

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115647	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Pruitthealth - Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Panthersville Road Decatur, GA 30034	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on resident, resident family and staff interviews, record review, and review of the facility policy titled, Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to report an allegation of verbal abuse by a staff member to the State Survey Agency (SSA) for one of 50 sampled residents (R) (R144). The deficient practice had the potential for the alleged abuse to continue and to affect other residents. Findings include: Review of the facility policy titled Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property revised 10/20/2025 revealed under Policy Statement: It is the policy of ?name of corporation' and its affiliated entities (collectively, the Organization) to comply with all applicable federal and state requirements regarding the reporting of patient abuse, neglect, exploitation, mistreatment, and misappropriation of property. Under Policy: 2. In accordance with applicable laws and regulations, the Administrator or his or her designee should notify the appropriate state agency (or agencies), the patient's attending physician, and the patient's designated representative of any allegation or incident described above and of the pending investigation. The state survey agency and the state agency for adult protective services should be notified in accordance with state law through established procedures of any allegations of abuse, neglect, exploitation or mistreatment, including injuries of an unknown source and misappropriation of patient property, within 2 hours after the allegation is made. If the events upon which the allegation is based involve abuse or result in serious bodily injury, report not later than 24 hours of being notified of the allegation. The Ombudsman should also be notified as required by state law. The Administrator or designee should direct an investigation into the allegation or incident. Interview on 03/1/2026 at 4:03 PM with Family of R144 revealed R144 was currently hospitalized . R144 telephoned her family member to report she overheard a Nurse comment an intent to slap someone as the Nurse was leaving R144's room following a request for her evening medications. R144's family member stated he came to the facility after hearing his mother's concerns and asked the facility staff why they had not notified the police regarding the alleged threat. The family member revealed that the Nurse who fielded his initial report did not act and told him he was getting ready to go home. The family member filed a police report on his mother's behalf the same evening. R144's family member further stated the facility would not release the name of the staff member who vocalized the threat nor provided any feedback regarding the abuse allegation, to date. R144 discharged from the facility in late December 2025. Review of a formal Grievance R144 filed on 12/15/2025 revealed the facility confirmed R144 reported a Nurse walked out after R144 requested evening medications and overheard the Nurse make a statement, I'm not going back in there. I may have to slap someone. On 12/17/2025, the facility documented the occurrence as a Customer Service matter and removed the Nurse from R144's assignment and listed an expectation for staff to attend inservices (training) for Good Customer Service. The facility did not file a report with the SSA nor completed an investigation to ensure R144 and other residents were free from abuse. Interview on 03/03/2026 at 12:31 PM with Certified Nursing Assistant (CNA) XX revealed the abuse reporting protocol of an alleged or real abuse occurrence; including verbalized threats included reporting of the allegation or incident occurrence to her (continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>supervisor and the facility Administrator, who was the Abuse Coordinator. The facility had two hours to report the occurrence to the SSA. CNA XX stated the facility held frequent educational trainings regarding abuse reporting including extensive online training and continuing education. Interview on 03/03/2026 at 12:38 PM with the Social Services Director (SSD) and Senior Care Coordinator confirmed the facility did make a police report on R144's behalf after verifying R144's concerns. Real or perceived allegations of abuse, including verbal threats, should be reported immediately, to include an abuse investigation. Interview on 03/03/2026 at 2:29 PM with the Administrator revealed the Administrator interpreted allegations of abuse, real or perceived, as reportable matters. If staff didn't report, they were culpable. The Administrator stated she always reported abuse occurrences, real or perceived to police and secured a case number from law enforcement. Additionally, a resident's Responsible Party and Physician, and the Long-Term Care Ombudsman were notified regarding occurrences.</p>

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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>Based on observations, staff and resident interviews, record review, and review of the facility's policies titled Care Plans, the facility failed to add indwelling urinary catheter irrigation to the care plan for one of 50 sampled residents (R) (R51). This deficient practice had the potential to cause errors in care and omission of service ordered by the physician. Findings include: Review of the facility's policy titled Care Plan, revised 10/21/2025, Section 3 under the comprehensive care plan should describe the following: The services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of R51 care plan dated 12/10/2025 indicated a problem of an indwelling catheter related to neurogenic bladder, BPH, and urinary retention. Interventions included, but not limited to, R51's spouse prefers urinary catheter to be changed at the urologist's office monthly and not the facility. Administer cranberry supplement for UTI (urinary tract infection) prophylaxis as ordered. Keep the catheter tubing free of kinks. Keep the drainage bag below the bladder level. Prevent tension on the urinary meatus from the catheter. Provide catheter care per policy. There is no mention of irrigating the urinary catheter. Review of the Physician's Orders for R51 included, but was not limited to: Irrigate the suprapubic catheter with 50cc (cubic centimeters) of normal saline every shift. An interview on 03/04/2026 at 11:25 AM with the MDS Coordinator revealed that she communicated with the IDT (interdisciplinary team) in morning meetings about changes to orders or residents' status and she should have been informed of the urinary catheter irrigation order so she or one of the unit nurses could add it to the care plan. An interview on 03/04/2026 at 3:40 PM with the Director of Nursing (DON) revealed expectations for care plan changes were either the Charge Nurse, Unit Manager, or MDS Coordinator should make the changes as soon as ordered. An interview on 03/04/2026 at 7:10 PM with the Administrator revealed that the MDS department stated they were caught up with the MDS's and the care plans at the last morning meeting, but that was not accurate.</p>