STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115629	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Sylvester	104 Monk Street Sylvester, GA 31791

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observation, interview, and record review, the facility failed to ensure call devices were accessible for one of 33 residents (Resident (R) 68) observed for call light accessibility. This failure had the potential to place R68 at risk of accident, injury, or unmet needs related to an inability to call for staff assistance. Findings include: Review of R68's Face Sheet, located under the Face Sheet tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including diabetes, dementia with agitation, insomnia, dizziness and giddiness, anxiety, lack of coordination, muscle weakness, and orthostatic hypotension. Review of R68's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/7/2025 and located under the MDS 3.0 Assessments tab of the EMR, revealed she scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. The MDS also revealed R68 was independent with bed mobility and transfers, and required setup/clean up assistance with using the bathroom. She used a wheelchair for locomotion. Review of R68's Care Plan, dated 4/9/2025 and located under the Care Plan tab of the EMR, revealed, [R68] is at risk for falls related to chronic orthostatic HTN [hypertension], dementia, hx [history] of CVA [stroke], and syncope. The approaches included: encourage resident to call for assistance with mobility and place call light within reach. During observations on 4/22/2025 at 10:08 am and 11:56 am in R68's room, the resident was lying in bed. Her call light cord was coiled and hanging on the call box on the wall behind the head of her bed, approximately three feet away. During an observation on 4/22/2025 at 1:57 pm in R68's room, the resident was lying in bed awake. Her call light cord was coiled and still hanging on the wall behind the head of the bed. During a concurrent interview, R68 stated the call light button was not in a place where she could reach it and stated she needed it to be within reach to call for help. She stated, They were cleaning, and they forgot to move it back, and added that it should be on her bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent observation on 4/22/2025 at 2:03 pm, Licensed Practical Nurse (LPN) 4 stated R68 was able to use her call light, and it should be placed within reach. LPN4 entered R68's room and confirmed the call light was not within the resident's reach. LPN4 moved the call light from the wall to R68's bed, and R68 was grateful. During an interview on 4/22/2025 at 2:05 pm, Certified Nurse Aide (CNA) 2 stated she typically placed the call light on R68's bed; however, sometimes the housekeeping staff moved it for cleaning and forgot to return it to the bed. CNA2 stated R68 would not be able to coil up her call light cord and hang it on the wall; she did not know how it got there. During a concurrent interview on 4/25/2025 at 11:25 am with the Administrator and Director of Nursing (DON), the DON stated all staff in-service trainings were held periodically, which included housekeeping staff, regarding the placement of call lights within resident reach. The DON stated that the training and her expectation were that the call light should be within reach of residents while they were in bed. The Administrator stated the facility did not have a policy addressing call light accessibility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, record review, and interview, the facility failed to ensure bathing and personal hygiene assistance were provided for one of three residents (Resident (R) 92) reviewed for bathing out of 32 sample residents. This failure had the potential to cause residents' bathing and personal hygiene preferences not to be met. Findings include: Review of R92's Face Sheet located in the resident's electronic medical records (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included bilateral above-the-knee amputations. Review of R92's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/3/2025 and located in the resident's EMR under the MDS tab revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out 15 points which indicated the resident was cognitively intact. The MDS indicated the resident did not exhibit any behaviors such as resisting care. The resident was assessed to require substantial to maximal assistance with personal hygiene. Review R92's Care Plan revised on 4/9/2025and located in the resident's EMR under the Care Planning tab revealed the resident needed assistance with activities of daily living (ADLs). Interventions included checking nails and assisting with care as tolerated and resident requires assistance with bathing. Observation and interview on 4/22/2025 at 10:28 am, R92 was lying in bed wearing a green tee shirt and an adult brief. The resident's hair was matted and uncombed, and his face was unshaven. The resident had long discolored fingernails with brown colored matter underneath the nails. R92 stated had not received a bath or shower since his admission to the facility. The resident stated that he was left lying wet, in urine, for long periods. The resident also stated that he did not like long fingernails and wished the staff would trim and clean his nails. Observation on 4/22/2025 at 1:30 pm revealed R92 was lying in bed and still wearing a green tee shirt and an adult brief. The resident remained unshaven, and his hair matted and uncombed. The resident's fingernails were long and discolored with brown matter underneath the nails. Observation on 4/23/2025 at 8:56 am revealed R92 was lying in bed and still had on the same green shirt as the day before and an adult brief. The resident's hair remained uncombed, and his face unshaven. The resident's fingernails were trimmed, but still had brown colored matter underneath the nails. Observation and interview on 4/23/2025 at 11:44 am, R92 was lying in bed with the same green shirt on as in the previous observations and in a freshly changed adult brief. The resident's hair remained matted and uncombed, and his face was unshaven. R92's fingernails had brown residue underneath the nails. R92 stated the staff had just changed his brief; however, the staff did not offer to bathe him or wash his face. The resident stated the staff did trim his nails, but that stuff remained under his nails. The resident stated the staff did not offer to soak his hands to clean under the nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/23/2025 at 3:00 pm revealed R92 was still wearing the same green shirt in only a brief, his hair matted and uncombed, and his fingernails with brown matter underneath the nails. Interview on 4/24/2025 at 10:10 am with Licensed Practical Nurse (LPN) 5 revealed R92 had never requested to have a shower. The LPN stated R92 would take bed baths but had a habit of refusing the bed bath at times. LPN5 stated the resident's refusal for bed baths was never documented. LPN5 stated the resident's tasks had to be segmented, meaning the staff had to perform the care in segments and not all at once. LPN5 also stated the resident was particular about nail care because the fingers were tender. LPN5 stated that she did not know if this was documented in his care plan. An interview on 4/24/2025 at 10:10 am with a Certified Nursing Assistant (CNA) 4 revealed she provided R92 with a complete bed bath, nail care, and encouraged the resident to be out of bed on this date. CNA4 stated that she was able to trim R92's fingernails on 4/23/2025, but really cleaned them today. CNA4 also stated the resident refused to take a bed bath yesterday, and she notified the nurse. Interview on 4/24/2025 at 2:30 pm with the Director of Nursing (DON) revealed R92 would at times refuse care; however, she was unaware that the resident's MDS and care plan did not reflect his refusal of care. The DON was unable to provide documentation of the resident's refusal of personal hygiene care. The DON stated the facility did not have a policy for ADL care or shower/bath.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12273 Based on observation, interview, record review, and review of the facility's policy titled Enteral Nutrition (Tube Feeding), the facility failed to ensure gastric residual was checked prior to administering enteral nutrition via gastrostomy tube (G-Tube) for one of two residents (Resident (R) 65) reviewed for G-Tubes out of 36 sampled residents. The failure to check R65's gastric residual increased the risk that the resident could experience health complications associated with the stomach not digesting the contents as expected. Findings include: Review of the facility's policy titled, Enteral Nutrition (Tube Feeding), reviewed 9/12/2024, revealed, . Procedures .2. The physician writes orders prescribing the formula, rate, route of administration, and flush orders for the individualized resident/patient. Review of R65's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 2/26/25 and located in the Aspen MDS Viewer, revealed the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE]. The MDS also revealed the resident was assessed as having a feeding tube (G-Tube) and received 51 percent or more of her calories via tube feeding for seven of seven days of the seven-day assessment period. Review of R65's Physician Orders found in the electronic medical record (EMR) under the Orders tab revealed an order dated 4/9/2025 of G-Tube: Check for residual before feeding. If residual is greater than 100 mL [milliliters], hold feeding and call MD [medical doctor] for further orders. Observation on 4/24/2025 at 2:10 pm, Licensed Practical Nurse (LPN) 2 approached R65 to start the G-tube feeding. LPN2 flushed the resident's G-tube with 30 mL of water. LPN2 then connected the line coming from the nutritional supplement and enteral feeding pump to the resident's G-tube and started the feeding. The LPN did not check the resident's gastric residual prior to the start of the enteral feeding pump. During an interview 4/24/2025 at 3:55 PM, LPN2 confirmed she did not check the resident's gastric residual per R65's physician's order. During an interview on 4/24/2025 at 4:45 pm, Registered Nurse (RN) 1 was asked to describe the process for checking a resident's gastric residual. RN1 stated that a clear syringe with a plunger should have been connected to the resident's G-tube, and the nurse should have slowly pulled out on the plunger to check and see if there was any gastric residual from the resident's last feeding. RN1 stated the nurse should have measured the amount of residual (if any) to ensure it was 100 mL or less prior to starting the resident's feeding.

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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** 16752 Based on observations, staff interviews, record reviews, and review of the facility's policy titled Enhanced Barrier Precautions, the facility failed to maintain their infection control and prevention program related to Enhanced Barrier Precautions (EBP) and hand hygiene for two of 15 residents reviewed for EBP (Resident (R) 211 and R65). Staff failed to wear the required personal protective equipment (PPE) while providing care to both residents. Additionally, nursing staff failed to perform hand hygiene in between glove changes when providing care to R65. These failures placed the residents at an increased risk of developing an infection. Findings include: Review of the facility's policy titled, Enhanced Barrier Precautions, revised 4/30/2024 indicated .Enhanced Barrier Precautions refers to an infection control interventions designed to reduce transmission of multi-drug resistant organism that employs targeted gown and gloves use during high contact resident care activities . wounds (i.e chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (i e. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes even if the resident is known to be infected or colonized with a multi-drug resistant organism (MDRO) . 1. Review of R211's Face Sheet located in the resident's electronic medical records (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included cerebral infarct with right side hemiplegia and hemiparesis; dysphagia, and post-gastrostomy. Review of R211's Physician's Order dated 4/3/2025, located in the resident's EMR under the Orders tab, revealed the resident was ordered Jevity 1.5 calorie (a nutritional supplement used for enteral feeding) feeding at 57 milliliters (mL) per hour for 20 hours. The order also indicated Enhanced Barrier Precautions. Observation on 4/22/2025 at 11:00 am revealed signage on R211's room door that indicated the resident was on EBP precautions. The signage directed staff to wear a gown and gloves when providing resident care. During an observation on 4/22/2025 at 1:55 pm, Licensed Practical Nurse (LPN) 5 entered R211's room carrying tube feeding supplies without donning a gown or gloves. LPN5 then exited the resident's room carrying an old tube feeding. Observation on 4/22/2025 at 2:05 pm revealed LPN5 entered R211's room again with tube feeding supplies and the LPN did not don a gown or gloves. Continued observation of the nurse in R211's room revealed LPN5 connected the resident's Gastronomy Tube (G-tube), and she did not have on a gown or gloves. During an interview on 4/22/2025 at 1:57 pm, Family Member (F) 211 stated she was in the room when LPN5 was working on the resident's feeding tube, and the LPN was not wearing a gown or gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2025 at 2:20 pm, LPN5 stated R211 was on EBP because he had a gastrotomy tube with a dressing. LPN5 acknowledged that she failed to follow the facility's EBP protocol for donning a gown and gloves when providing care for this resident. During an interview on 4/25/2025 at 10:00 am, the Assistant Director of Nursing (ADON), who was also the facility's Infection Preventionist, stated LPN5 had made her aware that she failed to follow the EBP guidance for PPE. 2. Review of R65's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 2/26/2025 and located in the Aspen MDS Viewer, revealed the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE]. The MDS also revealed the resident was assessed as having a feeding tube (gastronomy tube [G-Tube]) and received 51 percent or more of her calories via tube feeding for seven of seven days of the seven-day assessment period. Review of R65's Physician Orders found in the electronic medical record (EMR) under the Orders tab revealed an order dated 4/9/2025 of G-Tube: Check for residual before feeding. If residual is greater than 100 mL, hold feeding and call MD [medical doctor] for further orders. Observation on 4/22/2025 at 10:25 am revealed signage posted outside of R65's door, which indicated the resident was on EBP and directed that the personal protective equipment (PPE) of a gown and gloves was to be worn when staff were providing care to the resident. Continued observation revealed R65 was lying in bed in her room, being administered an enteral feeding, and her enteral feeding pump was sounding an audible alarm. R65 was receiving enteral feeding via her G-tube. During an observation and interview on 4/22/2025 at 10:27 am, Registered Nurse (RN) 2 entered R65's room to respond to the resident's enteral feeding pump alarm. The RN stated the alarm was informing her that the feeding was complete. RN2 then disconnected the feeding tube line from the resident's G-tube. Observation and interview on 4/24/2025 at 2:10 pm revealed LPN2 entered R65's room to restart the resident's enteral feeding pump. LPN2 performed hand hygiene and then donned a gown and gloves. Prior to approaching the R65, LPN2 doffed her gloves, adjusted her eyeglasses, rubbed her eye, and then donned new gloves. LPN2 then flushed R65's G-tube with water, attached the tubing to the G-tube, and started the enteral feeding pump. LPN2 did not perform hand hygiene prior to placing new gloves on after adjusting her glasses and rubbing her eye. LPN2 acknowledged that hand hygiene should have occurred between glove changes.