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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115512	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - West Atlanta	2645 Whiting Street N.W. Atlanta, GA 30318

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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: 115512	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Pruitthealth - West Atlanta		STREET ADDRESS, CITY, STATE, ZIP CODE 2645 Whiting Street N.W. Atlanta, GA 30318	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policies titled Occurrences and Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to thoroughly investigate a serious bodily injury of unknown source for one of ten sampled residents (R) (R7). Specifically, the facility failed to provide evidence of conducting interviews with R7, with staff who provided care for R7, with other residents, and with other pertinent outside agencies to determine the root cause of a serious bodily injury of unknown source. This deficient practice had the potential to put vulnerable residents at risk for injuries of unknown source to recur.Findings include:Review of the facility's policy titled Occurrences, reviewed 11/17/2025, revealed the Procedure section included, Investigation and Follow-up: . 7. The Administrator's findings will include, but not be limited to: Interview findings. Was abuse ruled out.A review of the facility's policy titled Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, reviewed 10/15/2025, revealed the Procedure section included, . 2. If it appears to a reasonable person that injury of unknown cause has occurred, interviews should be conducted. Signed statements should be gathered from: staff who cared for the patient just prior to and just after injury; other reliable patients in the vicinity nearby area; and any family or visitors who may have noticed anything. Once an injury of unknown source has been identified, staff should observe the patient and watch his or her behavior to see if the source of injury can be identified based on the patient's behavior (e.g., how the patients moves his or her arms, walks, pushed a wheelchair, behaves.).Review of the electronic medical record (EMR) for R7 revealed an admission date of 10/15/2025. Diagnoses included but were not limited to cognitive communication deficit, generalized muscle weakness, need for assistance with personal care, abnormal posture, vascular dementia, and other chronic pain.Review of the admission Minimum Data Set (MDS) assessment for R7, dated 11/13/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 9, indicating R9 had moderate cognitive impairment. Section GG (Functional Abilities and Goals) documented that R7 required extensive assistance for activities of daily living. Review of the care plan for R7, dated 10/17/2025, revealed a focus of R7 was at risk for falls and had a diagnosis of arthritis, noting that R7 had a fall on 10/17/2025. Interventions included but were not limited to frequent rounds at night and assistance for toileting and transfers.Review of the Progress Notes for R7 revealed an entry dated 10/15/2025 that documented R7 was incontinent of bowel and bladder and is a fall risk.Review of the Progress Notes for R7 revealed an entry dated 10/16/2025 that documented R7 can move bilateral upper extremities and lower extremities with some muscle weakness noted and can hold quarter-inch side rails with one staff assist to reposition himself in bed.Review of the Progress Notes for R7 revealed an entry dated 10/17/2025 by Licensed Practical Nurse (LPN) AA that documented a Certified Nursing Assistant (CNA) alerted this nurse the resident was on the floor with his head laying [sic] towards the door/foot of bed. When asked if he was hurt he said no and denied hitting his head. When asked what he was trying to do, he said he was trying to go in the house. This nurse told the resident he was already in the house and in his bed. Also stated not to get out of bed again so he wouldn't fall or hurt himself. He said ok however he is confused.Review of the Progress Notes for R7 revealed an entry dated 10/23/2025 that documented R7 was experiencing low blood sugar and was sent to the emergency room for evaluation. Review of the EMR for R7 revealed hospital documentation with a print date of 11/5/2025 that revealed a summary statement that documented that during this admission, computed tomography (CT) abdomen showed right femur intertrochanteric fracture, and ortho was consulted. Further review of the hospital documentation revealed an X Ray of R7's femur with a clinical indication listed as pelvic/hip pain following trauma. Found down after ground level fall. Under Impression, the findings include similar appearance of comminuted essentially nondisplaced intertrochanteric fracture of the right femoral neck. Review of the EMR for R7 revealed hospital documentation with a print date of 11/7/2025 that revealed under the section titled Right intertrochanteric femur fracture, CT abdomen on admission incidentally revealed a nondisplaced right intertrochanteric fracture, likely related to a fall one week prior. Orthopedic surgery performed rod fixation on 10/27. Review of the investigation of the injury of unknown source provided by the facility revealed a Witness Statement Form dated 10/30/2025 that documented, The Administrator approached us about the resident's fall and if he was in any pain. Following the nurse's documentation, there was no voiced complaints of or signs and symptoms of pain Further review revealed a second Witness Statement Form dated 10/30/2025

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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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policies titled Care Plans, the facility failed to follow the care plan to prevent complications for one of four sampled residents (R) (R7), who had a care plan focus for nothing by mouth (NPO). This deficient practice had the potential to negatively impact the resident's quality of life, quality of care and services received.Findings include:A review of the facility's policy titled Care Plans, revised 10/21/2025, under the subsection titled admission Comprehensive Plan of Care number four revealed, The care plan approach serves as instructions for the patient/resident's care and provides continuity of care by all partners.Review of R7's electronic medical record (EMR) revealed R7 was admitted on [DATE] with diagnoses that included but was not limited to pneumonia, dysphagia oropharyngeal phase, respiratory failure with hypoxia, and cognitive communication deficit.Review of R7's care plan initiated 10/16/2025 revealed, a focus of nutritional status that documented R7 required a feeding tube related to NPO. Interventions included but were not limited to give feeding and water flushes as ordered.Review of R7's physician's orders included but was not limited to an order dated 10/21/2025 for NPO and an order dated 10/16/2025 for gastrostomy tube (G-Tube).A review of R7's EMR revealed a progress note dated 11/15/2025 that documented R7 was observed with a food tray in front of him and food in his mouth and when R7 was asked to open his mouth, three shrimps were inside his mouth and resident was able to give them the shrimps. Further review documented no coughing, shortness of breath, or respiratory distress was noted at this time and instructions were given by the Director of Health Services (DHS) and Nurse Practitioner (NP) to monitor the resident and if any cough was noted, an X-ray could be ordered. Further review revealed the NPO diet slip was printed and given to kitchen staff and they were educated that resident was NPO.A review of R7's EMR revealed a progress note dated 11/23/2025 that documented that R7 had a change of condition on 11/22/2025 around 6:50 pm and was noted with an oxygen saturation level of 84% (percent) while on nasal cannula and at 2L(liters) on the concentrator. Further review revealed that R7 was documented as using his accessory muscles to breathe, and the NP gave an order to apply a non-rebreather mask on 15L of oxygen, which made the oxygen saturation level rise to 100% and 15 minutes later it came back down to 84%. Further instructions were given to send R7 to the hospital. Emergency medical services were called.A review of R7's EMR revealed hospital documentation with a print date of 12/11/2025 that documented under section titled Hospital Course, R7 was admitted from a nursing home with acute respiratory distress. On presentation, he required noninvasive ventilatory support and was found to have hypoxic respiratory failure with imaging revealing large left and moderate right pleural effusions and upper lobe predominant pulmonary opacities concerning for infectious or inflammatory etiologies. He was managed in the ICU with high-flow nasal cannula, diuresis, and empiric antibiotics, which were discontinued after negative infectious workup and recent antibiotic exposure. A left-sided thoracentesis was performed, removing 700 mL of clear yellow fluid, resulting in improved oxygenation and transition to low-flow oxygen, and subsequently weaned to room air. During his ICU course, he developed acute on chronic encephalopathy with episodes of unresponsiveness and hypoxia, suspected to be postictal following seizures. An interview on 12/17/2025 at 11:07 am with the Director of Health Services (DHS) confirmed that R7's NPO dietary restriction was in his care plan dated 10/16/2025, and R7's care plan was not followed as it should have been on 11/15/2025 when he was given a food tray. The DHS stated that the importance of a comprehensive care plan was to be able to identify the patient and potential negative outcomes of not following a resident's care plan could lead to poor care and medical errors. Cross Reference F689

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policies titled, admission Orders and Diet Order System, the facility failed to provide the appropriate nutritional treatment and services to prevent complications for one of four sampled residents (R) (R7), with dietary orders for nothing by mouth (NPO). Specifically, the facility failed to properly assess R7's dietary needs and clarify dietary orders on admission in addition to the facility failed to follow NPO dietary orders. This deficient practice placed R7 at risk to not receive the necessary care and services to meet nutritional needs.Findings include:Review of the facility's policy titled, admission Orders, issued 11/2002, under the section titled Policy, number one revealed, The orders must be reviewed by the admitting nurse and should at least address the patient/resident's dietary needs, medications (if applicable), and routine care to maintain or improve the patient/resident functional abilities. Number two revealed, The admitting nurse will make every effort to obtain admission orders will be made prior to the patient/resident's arrival. All hospital orders should be reviewed and authorized by the patient/resident's attending physician. It is preferred that this is also done prior to the patient/resident's admission to the healthcare center/agency and should occur no later than at the time of the admission when unable to do so in advance. If an order is illegible or needs further clarification it will be clarified at that time.Review of the facility's policy titled Diet Order System, revised 10/23/2025, under the section titled Policy Statement revealed, It is the policy of [Name] for the Dietary Department and the Nursing Department to have timely and ongoing communication to ensure each patient/resident has the correct diet order.Review of R7's Electronic Medical Record (EMR) revealed R7 was admitted to the facility on [DATE] with diagnoses that included but was not limited to pneumonia, dysphagia oropharyngeal phase, respiratory failure with hypoxia, cognitive communication deficit, generalized muscle weakness, and generalized epilepsy and epileptic syndromes.Review of R7's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Pattern) a Brief Interview for Mental Status (BIMS) score of nine, which indicated R9 had moderate cognitive impairment; Section GG (Functional Abilities and Goals) revealed, R7 required extensive assistance for activities of daily living; and Section K (Swallowing/Nutritional Status) revealed R7 had a feeding tube while a resident. Review of R7's physician's orders included but was not limited to an order dated 10/17/2025 for speech therapy for treatment for oropharyngeal dysphagia, an order dated 10/19/2025 for Levofloxacin 500 milligrams (mg) with instructions to give one tablet daily for five days, an order dated 10/21/2025 for NPO, an order dated 10/16/2025 for gastrostomy tube (G-Tube).A review of R7's EMR revealed a gastroenterology brief note dated 10/9/2025 that documented, prior to admission to the facility, R7 was brought in from his nursing facility on 9/3/2025 after being found bradycardic, hypoxic, and hypotensive. Emergency Medical Services (EMS) noted third-degree heart block, and the patient was admitted to the ICU for management of acute hypoxic respiratory failure requiring intubation, shock requiring vasopressors, and acute encephalopathy. During his ICU course, he was treated for aspiration pneumonia and Klebsiella bacteremia secondary to urinary tract infection, both of which have since resolved. The patient has experienced recurrent aspiration events throughout his hospitalization, ultimately necessitating G-tube placement for long-term nutrition. A review of R7's EMR revealed a progress note dated 10/15/2025 that documented, two ham and cheese sandwiches and ice water were provided to R7 by Licensed Practical Nurse (LPN) LPN AA.A review of R7's EMR revealed a progress note dated 10/16/2025 that documented R7 was observed with an abdominal binder and a G-tube. The Registered Dietician (RD) was notified who reviewed the G-tube orders.A review of R7's EMR revealed a Restorative Nursing Screening Tool Form dated 10/16/2025 that indicated R7's Swallowing was coded as chokes or coughs when swallowing. A review of R7's EMR revealed, a chest X-Ray dated 10/16/2025 indicated the reason for the X-ray was cough. Under the section titled Impression revealed, Probable chronic change cannot rule out developing right upper lung pneumonia.A review of R7's EMR revealed an Event Report dated 10/19/2025 revealed, pneumonia infection with an onset date of 10/17/2025. Chest X-ray demonstrating pneumonia, probable pneumonia, or new infiltrate. A review of R7's EMR revealed a progress note dated 10/21/2025 that documented that R7 continues antibiotic therapy for aspiration pneumonia and noted that R7 was still NPO and gets his medications via G-Tube.Further review of R7's physician's orders included but was not limited to an order dated 10/23/2025 to send to the emergency room for evaluation immediately, an order dated 11/8/2025 for NPO Status until Speech Therapy