STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115631	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Grandview	165 Winston Drive Athens, GA 30607

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 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** 50940 Based on observations, staff interviews, record review, and review of the facility's policy titled Medication Administration: Insulin Injections, the facility failed to ensure care and services were provided in accordance with accepted professional standards for two of 19 Residents (R) (R34 and R57) receiving insulin pens. Specifically, the facility failed to sanitize the insulin pen before attaching a new needle prior to use for R34 and by not properly administering the insulin pen for R57. Findings include: Review of the facility's policy titled Medication Administration: Insulin Injections, dated 7/18/2024 under the Policy section revealed, For insulin Pens: 1. Remove the cover from the pen and swab with an alcohol swab. Screw on a new needle and remove cap 6. Count to 10and remove the pen. Review of the manufacturer's instruction guide for using the Tresiba FlexTouch insulin pen revealed, Insert the needle into the thigh . Press and hold the dose button. After the dose counter reaches 0, slowly count to 6. Please note that if the needle is removed before the 6-second count is completed after the dose counter returns to 0, your dose may be up to 20% too low.' 1. Review of R34's clinical records revealed, a diagnosis that included but not limited to Type 2 diabetes mellitus without complications. Review of R34's Medication Administration Record (MAR) revealed, [Name] (insulin lispro) insulin pen; 100 unit/ml (milliliter); amount to administer per sliding scale, before meals and at bedtime with start date of 4/4/2024 and [Name] (insulin glargine) insulin pen; 100 unit/ml (3 ml); amount to administer 7 units subcutaneous twice a day with start date of 10/28/2024. During a medication pass on 3/19/2025 at 8:00 am, Licensed Practical Nurse (LPN) AA was observed preparing an insulin pen. LPN AA removed the cover and attached a needle without swabbing the pen with an alcohol swab before inserting the new needle prior to use for R34. In an interview on 3/19/2025 at 8:10 am with LPN AA following the insulin administration, she confirmed that she did not swab the pen but should have done it. 2. Review of R57's clinical records revealed, a diagnosis that included but not limited to Type 2 diabetes mellitus with other specified complications. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R57's MAR revealed, [Name] U-100 Insulin (insulin aspart u-100) insulin pen; 100 unit/mL (3 mL); amount to administer: per sliding scale with start date of 10/11/2024 and [Name] U-200 (insulin degludec) insulin pen; 200 unit/mL (3 mL); amount to administer: 10 units; subcutaneous with start date of 10/11/2024. During a medication pass on 3/19/2025 at 8:39 am, LPN BB was observed administering insulin to R57. The LPN prepared the insulin pen without issue and injected the prescribed 7 units of medication; however, she withdrew the syringe immediately without waiting the recommended 10 seconds before removal. During an interview on 3/19/2025, at 11:15 am, LPN BB was asked whether the pen should be held against the skin for six to 10 seconds when administering insulin pens. She was uncertain and revealed, that she typically listens for a click and counts one to two seconds before removing the pen. However, she confirmed that she did remove the pen immediately. She also confirmed that she failed to hold the pen in place for six to 10 seconds which could lead to insulin leakage, potentially resulting in the resident receiving less than the prescribed dose. During an interview on 3/19/2025 at 9:24 am with the Director of Nursing (DON) revealed, that the correct procedure for using insulin pens include cleaning the top of the pen, attaching the needle, priming with 2 units of insulin, cleaning the skin, injecting the medication, and holding the needle in place for 10 seconds. The DON revealed, this process was reviewed during annual competency checkoffs.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50940 Based on observations, staff interviews, record review, and review of the facility- provided documents titled Packaged Terminal Air Conditioner (PTAC) Preventative Maintenance Guide and Heating Ventilation, and Air Conditioning (HVAC): Clean Air Filters details the following steps, the facility failed to maintain a clean, sanitary, and comfortable environment as evidenced by dirty PTAC filters for 42 out of 42 residents' rooms on three Halls (Hall A, Hall B and Hall C) and the C Hall Dayroom. This deficient practice had the potential to compromise the health and safety of all 60 residents and staff by increasing the risk of respiratory and allergy symptoms due to inadequate air filtration and reduced fresh air circulation. Findings include: Review of the undated facility- provided document titled PTAC Preventative Maintenance Guide under the Three-Monthly PTAC Air Cleaning Tasks section revealed, 1. Air Filter .Clean the filter with a vacuum or running water .2. Vent Screen .Clean or replace the vent screen .3. Front [NAME] Remove the front grille and clean it with a dampened cloth . Review of the undated facility- provided document titled HVAC: Clean Air Filters details the following steps, revealed, 6. At a minimum, air filters are to be replaced or thoroughly cleaned depending on the type of filter every three months. 7. Clean evaporated coils if lint build up is present. Observations on 3/18/2025 between 9:00 am and 1:00 pm of the facility's air filters in residents' rooms revealed, that rooms on Halls A (15 out of 15 rooms), B (16 out of 16 rooms), and C (11 out of 11 rooms), as well as the C Hall dayroom, had heavily soiled air filters with a thick accumulation of dust, dirt, and debris. Originally white, the air filters appeared dark gray due to trapped contaminants. When lifted for inspection, they released visible dust clouds and were clogged with a dense layer of grime. During an interview with Housekeepers II and Housekeeper JJ on 3/19/2025 at 9:35 am, they revealed that they do not clean the air filters. However, they do clean the grills, wiping them daily when they clean the rooms. During an interview with the Director of Housekeeping on 3/19/ 2025, at 9:40 am, she confirmed during a facility tour that maintenance was responsible for cleaning the air filters. During an interview with the Maintenance Director on 3/19/2025, at 9:30 am, he stated that air filters were cleaned every three months, and maintenance staff clean the grills on the air filter covers as needed. He provided logbook documentation confirming that air filters were replaced every three months, with the most recent recorded change on 1/20/2025. Additionally, he stated that he cleaned the air filters on 3/18/2025, after being notified. During an interview with the Infection Preventionist (IP) on 3/20/2025 at 10:12 am, she stated that she expects the air filters to be clean and that maintenance was responsible for checking them. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Director of Nursing (DON) and the Administrator on 3/20/2025 at 10:14 am, it was revealed that there was no specific policy on environmental maintenance. They stated that they follow a three-month schedule, as the system alerts them when the air filters need to be cleaned. They confirmed that the air filters were due for cleaning soon and noted that they would naturally become filthy as the cleaning time approached. The policy on environmental maintenance, specifically regarding air filter cleaning, was requested but not provided.