STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115334	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Augusta	2541 Milledgeville Road Augusta, GA 30904

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled Freedom from Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property Mission Statement, the facility failed to protect the residents' right to be free from physical and sexual abuse by other residents for two of two residents (R) (R96 and R92) reviewed for abuse out of a total of 31 sampled residents. Actual harm occurred when R96 was physically abused by R64, resulting in R96 receiving a fractured clavicle and head laceration. Additionally, R92 was sexually abused by R93. Findings include: Review of the facility's policy titled, Freedom from Patient Abuse, Neglect Exploitation, Mistreatment and Misappropriation of Property Mission Statement, revised 11/15/2024, noted, It is the mission of [Corporation name] and its affiliated providers (collectively, the Organization) actively to preserve each patient's right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of patient property. The Organization recognizes that every patient has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The purpose of our abuse prohibition procedures is to assure that our partners are doing all that is within our control to create a standard of intolerance and to prevent any occurrences of any form of patient abuse, neglect, exploitation, mistreatment, and misappropriation of property. 1. Review of R96'sFace Sheet, located in the electronic medical record (EMR) under the Profile tab, revealed R96 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive, unsteadiness on feet, visual hallucinations, restlessness and agitation, and vascular dementia. Review of R96's Annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 8/28/2024 and located under the Resident Assessment Instrument (RAI) tab of the EMR, revealed R96 had a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated R96 was severely cognitively impaired. R96 was identified to wander about the facility, in and out of rooms and the halls. Review of R64'sFace Sheet, located in the EMR under the Profile tab, revealed R64 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, vascular dementia with agitation, restlessness, and agitation. Review of R64's Annual MDS, with an ARD of 5/23/2025 and located under the RAI tab of the EMR, revealed R64 had a BIMS score of three out of 15, which indicated R64 was severely cognitively impaired. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility investigation, provided by the Administrator, revealed on 6/21/2024, R64 was heard by a staff nurse to be yelling, Didn't I tell you to stay out of my room? As the nurse was responding, R64 was observed to grab R96 and throw R96 to the floor. Review of an After Visit Summary from the emergency room (ER), dated 6/21/2024, revealed diagnoses of closed, displaced fracture of acromial end of right clavicle, laceration of scalp, and abrasion of right knee. Review of R64's Progress Notes revealed a note dated 6/21/2024 at 6:01 pm of Writer was in Nursing office when she heard a big thump in the hallway. When going into hallway writer heard resident say 'He was in my room. I told him not to go into my room. Hospice nurse stated that he saw resident pick up the other resident and throw him to the floor. The other resident was laying on floor with blood to right side of head and saying his shoulder hurts. Administrator was called. Dr. [Doctor] was called. Dr. said to print 10-13 paper [process of initiating an involuntary mental health evaluation] to send resident out. Resident sister was called, no answer. Message left. Administrator said to call Police. Police called and was in building. Sister was in building, resident finally left with sister. Sister is to transport resident to [local Hospital] . Further review of R64's Progress Notes revealed a note dated 5/19/2024 at 3:20 pm of Writer and several other staff heard loud cussing and a loud noise coming from down Hall 2, went to this resident room where the loud cussing was coming from we all observed another resident lying on floor writer and staff removed resident out room of this resident who continued to be aggressive and cussing resident other resident was taken to his room but this resident when to other hall to the other resident room still cussing and threatening to harm resident. Administrator made aware of status advised to call this resident sister to come to Nursing facility to talk to resident, RP [Responsible Party] called and is on her way to facility resident is in his room at this time will continue to monitor . Review of R64's EMR revealed no further incidents of abuse between R64 and R96 or any other resident. Observations during the survey, from 6/23/2025 through 6/26/2025, revealed no concerns related to abuse. During an interview on 6/24/2025 at 10:18 am, the Administrator stated she could not find any other information to indicate what measures were taken to keep the two residents separated, as she was not employed in the facility at that time, and she found nothing in the previous Administrator's files. The Administrator confirmed all staff received abuse training yearly and as needed. The Administrator confirmed there had been no incidents of abuse involving R96 during her employment at the facility. During an interview on 6/26/2025 at 9:47 am, the Director of Nurses (DON) stated, I just started in December of 2024. I can't answer what was put in place at that time. During an interview on 6/26/2025 at 10:21 am, the Social Service Director (SSD) stated, I wasn't here at that time, I don't know what happened. [R64] has not had any behaviors since I've been here. 2. Review of R92's Quarterly MDS, with an ARD of 12/24/2024 and located in the RAI tab of the EMR, revealed an admission date of 9/15/2015, that R92 had a BIMS score of five out of 15, which indicated her cognition was severely impaired, and had diagnoses of Alzheimer's disease, glaucoma, and vascular dementia. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of R92's Care Plan, dated 7/30/2019 and located in the EMR under the RAI tab, revealed, Self-care deficit Activities of Daily Living related to: impaired mobility, hx [history] of muscle contractures, vision impairment, incontinent of B/B [bowel/bladder]. Resident requires mostly ext.[extensive] to total assistance/ [R92] has a specialty chair (name). An intervention included, Total assist with the Hoyer lift with appropriate number of staff members. Review of R92's Care Plan, dated 3/16/2020 and located in the EMR under the RAI tab, revealed R92 was at risk for alteration in psychosocial well-being related to a diagnosis of dementia. Interventions included, . Provide calm and safe environment to allow resident to express feelings related to situational stressor . Review of the facility investigation, dated 1/13/2024 and provided by the facility, revealed 1/13/2024 5:52 am Resident roommate alerted staff that another resident was in her room touching her roommate under the sheets, She hollered at man to get out of their room. Man asked resident 'who is you?' Man pulled his pants up and headed into the hallway, Resident [R92] skin assessment clear with no injuries noted, POA [Power Of Attorney] notified, no response, writer left message, Administrator notified, DON notified, Police notified (case #[number]\, MD [physician] notified, Rx [order] send out for further evaluation and treatment, Writer interviewed resident. Resident [R92] was asleep and does not remember the incident. Sending resident [R92] out to hospital for further evaluation via ambulance by stretcher . Review of R93's admission MDS, with an ARD date of 11/28/2023 and located in the RAI tab of the EMR, revealed an admission date of 11/21/2023, that R93 had a BIMS score of 12 out of 15, which indicated his cognition was moderately impaired, and had diagnoses of schizophrenia, apraxia following cerebral infarction, and Parkinson's disease. Review of R93's Care Plan, dated 8/8/2022 and located in the EMR under the RAI tab, revealed Mood State: [R93] is at risk for having signs and symptoms of mood distress as evidenced by verbalizing feeling down, depressed, or hopeless. 1/13/24: inappropriate touching of others. An intervention included, . Observe and report any changes in mental status, mood, behavior caused by situational stressor . Review of the facility investigation, dated 1/13/2024 and provided by the facility, revealed, . 7/13/2024 5:59 am Resident [R93] alert and oriented to person and place, no pain noted, writer was alerted by screaming resident in [room number], [R93] was in resident room with pants down sitting in chair, he was touching 22A [R92] inappropriately with covers pulled back, 228 [roommate] yelled at resident to 'get out of my room,', He responded 'Who is you?' [R93] pulled up his pants and exited to hallway, Nurse [name] was escorting resident in hallway and asking which way to go, Writer came out of office where I was charting, Writer saw that this was her resident so I escorted him back to his bed. He then got into his wheelchair and came back into the hallway looking into room from in the hallway. Family [name] was notified, did not answer, left message to call facility regarding resident behavior, MD aware, DON aware, Administrator aware, on coming staff aware that resident was placed on 1 on 1 monitoring, Police made aware case #[number], statements from staff collected . Resident touched another resident inappropriately while she was in her bed resting. Roommate caught him in the act. Yelled at resident and he pulled up his pants and exited the room into the hallway . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the clinical records for R92 and R93 revealed no further incidents. R93 was discharged from the facility following the incident and did not return. Observations during the survey, from 6/23/2025 through 6/26/2025, revealed no concerns related to abuse. During an interview on 6/24/2025 at 11:45 am, the Administrator stated she was not working at the facility at the time of the incident and stated abuse training is provided to staff annually. The Administrator stated she provided everything she could find for the investigation. During an interview on 6/25/2025 at 3:01 pm, R92's roommate was asked if she remembered a male resident about 1.5 years ago coming into her room, going over to her roommate's bed, and being inappropriate to her roommate. The roommate stated, Yes, just barely. The roommate stated she yelled for the nurse to get the male resident out of her room. The roommate stated she vaguely remembers the incident, and it only occurred once. During a telephone interview on 6/25/2025 at 3:08 pm, Licensed Practical Nurse (LPN)10 stated R93 went into R92's room, pulled his pants down, and put his hand in R92's brief. LPN10 stated R92 was not aware, as she had advanced dementia and did not respond. LPN10 went on to say the roommate woke up and saw R93 in her room and yelled for him to get out. LPN10 stated R93 was placed under constant surveillance until a more appropriate placement could be found two weeks later, and no other incident occurred.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and review of the facility's policy titled Pressure Injury Prevention Program, the facility failed to monitor for changes and intervene when a pressure ulcer worsened for one of six residents (R) (R9) reviewed for pressure ulcers out of a total sample of 33. R9 was first identified with a pressure ulcer on 3/21/2025. There was no documented monitoring of the pressure ulcer from 3/21/2025 until 3/31/2025, when the pressure ulcer was noted to have worsened from excoriation to an unstageable pressure ulcer requiring debridement. This caused R9 actual harm when she was subsequently found to have a wound infection and osteomyelitis (infection in the bone). Findings include: Review of the facility's policy titled, Pressure Injury Prevention Program, dated 3/18/2021, revealed, . pressure injury prevention includes assessing for the risk of development. A risk assessment should be performed on admission, at regular intervals, and when the resident experiences a significant change in condition. Risk factors for pressure injury development include mobility, continence, medications, cognitive status, nutrition, history of pressure injury, and impaired blood flow. Residents identified at risk must have interventions implemented to mitigate risk factors. Any resident who is identified with a 'Braden Scale for Predicting Pressure Score Risk' score of 18 or below should be placed on the 'Pressure Injury Prevention Program.' The 'Pressure Injury Prevention Program' consists of the following bundles . Those bundles included interventions of . monitor the skin of all at risk residents daily during ADL's [activities of daily living] and report any abnormal findings to the Charge Nurse . Minimize Pressure through turning and positioning, therapeutic support surface assessment, therapeutic seating surface assessment, and tissue tolerance assessment . Review of R9's Face Sheet, located under the Face Sheet tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses that included abnormal weight loss, type 2 diabetes mellitus, thyroid disorder, anemia, and anxiety. Review of R9's Care Plan, dated 5/26/2023 and located under the Resident Assessment Instrument (RAI) tab of the EMR, revealed, . [R9] is at risk for skin breakdown/pressure injury D/T [due to] immobility . Interventions included to assist with incontinent care as needed. There was no intervention to assist with repositioning. Review of R9's Annual Minimum Data Set (MDS), located under the RAI tab and with an assessment reference date (ARD) of 3/7/2025, revealed R9 had a Brief Interview for Mental Status (BIMS) score 12 out of 15, which indicated the resident was cognitively intact. It was recorded that R9 was dependent on staff for toileting hygiene and bathing/showering, and required partial to moderate assistance with bed mobility. It was recorded that R9 was always incontinent of bowel and bladder, was at risk for pressure ulcers, and did not have any pressure ulcers. Review of R9's Braden Scale for Predicting Pressure Ulcer Risk, dated 3/7/2025 and located under the Assessment tab of the EMR, revealed R9 scored 17, which indicated the resident was at mild risk for developing a pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R9's Progress Notes, dated 3/21/2025 at 5:52 am and located in the EMR under the Progress Notes tab, revealed, the resident's skin was warm and dry to touch, and she had a formed bowel movement. There was no documentation of any wound on her sacrum. Review of R9's Progress Notes, dated 3/21/2025 at 6:57 am and located in the EMR under the Progress Notes tab, recorded, . During incontinent care, it is discovered that the identified impairment to [R9] sacrum has worsened. Protective clean dry dressing applied and is intact. Nsg [nursing] will continue with close status monitoring . Review of R9's Situation, Background, Assessment, Review (SBAR) completed on 3/21/2025 and located in the Progress Notes tab of the EMR, revealed the Situation was excoriation (scraping or rubbing off the skin, resulting in an abrasion or raw area) to the sacrum. Documentation included, . resident scratches her backside. The Background described R9's medical condition and vital signs. The Assessment documented under skin evaluation that R9 had a wound. The description was . granulated [a type of connective tissue that forms on the surface of a healing wound] tissue to sacrum . The appearance was . wound noted to sacral area with granulated tissue 3 areas approx. [approximately] ½ to 1 inch . It was recorded that the primary care clinician was notified at 7:17 am with orders to clean and dress wound start wound care. Review of R9's Physician Orders, dated 3/21/2025 and located under the Orders tab of the EMR, revealed a treatment order for zinc oxide (a topical cream used to treat excoriation) to the excoriated area. Review of R9's Medication Administration Records (MARs), dated 3/21/2025 through 3/31/2025 and provided by the facility, revealed that the zinc oxide was applied as ordered. Review of R9's Progress Notes, Medication Administration Records, Treatment Administration Records, and Wound Management tabs of the EMR revealed no documented evidence of any measurements, descriptions, or monitoring of R9's excoriation after 3/21/2025 until 3/31/2025. There was no documented evidence of any treatment other than zinc oxide. Review of R9's Progress Notes, dated 3/21/2025 through 3/31/2025, revealed the resident had been diagnosed with an ileus (a painful obstruction of the ileum or other part of the intestines). Review of R9's Wound Management tab of the EMR, dated 3/31/2025, revealed she had an acquired sacral pressure ulcer. It was documented that the pressure ulcer measured 4 centimeters (cm) long by (x) 8cm wide x 0.1cm deep. It was considered unstageable due to the eschar (dead tissue covering the wound). Review of R9's Progress Note, dated 4/3/2025 at 8:35 am, and located under the Progress Notes tab of the EMR, revealed, . Wound care ordered. Wound to sacrum stable. Wound bed necrotic and intact tissue. Surrounding skin intact. No S/S [signs or symptoms] of infection noted . Review of R9's Progress Note, dated 4/3/2025 at 5:34 pm and located under the Progress Notes tab of the EMR, revealed, . [R9] was seen by the QSM [Quality Surgical Management] nurse practitioner. A new order noted to do a wound culture of sacral wound. Culture was done and ready for lab [laboratory] pickup . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a wound management note, dated 4/3/2025 and electronically signed at 7:52 pm by the Wound Nurse Practitioner (WNP), revealed that she educated R9 on the wound status, offloading, and repositioning frequently, and R9 verbalized understanding. Sharp debridement was completed to remove necrotic tissue. It was recorded that R9's status was discussed with her Primary Care Practitioner (PCP), along with wound status, wound treatment, and possible osteomyelitis. It was recorded that the WNP measured the wound, and it was 4cm x 8cm x 2cm and had a moderate amount of purulent (thick pus-like fluid that comes from a wound or infection) drainage that had an odor to it. Review of a Wound Management note, dated 4/7/2025 at 2:56 pm, written by the QSM, and provided by the facility, revealed the wound to the sacrum was declining, the wound bed had black necrotic tissue, surrounding skin was thin and dry, and there was a moderate amount of serosanguinous (thin watery) drainage. It was recorded that a low-air-loss bed was ordered, 18 days after the first documented evidence of R9's pressure ulcer. Review of R9's Care Plan, located under the RAI tab of the EMR, revealed an update on 4/7/2025 of . Resident refuses to be repositioned in bed. Resident refuses a wedge to help with positioning . Review of R9's Progress Note, dated 4/9/2025 at 4:42 pm and located under the Progress Notes tab of the EMR, revealed, . Wound culture obtained from sacral wound . At 4:51 pm, it was recorded, . sacral wound declining. Wound bed yellow and black necrotic tissue. Surrounding skin macerated (broken down and soft skin from prolonged exposure to moisture . Review of a Wound Management note, dated 4/10/2025 at 10:00 am, written by the QSM, and provided by the facility, revealed R9's sacral pressure ulcer measured 6cm x 8.5cm x 2.5 cm. The QSM classified the wound as a clinical stage 4 (severe, deep wound that extends through the skin and into the underlying muscle, tendon, or bone) with the tissue depth showing bone. It was recorded that the wound was a larger volume with a persistent odor and movable, nonviable, and fluctuant yellow/black tissue. It was recorded that the skin around the wound was denuded toward the left buttock, and there were concerns for osteomyelitis due to the appearance and the depth now to the bone. The possibility of R9 having osteomyelitis was discussed with her PCP, and initiation of antibiotics was recommended while awaiting the results of the wound culture. Review of R9's Progress Note, dated 4/13/2025 at 9:00 pm and located under the Progress Notes tab of the EMR, revealed, . Remains on ABT (antibiotic therapy) . for cellulitis of the buttocks . Review of R9's Progress Note, dated 4/17/2025 at 2:43 pm and located under the Progress Notes tab of the ERM, revealed, . Per QSM, resident will need a PICC [peripheral inserted central catheter] line. DX [diagnosis]: Osteomyelitis of vertebra, sacral and sacrococcygeal region . order placed with IV [intravenous] team for placement of line . Continued review revealed a Progress Note dated 5/22/25 at 12:36 pm by R9's PCP recorded, .[R9] is a chronically ill . Agreed with discontinuing IV antibiotics. Discussed R9's current and chronic conditions to include . sacral osteomyelitis . R/P [representative] states she does not want aggressive care measures for patient. Discussed Advance Directives and Hospice with R/P. R/P states she wishes to sign Pt [resident] up for Hospice . Hospice contacted and informed of consultation . During an observation on 6/25/2025 at 1:00 pm, R9 was noted to have a large sacral wound. The tissue was red, and no drainage was noted. The sacral bone was visible. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/26/2025, the Director of Nursing (DON) revealed she was aware R9 had a large sacral PU that was facility-acquired. When asked about what treatment and interventions had been put in place when R9's sacral PU had been discovered, the DON stated R9's PCP was called. The DON was asked why there was no order for treatments other than zinc oxide, as the pressure ulcer worsened, and why there was no measurement or monitoring between 3/21/2025 and 3/31/2025. She stated she was not aware that no treatment had been ordered for that time frame. The DON stated that the staff should have followed the pressure ulcer prevention program guidelines. The DON stated there was no root cause analysis completed to determine why R9's PU had deteriorated significantly in a short period of time. The DON stated she was unsure how the osteomyelitis had developed. She further stated she did not know when the resident's low-air-loss mattress had been placed on her bed. The DON stated interventions prior to her developing the sacral pressure ulcer included turning and repositioning every two hours and as needed, and providing prompt incontinence care. The DON confirmed there was no documented evidence that the resident had been turned and repositioned every two hours. She stated there was no place in the electronic medical record for the documentation to have been completed.