STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115608	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Ocilla	209 West Hudson Street Ocilla, GA 31774

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of the facility's policy titled Specialty Services: Dental Services, Vision, the facility failed to ensure that Activities of Daily Living (ADL) care services were provided for five of 33 sampled residents (R) R60, R31, R28, R41, and R36 related to nail care. Findings include: Review of the facility's policy titled Specialty Services :Dental Services, Vision, dated 9/5/2025 revealed, It shall be the responsibility of this healthcare center to obtain regular and emergency specialty services for each patient /resident to ensure the highest well-being of the residents. The healthcare center has specialty service providers who provides consultation , participates in Inservice education , and is available in case of emergency. Specialty Services include, but not limited to: Dental Services, Vision Services, Podiatry Services, Hearing Services, and Mental Health. 1. Review of R60's Electronic Health Record (EHR) revealed the following diagnoses that included but not limited to paraplegia and traumatic brain injury. Review of the admission Minimum Data Set (MDS) assessment for R60 dated 5/25/2025 for Section C (Cognitive Patterns) revealed, a Brief Interview Mental Status Score (BIMS) score of 99 which indicated severe cognitive impairments. Section GG (Functional Abilities and Goals) revealed that Review of R60's physician order dated 9/27/2022 revealed, an order that read, Podiatry /dental/ophthalmic care as needed. Observations on 9/16/2025 at 10:00 am and at 11:00 am revealed R60 lying in bed in a fetal position. R60's fingernails and toenails were extremely long, jagged, untrimmed and dirty with a brown substance under the nails and around the cuticles During an observation and interview on 9/16/2025 at 1:00 pm with Certified Nursing Assistant (CNA) GG and Wound Care Nurse Licensed Practical Nurse (LPN) GG, both confirmed that R60's nails were long, dirty, and required trimming. Both staff described the dark substances and discoloration as dirt. Review of R60's ADL care plan dated 9/27/2022 revealed a focus area intervention for nail care services. The intervention. stated shampoo/nail care as needed. Review of the Podiatrist onsite scheduled visit to the facility revealed the following onsite dates as 6/4/2025 and 7/10/2025 however there was no evidence that R60 received nail care services during on these visits. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Health Services (DHS) on 9/17/2025 at 4:09 am, the DHS confirmed that the podiatrist was in the building on the following dates. The DHS confirmed that R60 was not seen by the podiatrist by error. She reported that R60's nails should have been addressed during bathing. She reported that her expectations are for the certified nursing assistant to report any nail care needs. 2. Review of R31's Annual MDS assessment dated [DATE] for Section C (Cognitive Patterns) revealed, a BIMS score of 12 which indicated moderate cognitive impairment. Section GG (Functional Abilities and Goals) revealed, R31 was dependent for toileting and moderate assistance for personal hygiene and lower body dressing, shower/bathe. Review of the care plan for R31, dated 8/8/2025 revealed that R31 had a potential for ADL decline related to a history of cerebral infarction. Interventions included but not limited to: check nails, ensure they are clean, and provide assistance when needed. An observation on 9/16/2025 at 9:38 am revealed that R31 had long, brown finger nails. An observation and interview on 9/17/2025 at 8:06 am revealed, R31 had long, brown fingernails. R31 revealed that she did not want her nails that long. An observation and interview on 9/17/2025 at 1:50 pm with Certified Nursing Assistant (CNA) EE in room [ROOM NUMBER] revealed, she was trimming nails for the resident in bed B. She revealed that she just trimmed R31 nails (after the discovery). She further revealed that she was just given nail clippers and a list of residents that fingernails needed to be cut. The list included the two residents (R31 and her roommate). She denied knowing the policy around cutting fingernails nor had she received training from the facility and that the CNA's do not usually cut nails. CNA EE revealed that they would tell the nurse instead. CNA EE revealed that it had been months since the residents' nails were cut. 3. A review of R28's Quarterly MDS dated [DATE] for Section C (Cognitive Patterns) revealed that R28 had a BIMS score of 11 which indicated moderate cognitive impairment. Section I (Active Diagnoses) revealed diagnoses that included but not limited to Alzheimer's disease, chronic obstructive pulmonary disease, dysphagia, and muscle weakness. Section GG (Functional Abilities) revealed that the resident required moderate assistance with personal hygiene and upper body dressing and maximal assistance with showering/bathing, and lower body dressing. A review of the care plan for R28 dated 8/14/2025 revealed that R28 had a potential for ADL decline related to hip fracture. Interventions included but not limited to: setting up resident for ADLs. An observation and interview on 9/16/2025 at 9:50 am with R28 revealed that the resident had long fingernails. R28 revealed that she would like to have them cut. She revealed that the podiatrist cuts toenails, but no one cuts fingernails. She revealed that she had an ingrown toenail that had not been addressed. An observation and interview on 9/17/2025 at 9:19 am revealed R28 fingernails remained long and had not been addressed. R28 revealed that someone worked on her toenails last night. An interview and observation with the DHS on 9/17/2025 at 2:10 pm revealed R28's fingernails that were observed to be long and dirty nails was not acceptable. The DHS further revealed that residents (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be receiving routine nail care on bath days and that all CNAs received education on nail care and trimming. The DHS revealed that the expectation was that CNA's and nurses will follow the care plan. An interview with Clinical Competency Coordinator (CCC) on 9/18/2025 at 11:16 am revealed that CNA's receive education at hire, annual competency, and monthly through a computer education program. The education includes nail care training, and it was a part of the CNA's school training program. The CCC expectation was that CNA's will provide nail care to residents. 4. A review of the EHR revealed that R41 was admitted to the facility with diagnoses that included but not limited to type 2 diabetes mellitus, generalized muscle weakness, and cognitive communication deficit. Review of podiatry visits documents revealed R41 was seen on 7/14/2024, 9/19/2024, 11/27/2024, and 4/24/2025. There was no documentation of any additional visits. A review of the significant change MDS assessment dated [DATE] for Section C (Cognitive Patterns) revealed a BIMS score of 11, which indicated moderate cognitive impairment, Section GG (Functional Abilities and Goals) revealed that the resident was dependent on staff for personal hygiene care. Observation on 9/16/2025 at 10:49 am revealed R41's toenails were long, thick and yellow with a yellowish/brownish substance underneath them. Observation and interview with R41 on 9/17/2025 at 9:10 am revealed the resident's toenails long, thick, and yellow with a yellowish/brownish substance underneath them and not trimmed. R41 was asked about his toenails but did not appear to understand the question as he was not providing an answer to address the question. Observation of R41 on 9/18/2025 at 9:30 am revealed, R41 was lying in bed with his feet uncovered and his toenails were noted to be long, thick, yellow with a yellowish/brownish substance underneath and not trimmed. Observation and interview on 9/17/2025 at 2:10 pm with the DHS confirmed R41's toenails were long and dirty with a yellowish/brownish substance underneath them. She revealed that resident's nails should be trimmed by a CNA if they were not diabetic, otherwise they must be trimmed by a nurse. She revealed residents' nails should be cleaned and trimmed during bath or as needed. The DHS revealed that staff should document each time nail care was provided and also document refusals. She confirmed that all resident's should have ADL care plan as that was how staff know what interventions need to be implemented. DHS stated she was going to look for the resident's ADL care plan and get back to surveyor. When asked who completed care plans, DHS revealed that prior to coming to this facility she completed care plans so she has been updating them. Later when interviewed she confirmed that ADL care plans were present but older plans did not address specific ADL needs such as nail care and bathing but current plans do. Upon entering R41's room and observing the toenails, DHS stated that R41 may be receiving podiatry care for toenail trimming. DHS also confirmed that the resident's toenails were very long and discolored and should be receiving care to address the toenails. She confirmed that the care plan for R41 was not being implemented as there had been a failure to address nail care that was a part of personal hygiene. Interview with the DHS on 9/18/2025 at 10:10 am revealed that nail care was one of the competencies (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the nursing staff orientation, so staff was aware that nail care is a required care area for each resident. The DHS provided a copy of the CNA's complete orientation check list and Partner Orientation Checklist which listed nail care. The DHS revealed, it is her expectation that nail care, cleaning of the nails and trimming if residents were not receiving podiatry care needs to be done on bath days or upon request from residents. 5. A review of the EMR revealed that R36 was admitted to the facility with diagnoses that included but not limited to major depressive disorder, recurrent, severe with psychotic symptoms and unspecified dementia, unspecified severity, with other behavioral disturbance, and generalized weakness. A review of the quarterly MDS assessment dated [DATE] for Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of seven, which indicated severe cognitive impairment and Section GG (Functional Abilities and Goals) revealed the resident was dependent on staff for personal hygiene care. A review of the care plan dated 9/4/2025 revealed an intervention that included but not limited to staff to set up resident for ADLs. Observation and interview on 9/16/2025 at 9:40 am with R36 revealed his fingernails were long with a brown and yellow substance underneath them. R36 revealed his fingernails needed to be trimmed and cleaned. Observation and interview on 9/17/2025 at 1:00 pm with R36 revealed his fingernails were long with a brown and yellow substance underneath them. R36 revealed he would like his fingernails to be trimmed and cleaned. Observation and interview on 9/17/2025 at 2:10 pm with the DHS confirmed the resident's nails were long and dirty with a yellow-brown substance. The DHS confirmed that all residents have an activity of daily living (ADL) care plan, as that was how staff know what interventions need to be implemented. She confirmed that the care plan for R36 was not being implemented by failure to address personal hygiene including nail care. Interview on 9/17/2025 at 2:15 pm with CNA BB revealed that he cleans nails when giving a resident a bath. CNA BB revealed, he would only trim a resident's nails if they were not diabetic and if resident allowed him to do so. He stated he doesn't normally care for R36 but that he was going to give the resident a bath and provide nail care since the resident's nails were soiled and long. Cross Reference F656

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of facility's policy titled Enteral Nutrition (Tube Feedings), the facility failed to follow physician orders and professional standards of care for one of four residents (R) R31 that received enteral feedings. This deficient practice had the potential to place R31 at increased risk of complications and adverse clinical outcomes. Findings include:Review of the facility policy titled Enteral Nutrition (Tube Feedings), with a review date of 9/12/2024 revealed: 2. The Physician will write orders prescribing formula, rate, route of administration, and flush orders for individual patient/residents. Review of the Annual Minimal Data Set (MDS) for R31, dated 8/8/2025 revealed that Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Section I (Active Diagnoses) diagnoses included, but not limited to: type 2 diabetes, cerebral infarction, congenital stenosis and stricture of esophagus, gastrostomy tube, chronic nausea and vomiting, and dysphagia.Review of the care plan for R31, dated 8/8/2025 revealed, R31 needed tube feedings related to her diagnosis of congenital stenosis and stricture of esophagus. The goal was to maintain nutritional stability via enteral tube feeding. Interventions included: flush as ordered, follow enhanced barrier precautions, treatment as ordered by medical doctor, and tube feedings as ordered.Review of the Physician Orders for R31 dated 8/6/2024 revealed, gastrostomy tube (G-tube) residuals are checked before feeding and if residual is greater than 100 milliliters (ML) then hold the feeding and call the medical doctor for further orders every shift; check placement prior to med administration/flushes every shift; and formula [name] via G-tube bolus 237ML after meals and bedtime (four times a day.) Special instruction orders included: flush with 200ML water after each feeding, after every meal and at bedtime. Observation of R31 enteral feeding process on 9/17/2025 at 8:06 am revealed, Licensed Practical Nurse (LPN) CC dressed out in gown and gloves. LPN CC did not check placement or residual prior to connecting the large syringe used for bolus administration of formula. LPN CC flushed with cold water poured into a drinking cup from her medication cart water pitcher. She poured the water into the large syringe up to the 60ML measurement line on the side of the syringe and then poured the remaining water from the cup up to 50ML measurement line. LPN CC disconnected the syringe. R31 immediately vomited but declined nausea medication offered by the nurse.Interview with LPN CC on 9/18/2025 at 8:30 am confirmed, LPN CC did not check residuals or placement and did not measure the water. She also confirmed that she did not flush with 200ML of water as ordered by the physician. She states she has received an in-service on tube feedings. Interview with Assisted Director of Health Services (ADHS) on 9/18/2025 at 10:09 am revealed, the enteral tube feeding process includes the nurse gathering supplies, follows enhanced barrier precautions and sets up their supplies in a clean manner. The nurse checks residuals, administers the formula and flush per the physician orders.Interview with the Director of Health Services (DHS) on 9/18/2025 at 10:39 am revealed, the expectation is that nurses' follow policy. They are expected to complete the task as ordered by the physician. Nurses receive education and annual competency for enteral tube feedings.

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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, and the facility's policy, Infection Control-Dining Services, the facility failed to ensure that staff used proper hand sanitation methods during one of two meal observations. This deficient practice had the potential to affect the 10 residents dining and contribute to the potential spread of infectious disease.Findings include:Review of the facility policy titled Infection Control-Dining Services with a review date of 11/30/2023 revealed, 2. All partners will wash their hands just before they start to work in the kitchen and when they have used their hand in an unsanitary way such as smoking, sneezing, using the restroom, handling poisonous compounds, dirty dishes or handling patients/residents.Observation on 9/17/2025 at 12:31 pm revealed, Certified Nursing Assistant (CNA) EE passing out food trays to 10 residents in the dining hall area. She passed out food trays without sanitizing her hands. She then assisted one resident by adjusting her positioning. CNA EE touched the resident's arms, shoulders, and her seat. CNA EE did not sanitize her hands before passing more additional food trays. Interview on 9/17/2025 at 12:35 with CNA EE confirmed, she did not sanitize her hands before passing food trays, between passing food trays, or after touching the resident with positioning assistance. CNA EE stated she is supposed to sanitize her hands before and between passing food trays and anytime she touches a resident.Interview on 9/18/2025 at 9:13 am with the Administrator revealed, all staff should be sanitizing their hands between passing food trays. They receive training on infection control at least monthly.Interview on 9/18/2025 at 2:05 pm with the Infection Preventionist revealed, it is her expectation that staff sanitize the hands of residents and their own hands before food trays are passed and between passing each food tray. She stated staff receive training monthly on infection control practices.