| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115719 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/20/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pruitthealth - Rome | 2 Three Mile Road NE<br>Rome, GA 30165 |

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) |
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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and family interviews, record reviews, and review of the facility policy titled Care Plan, the facility failed to develop and implement the care plan for three of 24 sampled residents (R113, R85, and R53) related to (1) developing a care plan for verbalization/refusal of Activities of Daily Living (ADL) care for R113; (2) developing a care plan for Range of Motion (ROM) and implementing a care plan related to nail care and oral care for R85; and (3) implementing a care plan related to nail care for R53. Actual harm was identified to have occurred on 1/13/2026, when Certified Nursing Assistant (CNA) EE failed to implement interventions for R113 during Activities of Daily Living (ADL) care, resulting in R113 sliding from the wheelchair onto the floor and sustaining a right femur fracture.Findings included:1. A review of the electronic medical record (EMR) revealed that R113 was admitted to the facility on [DATE], with diagnoses including, but not limited to, Alzheimer's disease, major depressive disorder, generalized anxiety disorder, schizoaffective disorder, osteoarthritis, and abnormalities of gait/mobility. A review of the quarterly Minimum Data Set (MDS) assessment for R113, dated 1/6/2026, documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive impairment with the inability to complete the interview.A review of the care plan for R113 revealed no care plan in place for intermittent verbalization/refusal of ADL care. During a telephone interview on 2/17/2026 at 4:55 pm, CNA EE revealed that when she entered R113's room on 1/13/2026, she could tell that she was already agitated. She stated that in her attempt to assist R113 with ADL care, R113 slid from the wheelchair onto the floor on her left side.A review of the progress notes dated 1/13/2026 documented that at 7:51 am, R113 had a witnessed fall by staff while being adjusted on her wheelchair and sustained a supracondylar fracture to the right femur.2. During an observation on 2/17/2026 at 10:24 am, 2/17/2026 at 3:59 pm, and 2/19/2026 at 9:31 am, R85 was observed lying on his back with both hands tightly closed in a fist. There were no splints or rolls in the resident's hands.During an observation on 2/19/2026 at 9:37 am, CNA II was observed providing am care for R85. R85's hands were not washed; no mouth or foot care was provided. Upon completion of R85's bath, CNA II removed R85's socks, which showed the great toe was thickened with a buildup of debris beneath the toenail. The nails appeared to have a yellowish discoloration. CNA II stated they don't do anything for R85's hands. No skin or foot care was provided during this observation. CNA II stated the CNA's do not trim toenails. A review of the EMR revealed that R85 was admitted to the facility on [DATE] with diagnoses including, but not limited to, aphasia (difficulty speaking) following cerebral infarction, quadriplegia (unable to move arms and legs) related to a cerebral vascular accident (CVA), contracture, unspecified hand, contracture of muscle, multiple sites (a contracture is tightening or shortening of muscles/joints that causes them to be unable to be moved), and diabetes type 2.A review of the quarterly MDS assessment dated [DATE] documented that R85 was severely impaired - never/rarely made decisions, and was dependent on staff for personal<br><br>(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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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | hygiene, including combing hair, shaving, washing/drying face, hands, and nail care.A review of the care plan dated 1/28/2026 revealed R85 was dependent on staff for dressing, oral hygiene, personal hygiene, and bathing. The care plan specified checking nails for cleanliness and ensuring they are clean. There were no care plan interventions related to upper extremity contractures or range of motion.During an interview on 2/19/2026 at 10:50 am, Licensed Practical Nurse (LPN) JJ stated that R85 did not have any resident-specific interventions for nail care and confirmed that there was no care plan for contractures. The care plan only specified turning and repositioning on rounds. LPN JJ verified there was no documentation that showed the resident refused care or that care planned interventions were tried.3. During an observation on 2/17/2026 at 10:33 am, R53's fingernails were observed to be long and jagged. R53 stated he had asked for them to be cut a while ago, and added his toenails were really long. R53 removed his shoes and socks, which revealed that his toenails were overgrown on both feet, curling into the skin. The toenails were cloudy/tan colored and were curled up on the side of the nails, pulling away from the nailbed.A record review of the EMR revealed that R53 was admitted to the facility on [DATE], with diagnoses including, but not limited to, vascular dementia, emphysema, and chronic obstructive pulmonary disease.A review of the admission MDS assessment dated [DATE] revealed a BIMS score of nine, indicating that R53 had moderate cognitive impairment. A record review of the admission MDS assessment dated [DATE], revealed that R53 required staff assistance for set up/cleanup for personal hygiene.A review of the care plan for R53, with a start date of 9/3/2025, revealed R53 experienced an ADL self-care decline related to recent hospitalization, and an approach included, but was not limited to, checking nails and ensuring they are clean.A review of the care plan revealed that R53 required staff assistance for ADL care. R53's care plan specified that staff should check nails and ensure they are clean. During an interview on 2/18/2026 at 1:05 pm, CNA KK stated that all CNAs can trim fingernails. Podiatry comes every two months. CNA KK stated that usually she does nailcare during the shower. She stated she does not do toenails.During an interview on 2/19/2026 at 10:40 am, CNA MM stated she trimmed R53's nails. CNA MM stated the shower aid should be doing nail care. The shower aid can trim nails as long as they are not diabetic. CNA MM stated she trimmed R53's nails and said it was painful, but felt better when it was done. CNA MM stated she did not know who normally trimmed R53's nails. During an interview on 2/19/2026 at 11:27 am, the Director of Health Services (DHS) stated she talked to the NP, and she confirmed that R53's toenails were long. The DHS stated that a resident-specific care plan would identify the needs of each resident and that care plans are supposed to be resident-specific.During an interview on 2/19/2026 at 10:50 am, LPN JJ stated R53 did not have resident-specific interventions for nail care. LPN JJ verified there was no documentation that the resident refused care or had care planned interventions tried or documented.A review of the facility's policy titled Comprehensive Care Plans, implemented in March 2025, revealed that the care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality and incorporate culturally competent and trauma-informed care as indicated. The comprehensive care plan will be prepared by an interdisciplinary team that includes, but is not limited to, the resident and the resident's representative, to the extent practicable, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. A review of the policy titled Care Plan, revised 10/21/2025, documented that the care plan approach serves as instructions for the patient/resident's care and provides continuity of care by all partners. When approaches that involve the CNA have been added<br><br>(continued on next page) |

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| | 115719 | A. Building<br>B. Wing | 02/20/2026 |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | to the care plan, those approaches should also be included on the CNA Care Record or Resident Profile/Care Plan. Updates to the care plans should be made with any changes in condition at the time the change in condition occurred. Care plans will be updated by nurses, Case Mix Directors (CMD), or any other interdisciplinary team member so that the care plan will reflect the patient/resident's needs at any given moment. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record reviews, and review of the facility policies titled Occurrences and Dementia Care Policy, the facility failed to ensure the safety of one of three residents (R) (R113) reviewed for falls. Actual harm was identified to have occurred on 1/13/2026, when Certified Nursing Assistant (CNA) EE failed to implement interventions for R113 during Activities of Daily Living (ADL) care, resulting in R113 sliding from the wheelchair onto the floor and sustaining a right femur fracture.Findings included:A review of the progress notes dated 1/13/2026 documented at 7:51 am revealed that R113 had a witnessed fall by staff while being adjusted on her wheelchair, that R113 slid off the wheelchair onto a sitting position with no apparent injury, that she denied pain at the time, and was assisted back in the wheelchair. Further review of the 1/13/2026 progress notes revealed that at 11:33 am, R113 complained of pain in her right leg, was given Tylenol (a pain reducer), was seen by the Nurse Practitioner, and a new order was received for a right lower extremity x-ray. At 8:27 pm, an x-ray confirmed a supracondylar fracture to the right femur. A review of the progress note dated 1/21/2026 at 9:10 am by the Director of Health Services (DHS) documented an Interdisciplinary Team (IDT) Fall note that R113 returned to the facility after a fall on 1/13/2026 while an aide was dressing the resident and that R113 slid from the edge of the wheelchair with no immediate signs of injury but later R113 complained of right leg pain. Nurse Practitioner in the facility visited R113 and ordered a mobile x-ray that showed a right femur fracture. R113 was sent to the local emergency room for evaluation and treatment.A review of the electronic medical record revealed that R113 was admitted to the facility on [DATE], with diagnoses including but not limited to Alzheimer's disease, major depressive disorder, generalized anxiety disorder, schizoaffective disorder, osteoarthritis, and abnormalities of gait/mobility. A review of the quarterly Minimum Data Set (MDS) assessment for R113, dated 1/6/2026, documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive impairment with inability to complete the interview, severely impaired daily decision making, and inattention with disorganized thinking was continuously present, and is dependent with upper and lower body dressing.A review of a facility's in-service sign-in sheet dated 8/18/2025 revealed a topic of Care of Combative Resident that stated, If a resident becomes combative or agitated during care, stop care, redirect/diffuse if possible, and obtain resident safety and dignity, then go for help. If you are unable to leave the resident, yell for assistance and use the call light. Stop actions causing behaviors. It was observed that CNA EE signed the sheet as being in attendance for the training.A review of a facility's in-service sign-in sheet dated 10/7/2025 revealed a topic that stated, If a resident becomes combative/agitated during care, STOP, Reassess Situation, ensure resident safety and dignity, and get help. If unable to leave, use the call light and yell for help if needed. It was observed that CNA EE signed the sheet as being in attendance for the training.During a telephone interview on 2/17/2026 at 4:55 pm, CNA EE revealed that when she entered R113's room on 1/13/2026, she could tell that she was already agitated. She stated that she was assisting R113 to put on a shirt that had to be pulled over the top of her head and that R113 was pushing against her to get the shirt off. She stated that she was pushing the shirt down when the resident slid from the wheelchair onto the floor on her left side. CNA EE stated she called for the nurse, the nurse came into the room to assess R113 and found no injury. She stated that R113 was not complaining of pain at that time, so assisted R113 from the floor back into the wheelchair. She stated that she and CNA DD assisted R113 onto the edge of the bed, and it was then that she started complaining of pain in her right leg. She said she notified the nurse. CNA EE stated that she redirects a<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | resident who has negative behaviors and would not necessarily call for assistance. She stated that there are times when a resident has negative behaviors that she will walk away and give them a while before returning and trying again, but she did not feel she needed to do that with R113 because she can just redirect her. CNA EE stated that she received education related to how to deal with residents with behaviors.During a telephone interview on 2/18/2026 at 11:00 am, a family member of R113 revealed that on the day of the fall, a CNA was attempting to assist R113 with putting on her top while she was agitated and resisting. The family member stated that R113 usually had 2 to 3 people assist her and cannot understand why the CNA did not stop when R113 was agitated and she slipped out of the wheelchair and sustained a fracture.During an interview on 2/18/2026 at 2:54 pm, the Education Coordinator revealed that in a situation where a resident becomes physically resistant to care and agitated during changing their clothes, she would expect staff to ensure the resident was decent and then get help, but not to leave the resident until assuring the safety of the resident. Education Coordinator stated for the situation with R113 when she slid from her chair with the CNA present on 1/13/2026, she would hope that the CNA would have stopped when R113 began trying to pull off the shirt while the CNA was trying to put it on her, especially if she knew she was already agitated and if necessary, yell out for help but not leave the resident to ensure her safety.During an interview on 2/19/2026 at 12:21 pm, the DHS revealed that for residents with behaviors that could result in potential injury to self or staff, the staff receive regular education related to how to care for residents with dementia and behaviors. She stated that specific education related to challenging behaviors is provided regularly through in-house staff, providing education as well as online. The DHS stated it was her expectation that staff would stop what they are doing and retrieve additional help when a resident is agitated, resistant to care, and unable to be redirected.A review of the facility policy titled Occurrences, revised 1/11/2024, documented Policy Statement: The healthcare center recognizes that due to the frailty of the patients/residents served, there is an increased risk of occurrences that may result in injury to the patient/resident and/or others. To prevent occurrences, each patient/resident will be observed and assessed for risks. Appropriate, realistic interventions will be implemented in accordance with their care plan.A review of the facility policy titled Dementia Care Policy, revised 10/19/2021, documented Policy Statement: [Name of the facility] recognizes that no single strategy is sufficient and some residents with dementia will need a combination of approaches that might include prescribing of appropriate medications and specialized psychological interventions. Procedure: 2. [Name of the facility] partners are encouraged to see residents with dementia as a whole person and accept their reality. 3. [Name of facility] partners are required to treat residents with dementia with respect and dignity. 4. Approaches to providing care for residents with dementia include: a. Communication 2. Be mindful of non-verbal communication. 7. Don't argue or contradict. 9. Slow down (slower is faster). Be patient and give the resident time to respond without feeling rushed. |