administering medication via a different route. The nurse then proceeded to apply topical ointment rubbing it on to the affected area on the resident's right lower extremity. The nurse then changed gloves, performed hand hygiene, and administered insulin as per doctor's order with no observational concerns.</p> <p>When the surveyor questioned the nurse immediately after observing a medication pass about not sanitizing her hands after removing dirty gloves and before putting on a new pair to administer medication via a different route, she acknowledged that she should have performed hand hygiene at that time.</p> <p>In an interview on 3/6/2025 at 2:45 pm with the DHS, he revealed that staff were expected to follow facility policies and procedures when using PPE for high-contact resident care on EBP. Additionally, they must sanitize their hands according to facility guidelines immediately after removing gloves and before putting on a new pair.</p> | | |