STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115529	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Griffin	619 Northside Drive Griffin, GA 30223

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, resident and staff interviews, and record review, the facility failed to maintain dignity for three of 41 sampled residents (R) (R27, R21, and R20). This deficient practice had the potential to place R27, R21, and R20 at risk of a diminished quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life. Findings include: 1. Review of the medical record for R21 revealed diagnoses, including but not limited to, cerebrovascular disease, aphasia following cerebral infarction, hemiplegia following cerebrovascular disease affecting left dominant side, and dysphagia. Observation on 7/15/2025 at 12:15 pm, during dining room service for lunch, revealed that the Activities Director offered R21 two spoons of food while standing over her. She then walked away to assist other residents. 2. Review of the medical record for R27 revealed diagnoses, including but not limited to, cerebral infarction, hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominant side, aphasia, dysphagia, and dementia. Observation on 7/16/2025 at 12:45 pm, during dining room service for lunch, revealed the Activities Director feeding R27 while standing over her. Further observation revealed that, after offering R27 three spoons of food, the Activities Director stopped to assist another resident. In an interview on 7/17/2025 at 5:20 pm, the Activities Director acknowledged she should not have stood over the residents in the dining room while assisting them with their meals, and stated she should have sat down in a chair next to the resident while assisting with the meal to preserve their dignity. 3. Review of R20’s Quarterly Minimal Data Set (MDS) assessment, dated 5/26/2025, revealed that Section M (Skin Conditions) documented that R20 had a stage 4 pressure ulcer to her right hip. Observation on 7/17/2025 at 9:43 am revealed that the Wound Care Nurse (WCN) provided wound care for R20 in the resident's room, without closing the window blinds. Further observation revealed R20’s buttocks were facing the window. In an interview on 7/17/2025 at 10:20 am, the WCN confirmed she performed wound care for R20 and did not close the window blinds. She stated she should have closed the blinds.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled Oxygen Administration, the facility failed to regulate the oxygen flow meter to the ordered flow rate for one of seven residents (R) (R23) receiving continuous oxygen. This deficient practice had the potential to place R23 at increased risk of respiratory complications. Findings include:Review of the facility policy titled Oxygen Administration, dated 8/2/2023, revealed the Policy section stated, It is the policy of [name of corporation] to provide oxygen safely and accurately to appropriate patients/residents. The Procedure section included, .4. Regulate liter flow to ordered/desired rate.Review of the Significant Change Minimal Data Set (MDS), dated [DATE], revealed Section I (Active Diagnoses) documented diagnoses including, but not limited to, cerebrovascular disease, chronic obstructive pulmonary disease, and hypertension. Section O (Special Treatments, Procedures, and Programs) documented that R23 received oxygen therapy.Review of the care plan, dated 6/5/2025, for R23 revealed that R23 had impaired gas exchange that required the use of oxygen therapy, nebulizer treatment, suctioning as needed, and the head of the bed to be elevated due to shortness of breath while lying flat. Interventions included administering oxygen as ordered, observing oxygen precautions, and maintaining the resident's safety during oxygen administration. Review of the Physician Orders for R23 revealed an order dated 10/8/2024 for oxygen at 3 liters per minute (LPM) via nasal cannula (NC) continuous every shift.Observations on 7/15/2025 at 10:31 am and 11:20 am revealed R23 was receiving oxygen via a NC with the flow rate set at 2.5 LPM. In a concurrent observation and interview on 7/15/2025 at 11:21 am, Licensed Practical Nurse (LPN) EE stated R23's oxygen flow meter was set at 3 LPM. Observation revealed that LPN EE was standing upright to read the flow meter, and she stated that the flow meter should be read at eye level. LPN EE read the flow meter at eye level and confirmed the meter was not set to 3 LPM. Observation on 7/17/2025 at 9:29 am revealed that R23's oxygen flow meter was set above 3 LPM and the nasal cannula was only in place in one nostril. LPN EE confirmed the NC was only in one nostril and corrected the flow rate. In an interview on 7/17/2025 at 12:30 pm, the Director of Health Services (DHS) revealed that the nurse should check the oxygen concentrator every day and when they go into the room, and the expectation was that the nurse would ensure the NC was in the resident's nose and the oxygen was set at the ordered rate.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interviews, record review, and review of the facility policy titled, Receipt and Storage of Solutions, Medications and Supplies, the facility failed to ensure an opened multiuse medication vial was dated when opened on one of two medication carts (Cart A). In addition, the facility failed to ensure that one of two medication carts (Cart A) was maintained in a sanitary manner. These deficient practices had the potential to place the residents at risk of receiving outdated medications and medications from an unsanitary environment. Findings include:Review of the facility policy titled, Receipt and Storage of Solutions, Medications and Supplies, reviewed 7/3/2024, revealed the Policy Statement stated, Solutions and or medications and ancillary supplies must be stored appropriately prior to administration of infusion therapy.During concurrent observation and interview on 7/16/2025 at 12:28 pm of medication Cart A, observation revealed one opened multiuse vial of lidocaine (a medication used to numb skin or tissue) without an opened date. Further observation revealed a brown substance on two of the medication cart drawers. In an interview, Licensed Practical Nurse (LPN) JJ confirmed the open vial of lidocaine was not labeled with an open date and stated she was unsure when the vial was opened or when it should be discarded. LPN JJ confirmed the brown substance on the cart drawers and stated she may have spilled a protein drink on the cart.In an interview on 7/16/2025 at 2:17 pm, the Unit Manager revealed that opened medication vials were good for 28 days, except for some insulins, and the expectation was for an opened medication vial to be labeled with an opened or discard date.In an interview on 7/16/2025 at 2:34 pm, the Pharmacy Consult revealed that he did not remember a vial of lidocaine on the cart during his rounding on 7/15/2025. He stated he was unsure how long the vial was good after opening. He further stated that his job was to evaluate the cart for any expired medications.