STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115206	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Center for Nursing and Healing	811 Kennesaw Avenue Marietta, GA 30060

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, record review, and review of the facility policies titled, Transmission-Based (Isolation) Precautions and Hand Hygiene, the facility failed to follow infection control protocols and precautions measures for one of eleven residents (R) (R2) with wounds. The deficient practice had the potential to spread microorganisms and infections.Findings include: Review of the facility policy titled, Transmission-Based (Isolation) Precautions date implemented 10/1/2022 and revised 9/12/2022 indicated under Policy, It is our policy to take appropriate precautions to prevent transmission of pathogens. f. The facility will have PPE (personal protective equipment) readily available near the entrance of the residence room and will don (put on) appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions. Review of the facility policy titled, Hand Hygiene revised June 2025 indicated under Policy, staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.6. a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the admission Record revealed that R2 was admitted to the facility with diagnoses of, but not limited to anxiety disorder, gastro-esophageal reflux disease without esophagitis, other asthma, colostomy status epilepsy, not intractable, with status epilepticus, other neuromuscular dysfunction of bladder, quadriplegia, pressure ulcer of sacral region, Stage 4, bipolar disorder, osteomyelitis of vertebra, sacral and sacrococcygeal region, subluxation of C5/C6 cervical vertebrae, sequela, unspecified protein-calorie malnutrition, local infection of the skin and subcutaneous tissue, muscle weakness (generalized), other lack of coordination, need for assistance with personal care, cognitive communication deficit, depression. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/29/2025
NAME OF PROVIDER OR SUPPLIER: Marietta Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE: 811 Kennesaw Avenue Marietta, GA 30060	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 9/24/2025 at 11:51 am in room B16 (R2's room) revealed a posting outside of room door instructing that EBP was required for close contact with resident, and no PPE visibly available for resident care or visitors observed in room. No EBP station was hanging from residents' door as observed for other rooms in the hallway with EBP signage postings. Resident was bed bound and verbal, with an air pressure relief mattress, and heel boots on both feet. Wound care was observed performed by Licensed Practical Nurse (LPN) CC. LPN CC donned PPE and clean gloves before entering the residents' room. The treatment table was sanitized and prepped with wound care supplies per physician orders in the hallway prior to entering R2's room. The nurse ensured incontinence care was performed prior to wound care observation. Certified Nursing Assistant (CNA) BB entered the room, obtained gloves from the wall in R2's room without sanitizing hands before moving the residents' bedside table. CNA BB then assisted the nurse with repositioning R2 to their side without donning PPE prior to care. CNA BB held the resident in place while the nurse removed the old wound dressing. The nurse removed a scantly soiled packing and dressing, removed soiled gloves and donned clean gloves without first sanitizing her hands. The surveyor stopped LPN CC from continuing with wound care to first sanitize their hands before continuing care. LPN CC had to leave the room to retrieve their hand sanitizer that was locked in the treatment cart, then retrieved a new box of gloves as the box of gloves on the treatment table was empty. When CNA BB was asked why they didn't have PPE on while they assisted the nurse with wound care, isn't the resident on enhanced barrier precautions, CNA BB stated, I'm not sure. The surveyor pointed to the signs posted on the residents' room door. CNA BB stated, Oh, yes. I should have PPE on. The surveyor asked CNA BB, Why is hand hygiene important? CNA BB responded, To stop the spread of germs. LPN CC returned to the room with gloves and hand sanitizer. LPN CC sanitized their hands and donned new gloves. LPN CC removed the old dressing; no date was observed on the dressing. No odor or discolored discharge were observed with the wound. Wound was a circular decubitus ulcer, Stage 4, 5 cm x 3 cm with healthy pink flesh, scant discharge present with pocketing but no tunneling present. LPN CC discarded the soiled gauze and gloves. LPN CC sanitized their hands. LPN CC explored in her pants pockets for a pen to date the 4 x 4 gauze. LPN CC donned clean gloves. The surveyor stopped LPN CC a second time from continuing with wound care to first sanitize their hands before donning new gloves before continuing care. LPN CC sanitized their hands and donned clean gloves before gauze packing and clean 4 x 4 dressing dated 9/24/2025 were applied. Clean wound dressing supplies were handled in a way to prevent cross-contamination. Then LPN CC removed the trash and put soiled gloves in a trash bag at the foot of the bed. LPN CC and CNA BB repositioned the resident and applied foam wedges and pillows and adjusted resident in bed. CNA BB doffed (removed) soiled gloves after picking up R2's empty cup that fell off the bedside table to the floor while LPN CC stabilized R2. CNA BB reached in their scrub pocket for new gloves and donned gloves without first sanitizing or washing hands. CNA BB repositioned resident's bedside table in reach of R2. CNA BB doffed gloves and then washed hands with soap and water in the residents' restroom. LPN CC doffed gloves and gown in the trash, sanitized the treatment table, then sanitized hands after service was completed. An interview on 9/24/2025 at 12:15 pm with Unit Manager Registered Nurse (RN) AA revealed that LPN CC and CNA BB did not follow infection control and enhanced barrier precautions during the wound care observation. RN AA reported that staff have been in-serviced on hand hygiene and EBP. RN AA stated that they were surprised that LPN CC and CNA BB did not follow infection prevention protocols during the observation. RN AA stated that they would in-service nursing staff again.