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	02/25/2024

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 39844 Based on observations, record review, resident and staff interviews and review of the facility policy titled, Grievances: Healthcare Centers, the facility failed to ensure resident grievances were addressed for residents attending the Resident Council Meetings and grievances filed through the facility grievance process. The facility census was 51 residents. Findings include: Review of the facility policy titled Grievances: Healthcare Centers reviewed/revised 1/10/2024 revealed: It is the policy . to follow an established process whereby patients and/or other customers may have their grievances and complaints resolved in a prompt, reasonable, and consistent manner. All partners should take an active part in efforts to resolve grievances and complaints without discrimination or retaliation against a person filing a grievance or complaint. The Administrator of each healthcare center serves as its grievance official and is responsible for the following: overseeing the grievance process, receiving, and tracking grievances through the conclusion; leading necessary investigations; .issuing written grievances decisions to the person who filed the grievance, and coordinating with the state and federal agencies as necessary in light of specific allegations. 5. The grievance/complaint should be resolved in three business days. Review of the grievances revealed: 2/15/2023 Date Administrator/designee received grievance: 2/15/2023 related to missing money steps to investigation. No Summary. Not signed by the investigator. Not signed by Administrator. Not signed by staff who informed the person filing the grievance. Unknown if the person filing grievance was informed of results. 4/4/2023 Date Administrator/designee received grievance: Related to missing clothes-No second page. 4/16/2023 Date Administrator/designee received grievance: 4/16/2023 related to damaged clothes-No second page. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/9/2023 Filed by Activity Director on 8/9/2023. Date Administrator/designee received grievance: 8/9/2023 related to residents wanting to go shopping-No steps to investigation. Summary completed. Not signed by the investigator. Not signed by Administrator. Not signed by staff who informed the person filing the grievance. Unknown if the person filing grievance was informed of results. 8/9/2023 Filed by Activity Director on 8/9/2023. Date Administrator/designee received grievance: 8/9/2023 related to residents want personal menus with alternatives-No steps to investigation. Summary completed. Not signed by the investigator. Not signed by Administrator. Not signed by staff who informed the person filing the grievance. Unknown if the person filing grievance was informed of results. 1/29/2024 Date Administrator/designee received grievance: 1/29/2024 related to residents' desire to have church services again-No steps to the investigation. Summary completed. Not signed by Administrator. Not signed by staff who informed the person filing the grievance. Unknown if the person filing grievance was informed of results. 2/14/2024 Filed by the Activity Director related to a resident wants to talk to the Administrator. Date Administrator/designee received grievance: 2/14/2024. No steps to investigate. Summary completed. Not signed by Administrator. Not signed by staff who informed person filing the grievance. Unknown if the person filing grievance was informed of results. Interview on 2/24/2024 at 9:42 am with Activity Director (AD) revealed they have a meeting every month. The Ombudsman comes to the meetings every so often. Concerns are written on a grievance form and given to the appropriate department manager. The department manager will then investigate and meet with the resident with a resolution. All grievances are talked about in morning meetings and during the monthly Quality Assurance meeting. Interview on 2/25/2024 at 9:10 am with Administrator revealed the process for receiving a grievance is that anyone can write up a grievance. The grievance is then given to the department manager of the area of concern. The manager will investigate the grievance and get with the resident when an attempt to resolve the issue. They discuss each grievance every Friday during the Interdisciplinary Team (IDT) meeting. The Administrator stated he would sign the grievance only when the grievance is resolved. He indicated he has not been getting the grievances from the Resident Council meeting concerns. Interview on 2/25/2024 at 9:31 am with AD, revealed she has not been trained on taking a grievance. She indicated she has overlooked the grievance related to resident requesting to see the Administrator. The Administrator was not aware of the grievance. The AD indicated she informed the Unit Manager (UM). An interview with the UM revealed she was unaware of the grievance that a resident requested to see the Administrator. Interview on 2/25/2024 at 9:41 am with Social Services Director (SSD) revealed she is responsible for the grievance process. The SSD stated she reviews the grievances daily and discuss on them Fridays during the IDT meeting. The previous Administrator was in charge before the current Administrator. She indicated the grievance related to a resident wanting to talk to the Administrator was not given to her.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39844 Based on observations and staff interviews the facility failed to ensure residents' furniture was in good and functional condition related to one broken dresser drawer. The facility failed to ensure that it was maintained in a safe, clean and comfortable home-like environment in three of 13 rooms related to missing base boards, a hole in a closet door, and dust buildup on the filters of two packaged terminal air conditioner (PTAC) units. Finding include: Initial environmental observation rounds on 2/23/2024 starting at 8:31 am revealed: room [ROOM NUMBER]-PTAC unit noted with dust buildup on the filter. A 3-inch hole near the base on A bed closet door. Missing base board behind B bed and loose base board by bathroom door. room [ROOM NUMBER]-PTAC unit noted with dust buildup on the filter. room [ROOM NUMBER] shared dresser was missing the 3rd drawer front. Observation on 2/24/2024 at 9:00 am revealed: room [ROOM NUMBER]-PTAC unit noted with dust buildup on the filter. A 3-inch hole near the base on A bed closet door. Missing base board behind B bed and loose base board by bathroom door. room [ROOM NUMBER]-PTAC unit noted with dust buildup on the filter. room [ROOM NUMBER] shared dresser was missing the 3rd drawer front. Observation and interview on 2/24/2024 at 1:05 pm with the Maintenance Director (MD) revealed he does not have a schedule to clean the PTAC unit filters. He agreed both filters observed needed to be cleaned. The MD stated he was unaware of the loose baseboard and would need to order more baseboards. He was unaware of the missing drawer and the hole in the closet door. The MD further revealed staff should report any concerns in the electronic reporting system. He does not recall receiving any of the observed concerns in the system, and they do not have a maintenance book. He further indicated he does not have a policy on maintenance. Interview on 2/24/2024 at 1:12 pm with Unit Manager (UM) revealed whenever any staff member finds a concern related to a maintenance concern, it should be reported in the electronic reporting system. Interview on 2/25/2024 at 8:59 am with Administrator revealed any staff member in any department can put a maintenance concern into the electronic reporting system. He indicated instructions on how to put a concern into the electronic reporting system are posted at the nurse's desk. The Administrator stated the MD should be looking at the requests daily. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated document titled How to Enter a Work Order-Matrix Care revealed a step-by-step procedure for putting in a work order. The document was posted in view behind the nurse's desk.

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42464 Based on record review, staff interviews, and a review of facility policy titled MDS Assessment Accuracy, the facility failed to complete a Quarterly Minimum Data Set (MDS) Assessment not less than every three months for three of 36 residents (R) (2, 21, and 43) of 36 sampled residents. Findings include: A review of facility policy titled 'MDS Assessment Accuracy' last revised 12/6/22 revealed: 'Procedure 2. ARDs (assessment reference dates) will be set as follows: .Quarterly Assessment (Non-Comprehensive) ARD must be no later than 92 calendar days from the previous OBRA Assessment of any type. Record review of MDS Assessments for R2 revealed that a Quarterly MDS Assessment was completed on 10/1/2023. No other assessments were completed after that date. Record review of MDS assessments for R21 revealed a Quarterly MDS dated [DATE] was started but not completed. R21 had a previous Quarterly MDS assessment completed on 10/13/2023. Record review of MDS assessments for R43 revealed a Quarterly MDS dated [DATE] was started but not completed. R43 had a previous Quarterly MDS assessment completed on 10/24/2023. Interview on 2/24/2024 at 9:10 am with the MDS coordinator revealed that R2 had not had an MDS assessment since 10/1/2023 because she had not had time to complete one. The MDS coordinator further revealed she had started MDS assessments on R21 and R43 but had not had the opportunity to complete them because of other job duties. Interview on 2/24/2024 at 9:15 am with the Administrator revealed that he expects MDS assessments to be completed in a timely manner.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42464 Based on record review and staff interviews, the facility failed to ensure that the Minimum Data Set (MDS) assessments were transmitted within 14 days of completion of to CMS's (Centers for Medicare and Medicaid Services) Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for eight residents (R) (24, 29, 23, 35, 1, 12, 7, and 18) of 35 sampled residents. Findings include: 1. A review of R24 MDS list revealed a Quarterly MDS dated [DATE]. Further review revealed the MDS was completed but not transmitted. 2. A review of R29 MDS list revealed a Significant Change MDS dated [DATE]. Further review revealed that the MDS was completed but not transmitted. 3. A review of R23 MDS list revealed an Annual MDS dated [DATE]. Further review revealed that the MDS was completed but not transmitted. 4. A review of R35 MDS list revealed a Significant Change MDS dated [DATE]. Further review revealed that the MDS was completed but not transmitted. 5. A review of R1 MDS list revealed a Quarterly MDS dated [DATE]. Further review revealed that the MDS was completed but not transmitted. 6. A review of R12 MDS list revealed a Quarterly MDS dated [DATE]. Further review revealed that the MDS was completed but not transmitted. 7. A review of R7 MDS list revealed an Annual MDS dated [DATE]. Further review revealed that the MDS was completed but not transmitted. 8. A review of R18 MDS list revealed a Quarterly MDS dated [DATE]. Further review revealed that the MDS was completed but not transmitted. An interview with the MDS coordinator on 2/24/2024 at 9:10 am revealed that R24, R29, R23, R35, R1, R12, R7, and R18 have not been submitted because they are awaiting a Registered Nurse (RN) signature. She stated that the MDS assessments were late and should have been submitted within 14 days of completion. Interview on 2/24/2024 at 9:15 am with the Administrator revealed he was unaware of MDS's being late. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	An interview with the Regional [NAME] President on 2/24/2024 at 9:16 am revealed that there is an MDS corporate 'floater' who is available for any facility that needs assistance with MDS completion. He revealed that he would expect the MDS Coordinator to reach out to the floater to assist as needed so MDS assessments can be completed on time. An interview with the Director of Health Services on 2/25/2024 at 8:45 am revealed that she was unaware that MDSs were behind or late. She stated that she does not keep up with MDSs because the MDS coordinator has a consultant she can reach out to who also signs off on the MDS assessments.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42464 Based on record review, staff interviews, and a review of the facility policy titled Admission Policy for Healthcare Centers, the facility failed to ensure that one of 36 residents (R) (50) sampled with a mental illness had a Level I Pre-admission Screening and Record Review completed prior to admission to determine the need for specialized services. Findings include: A review of the facility policy 'Admission Policy for Healthcare Centers' last revised 1/4/2021 revealed: 'Collection of Paperwork-Prior to admission, the Admissions Director will obtain the following information and upload it to (name of electronic medical records). The upload will include all verification and be available for the financial counselor to validate the secured payment source: Copy of state specific PASSAR FORM.' R50 was admitted to the facility on [DATE] with diagnoses including but not limited to moderate intellectual disabilities, anxiety disorder, and schizophrenia. A record review of the Admission Minimum Data Set (MDS) revealed a Brief Interview for a Mental Status score of 99 out of 15, indicating a severe cognitive decline. Record review of R50 Electronic Medical Record (EMR) revealed no Level I PASARR screening. In an interview on 2/25/2024 at 8:50 am, the Social Worker stated she was unsure if the resident had a level I or II PASARR. She further revealed that the resident was admitted from a group home setting, and they have requested the information from the group home, but she has not submitted one. Interview on 2/25/2024 at 9:05 am with the Admissions Director revealed she did R50's admission paperwork and did not recall if the resident had a level I or II PASARR. Interview on 2/25/2024 at 9:33 am with the Administrator stated all residents should have a level I PASARR completed on admission or within 30 days of admission. The Administrator confirmed R50 did not have a level I PASARR completed prior to admission or within 30 days of admission. A follow-up interview with the Admissions Director on 2/25/2024 at 10:25 am revealed that she is responsible for ensuring residents have a level I PASARR when admitted . She stated she did not submit a PASARR for R50 because she did not know she was supposed to.

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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. 45813 Based on observation, staff interview, record review, and a review of the facility policy titled, Care Plans, the facility failed to follow a care plan for one of five residents (R) (28) reviewed for unnecessary medications. The deficient practice had the potential to cause R28 to not receive treatment and/or care according to their needs. Findings include: A review of the facility policy titled, Care Plan, with a revision date of 7/27/2023, revealed under Admission Comprehensive Plan of Care: 4. The care plan approach serves as instructions for the patient/resident's care plan and provides continuity of care by all partners. Short and concise instructions, which can be understood by all partners, should be written and have a relationship to the problem and goal (s). Record review of the care plan for R28 revealed the resident had a plan of care developed for psychotropic drug use - resident receives antianxiety (Buspirone) medication due to a diagnosis of Anxiety. A review of the care plan interventions included attempting a gradual dose reduction if/as indicated. Record review of the Physician Order Report for R28 dated 1/24/2024 through 2/24/2024 indicated buspirone tablet 10 milligrams (mg) (a medication used to treat anxiety) one tablet by mouth twice a day was started on 9/21/2023 and had a discontinued date of 1/24/2024 (discharged to the hospital). Buspirone tablet 10 mg twice daily was restarted on 1/25/2024 upon readmission to the facility and discontinued on 2/19/2024 (discharged to the hospital). Further review of the physician orders revealed buspirone 10 mg twice daily was restarted on 2/19/2024 when the resident returned to the facility. Interview on 2/25/2024 at 9:25 am with Director of Health Services (DHS) revealed that care plans are implemented according to the care needs of the residents. She further stated that it is her expectation that the staff follow the plan of care implemented for the resident. DHS further stated that if the gradual dose reduction (GDR) was not implemented as ordered by the physician the care plan was not being followed. Interview on 2/25/2024 at 9:38 am with the Minimum Data Set (MDS) Coordinator revealed that the care plan was implemented according to the residents' care area needs. She verified the verbiage on the care plan and stated if the physician wanted the dose reduction of the antianxiety medication and the nurses did not implement the orders the care plan was not being followed. She also stated that the care plan is a working one, and the nurses have access to the care plans. Cross reference F758

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42463 Based on staff interviews, record review, and review of the facility's policy titled Physician Orders, the facility failed to follow physician orders for one of 36 sampled Residents (R) (R154). Specifically, the facility failed to transcribe the correct doses of Eliquis (a medication to treat and prevent blood clots) into the Electronic Medical Record (EMR) system and administer the medication as ordered. Findings include: Review of the facility's policy titled, Physician Order dated 7/19/2023 under the Policy Statement revealed Physician orders must be completed and legible when written by the physician, physician extender or transcribed by the licensed professional. Written orders for medications may be transcribed by a licensed professional nurse or licensed pharmacist. Faxed orders are considered to be original physician's orders. Under the section titled, Written Orders revealed 3. Any dose or order that appears to be inappropriate due to patient/resident's age, condition, or diagnosis should be verified with the attending physician and Medical Director if necessary. Review of the Face Sheet located in the EMR for R154, revealed she admitted on [DATE] with diagnoses that included pulmonary embolism with acute cor pulmonale, lobar pneumonia, Wernicke's encephalopathy, hypertension, and hyperlipidemia. Record review of the most recent Admission Minimum Data Set (MDS) for R154 dated 10/21/2023 revealed Section C: Cognitive Patterns, a Brief Interview of Mental Status (BIMS) score of 15, which indicated she had intact cognition; Section N: Medications, indicated she was taking an anticoagulant medication during the last seven days or since admission/entry or reentry if less than seven days. Review of the hospital records titled, After Visit Summary for R154, dated 10/17/2023 revealed she was hospitalized from 9/20/2023 through 10/17/2023 for blood clots in lungs. Further review of the hospital records revealed discharge orders for Eliquis (apixaban) 5 (five) mg (milligrams); oral every 12 Hours for 321 doses. Review of Prescription Order for R154 revealed Eliquis (apixaban) tablet; five (5) milligram (mg) oral every 12 hours times two (x 2) to be given at 9:00 am and 9:00 pm with start date of 10/17/2023 and end date 10/17/2023. The order was created and verified by the Director of Health Services (DHS) on 10/17/2023 and signed by the Medical Director (MD) on 10/20/2023. Record review of the Medication Administration Record (MAR) for R154 dated 10/1/2023 through 10/31/2023 revealed Eliquis (apixaban) 5 mg; oral Every 12 Hours (x 2) had been signed as administered on 10/17/2023 for one dose. The MAR did not indicate Eliquis had been administered on any other days. Record review of the MAR for 154 dated 11/1/2023 through 11/30/2023 revealed there were no orders to administer Eliquis (apixaban) 5 mg. Review of R154's Transition of Care/Discharge Summary revealed she was discharged from the facility to home on 11/4/2023 and did not include the medication orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physician Order Report 10/17/2023 through 2/24/2023 revealed start date and end date of 10/17/2023 for Eliquis (apixaban) 5 mg; oral Every 12 Hours (x2); 9:00 am, 9:00 pm. Interview on 2/25/2024 at 8:25 am with the Director Health Service (DHS) revealed when asked about the process for medication reconciliation when transcribing new admission orders into the EMR, DHS reported the charge nurses were responsible for transcribing new admission orders in the system when residents are admitted into the facility. DHS reported that she, the Assistant Director of Health Services (ADHS), or the Unit Manager (UM) would complete a 24-hour chart check to verify orders were correct and completed. She reported the Medical Director would review the orders within 24 hours after the resident's admission. DHS reported the Pharmacy would further review the orders once transcribed into the system and compare them to the hospital orders that are uploaded in the system for any discrepancy before sending the medications to the facility. She reported if the pharmacy identified any discrepancies, they would alert the facility and would not send medication. DHS verified the hospital discharge orders for Eliquis 5mg every 12 hours for 321 doses and the facility's admission orders for Eliquis 5mg every 12 hours with a start and end date of 10/17/2023 x 2. She confirmed there was a discrepancy with the medication order. DHS verified the Transition of Care/Discharge Summary and R154's Physician Order Report that was sent with R154 when she was discharged home did not include orders for Eliquis. DHS stated her expectations for all nurses were to accurately transcribe orders into the system as ordered by the physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45813 Based on staff interviews, record review, and review of the facility policy titled Monitoring of Antipsychotics, the facility failed to ensure one of five residents (R) (28) reviewed for unnecessary medications received medications as ordered. Specifically, the facility failed to decrease the dose of buspirone (an antianxiety medication) for R28 as ordered by the physician. Findings include: A review of facility policy titled Monitoring of Antipsychotics, revised 7/20/2020 revealed the Policy Statement: Patients/residents receive antipsychotic medications only when medically necessary. Every effort is made for patients/residents who use antipsychotics to receive the intended benefit of the medications and to minimize the unwanted effects of the antipsychotic medications. The Procedure section line numbered 6 stated: Gradual dose reduction is attempted with all patients/residents who receive antipsychotic medications. A review of R28's Face Sheet revealed the resident was admitted to the facility with a diagnosis including anxiety disorder and major depressive disorder. Record review of the Physician Order Report for R28 dated 1/24/2024 through 2/24/2024 indicated buspirone tablet 10 milligrams (mg) (a medication used to treat anxiety) one tablet by mouth twice a day was started on 9/21/2023 and had a discontinued date of 1/24/2024 (discharged to the hospital). Buspirone tablet 10 mg twice daily was restarted on 1/25/2024 upon readmission to the facility and discontinued on 2/19/2024 (discharged to the hospital). Further review of the physician orders revealed buspirone 10 mg twice daily was restarted on 2/19/2024 when the resident returned to the facility. A review of a Consultant Pharmacist Communication to Physician document for R28 dated 10/4/2023 revealed a recommendation for anxiolytic drug evaluation per CMS guidelines pertaining to use in the elderly. Please consider a trail reduction to Buspirone 5 mg twice a day. Further review of the recommendation revealed the facility's physician wrote an order for dose reduction to decrease buspirone (a brand name for Buspar) to 5 milligrams twice daily. This order was dated 10/6/2023. A review of the _____ Psychiatry Follow Up note with a date of service of 12/27/2023 revealed a list of R28's current medications to include Buspar 10 mg 1 tablet twice daily. Further review of the report revealed a recommendation/plan to discontinue Buspar and start Vistaril 25 mg twice daily for anxiety. Record review of the Electronic Medication Administration Record (eMAR) for October 2023 through February 24, 2024, revealed that R28 received buspirone 10 mg tablet twice daily at 9:00 am and 9:00 pm every day. A further view of the eMAR revealed that Vistaril was not started. A review of the progress notes revealed no documentation related to notifying the physician of the recommendation made by the behavioral service geriatric Nurse Practitioner. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/24/2024 at 1:12 pm with Licensed Practical Nurse (LPN) Unit Manager (UM) EE revealed that she, along with other nurses, are responsible for following up on pharmacy recommendations once they are signed by the physician. LPN UM EE further stated that if medications change, the changes are entered into the EMR, and the resident and/or responsible party are informed of the medication changes. Interview on 2/24/2024 at 1:24 pm with Assistant Director of Health Services (ADHS) revealed once the pharmacy recommendations are received, if the physician is not at the facility, the recommendations are hand delivered to his office for review. If the physician agrees with the pharmacist's recommendations, he will mark that on the form, the nurses enter the new order into the EMR and discontinue the old order if applicable. The recommendation is then uploaded into the EMR. She further stated this process at the facility had not changed. Interview 2/24/2024 at 1:36 pm with Director of Health Services (DHS) verified the physician agreed to decrease Buspirone to 5 mg on 10/6/2023 for R28. DHS also verified that the behavioral service Nurse Practitioner gave recommendations to discontinue the Buspirone and start Vistaril. DHS further revealed the order change was not made in the EMR. DHS also verified that the recommendation from the behavioral service was not followed up on. DHS stated that the order dated 4/2023 was not discontinued until 1/25/2024, when R28 was discharged to the hospital. DHS stated the change should have been made but the process was not followed. DHS further stated that she expected the physician's orders to be carried out and followed. She further stated she holds a clinical meeting daily to check on these things, and that she is overall responsible for ensuring compliance. Cross-reference F656

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44959 Based on observation, staff interview, and record review, the facility failed to ensure staff followed recipes for preparing pureed meals to avoid compromising the nutritive value of food items served to residents on a pureed diet when compared with items served to residents on a regular diet for seven of 55 residents receiving a pureed diet. Findings Include: Review of the lunch menu for 2/23/2024 revealed items which included baked lasagna, mashed potato Garlic bread and brownie. Observation on 2/23/2024 at 12:00 pm with the Dietary Manager (DM) of pureed food items revealed DM placing approximately 8oz (ounces) of lasagna and three slices of bread for seven residents into the food processor. The DM then placed an unmeasured amount of hot water she got from the sink into the food processor. She turned on the food processor. After approximately 30 seconds, the dietary manager checked the consistency of the bread/lasagna and added more unmeasured amount of water into the processor. She then turned on the food processor for approximately one minute and then placed the mixture in a pan to be placed on the steam table. Interview on 2/23/2024 at 12:15 pm with DM revealed that she does not have a recipe book, and just knows how much liquid to add to the puree. The DM stated that moving forward, she plans to follow the recipe book. Telephone Interview on 2/23/2024 at 12:23 pm with Registered Dietitian (RD) revealed that the facility should have a recipe book for lasagna puree and should not use water and bread to puree lasagna. Review of the recipe for puree lasagna provided by the facility revealed puree beef lasagna servings 25, portion 6 oz, procedure - measure amount of beef lasagna per recipe and place in the food processor, puree the beef lasagna until the consistency is pureed. The procedure did not indicate using bread, water, or any liquid.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44959 Based on observations, staff interviews, and a review of the facility policy titled, Cleaning Procedure: Kitchen Area, the facility failed to ensure the exhaust hood filters were clean and free of dust; failed to label properly and date opened food items; failed to ensure the kitchen equipment was properly cleaned to prevent cross contamination; failed to ensure the ceiling was free from chipped and peeling sheetrock. This has the potential to affect 55 residents receiving an oral diet. Findings include: A review of the facility policy titled, Cleaning Procedure: Kitchen Area, It is the policy of [NAME] Health to maintain a clean and sanitary environment to prepare patient/resident meals, under walls, ceilings, floors, and vents -check walls, ceilings, floors, and vents for chipped and /or peeling paint, keep in good repair. Under oven - Wipe off oven spills and splatters as they occur. Dirty hood filters pose a potentially high fire hazard; therefore, cleaning hood filters must be part of a strictly enforced cleaning schedule. Hood filters must be free of grease and dust at all times. During Initial walk thru on [DATE] 8:00 a.m. with the Dietary Manager (DM) an observation of two ovens that had burnt food stains, in the food pantry opened cake mix with no open date, white food container with no label and date. bag of bread crumps with no dates, an expired frozen mixed vegetables in the freezer, a sheet rock falling of the ceiling close to the hood. A sticky brown substance behind the oven and dust mites on top of the hood. A follow up walk through on [DATE] 9:15 am of the main kitchen revealed all previous observations including the ovens had burnt food stains, in the food pantry opened cake mix with no open date, white food container with no label and date. A bag of bread crumps with no date, expired frozen mixed vegetables in the freezer, sheet rock falling of the ceiling close to the hood. A sticky brown substance behind the oven and dust mites on top of the hood. All observations were confirmed with the DM during this walk-through. During an interview on [DATE] at 10:45 a.m. with DM, she confirmed all the observations and stated that all opened items should be labeled and dated in cooler and dry storage. She also stated that staff should clean all equipment after use at the end of each shift. The DM stated that she would go back and inspect. During the survey, a request for the facility to provide a labeling and storage kitchen policy, but the facility was unable to provide a policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on observations, staff interviews, record review, and review of the facility's policy titled, Infection Control-Linen and Laundry, the facility failed to maintain an effective infection control program by failing to post COVID -19 (Coronavirus Disease) signage at the front exterior entrance to provide notification of active Covid in the facility. In addition, the facility failed to ensure infection control policies were followed during the handling, storage, and processing of linens. These failures had the potential to spread infection due to cross-contamination to 55 residents residing in the facility. Findings include: Review of the facility's policy titled Infection Control- Linen and Laundry, revised 11/30/2023 revealed it is the policy of all [NAME] Health Healthcare Centers to implement and adhere to the policy to mitigate or decrease infections cause by sources of microbial contamination through collection, handling, sorting, transportation, processing, and storage of laundry. 5. Laundry Process a. Soiled laundry i. The soiled laundry area is to be completely separated from the clean laundry area. b. Clean laundry v. At the end of the workday, all unprocessed, clean laundry is covered. Visitation is conducted according to residents' rights for visitation and in a manner that helps decrease COVID-19. Upon entrance into the facility 2/23/2024 at 7:30 am there were not any signs posted on or near the entrance door informing visitors that the facility was currently in a COVID outbreak. Upon entrance into the facility, surveyors were greeted by the Housekeeper/Laundry Supervisor who informed surveyors the facility had COVID positive residents. This was confirmed by the Director of Health Services (DHS) and Administrator. The DHS reported that the importance of having the sign notification was to make sure visitors and staff were aware of COVID positive residents and staff, so they could protect themselves. During an interview on 2/23/2024 at 8:36 am with DHS confirmed the facility was currently in COVID outbreak status. DHS further stated that the outbreak began on 2/22/2024, and there were Three residents and one staff member confirmed positive for COVID. The DHS further stated one resident was potentially exposed to COVID and is also on Transmission Based Precautions (TBP). DHS further stated she instructed the nurses yesterday (2/22/2024) to post the signage on the entrance doors for the staff and visitors, but it was not done. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the laundry 2/24/2024 at 9:02 a.m. with Laundry Supervisor revealed that facility had one industrial washer and one industrial dryer. The laundry is divided into three separate areas. The dirty area, the clean area, and another area containing the washer and dryer and a clean cart of residents clothing. Further observation of the laundry revealed a dirty area with storage containers where staff deposits trash and dirty linen. On the opposite wall, there were two large yellow barrels. The Laundry Supervisor stated that the laundry aide separates the laundry and places it into the yellow barrel to transport it to the washing machine. Leaving the dirty area, the yellow uncovered barrels containing dirty linen pass an uncovered cart containing the resident's clothing. Laundry Supervisor confirmed the uncovered cart contained residents clothing that had been processed and would be distributed back to residents on the clinical unit. Further observations revealed that the one industrial washer and one industrial dryer were positioned side by side in the third area of the laundry. There was clothing being processed in both machines at the time of this observation. In addition, there was a yellow barrel containing dirty laundry positioned in front of the washing machine. The Laundry Supervisor further revealed clothes are placed directly in the dryer from the washing machine, after the clothes are dried, placed in a metal basket and taken into the clean area to be folded and clothing are placed back into the third area on the clothing rack for distribution to residents. The Laundry Supervisor stated that the laundry had always been set up that way and agreed there were risks of cross-contamination. During the tour of the laundry, the medical records clerk, followed by another staff member carrying a cart containing multiple boxes, entered the clean area, proceeded through the laundry (crossing the rack of uncovered clean clothing), and exited the back door. The Laundry Supervisor stated that the staff uses the clean area as a path to the storage room in the back of the facility. During an interview and walking rounds on 2/24/2024 at 9:26 a.m. with the Administrator, revealed that he was not aware of the process of the potentially cross contamination in the laundry and was unaware of staff entering the clean area of the laundry as a route to the storage room in the back of the facility. He stated the facility would have to change the process. The administrator further stated that he was aware of the location of the dryer and the washing machine being positioned side by side in the laundry but had not addressed the issue with anyone. During an interview 2/24/2024 at 9:37 am with Medical Records Clerk revealed she was aware she was wrong for entering the clean area of the laundry with the boxes of records. She further stated that she was not thinking and was trying to get the records to the back of the building to meet a truck. Medical Records Clerk further stated she was aware her actions contaminated the clean area of the laundry. A policy was requested by the survey team regarding Covid-19 notification signage sign posting. The facility failed to provide a policy specifically related to the requirement of posting at the entrance alerting visitors that the facility was currently in outbreak of COVID 19.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 45813 Based on record review, staff interview, review of policy titled Infection Prevention and Control Program Surveillance Reporting and Antibiotic Stewardship Program the facility failed to provide evidence of a process for periodic review of antibiotic prescribing practices, and to document follow-up measures in response to the data for ten of twelve months of infection control data reviewed (February 2023 through January 2024). This had the potential to affect any resident who was prescribed an antibiotic. The facility census was 55residents. Findings include: Review of the facility's policy titled, Infection Prevention and Control Program Surveillance Reporting revised 11/30/2023 revealed: It is the policy of this facility to establish and maintain an Infection Control Program that includes detection, prevention, and control of the transmission of disease and infection among patients/residents and partners. Procedure: 1. Patient/resident infections cases are monitored and documented by the Infection Preventionist (IP). The IP review cases of infections, including tracking and analysis of the findings and develops an action plan to resolve identified concerns. 2. A report of residents infections, Epidemiology Report, and monthly Tuberculosis (TB) reports are submitted. Monthly to the Administrator and Director of Health Services (DHS) Quarterly to the Infection Control Committee. Review of the facility's policy titled, Antibiotic Stewardship Program revised 11/30/2023 revealed: Accountability: a. The Antibiotic Stewardship Program (ASP) Team will be established to be accountable for promoting and overseeing antibiotic stewardship activities. b. The ASP Team will monitor and review the following data: I. Infection and antibiotic usage patterns on a regular basis. ii. Antibiogram reports for trends of antibiotic resistance. iii. Antibiotic resistance patterns for multidrug resistant organisms, (e.g., MRSA, VRE, ESBL, CRE, C auris, etc.) and Clostridium difficile infections. iv. Number of antibiotics prescribed (e.g., days of therapy) and the number of residents treated each month. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	v. Include a separate report for the number of residents on antibiotics that did not meet criteria for active infection. Tracking: a. The IP will be responsible for infection surveillance and multi-drug resistance organism (MDRO) tracking. b. The IP, along with the DHS, will collect and review the following data such as: I. Documentation of completion of antibiotic choice, dosage, duration, indication and route of administration. ii. Whether appropriate tests, such as a lab and/or cultures, were obtained before ordering antibiotic. Iii. Whether the antibiotic was changed during the course of treatment. Review of the facility's Antibiotic Stewardship Log revealed that the facility's policy is not being utilized as indicated below: For the months of June, July, August, September, October, November, December 2023, and January 2024 there was nothing in the book under the tab. For February and March 2023, the forms are in the book properly labeled without any data on the forms. For April and May 2023, there was not a line listing of the antibiotics/infections. In addition, the facility's infection rate was only calculated for the months April and May 2023. Review of Antibiotic Medications Reports provided by the facility's pharmacy revealed that it contained a listing with the resident's name; start date, end date, drug label name, order duration, and provider. Further review of this report revealed that it did not capture the organism if a culture was done, and the organism's susceptibility to the ordered antibiotic. In addition, this report did not indicate if the McGeers criteria was met or if the infection was a true infection. During an interview 2/23/2024 at 9:39 AM with Director of Health Services (DHS) revealed she had begun to track the antibiotics prior to taking the interim DHS role in May 2023. DHS stated that the new orders for antibiotics are reviewed in the daily clinical meetings to make sure that orders were entered correctly into the electronic record. She stated since that time it had not been done after May 2023. DHS stated that residents with new orders for antibiotics are discussed in the morning meeting to ensure the medications have been started and are in the electronic record and that is all that is done. She looked at the infection control book and confirmed mapping trending and surveillance of the program are not being monitored. She further stated that monthly infection control meetings are not conducted in the facility. She stated that typically with the antibiotic stewardship all was done was verifying the orders and the durations of the antibiotic therapy was correct. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview 2/23/2024 at 9:39 AM with DHS revealed she further had begun to track the antibiotics prior to taking the interim DHS role in May 2024. She stated since that time it had not been done after May 2023. DHS stated that residents with new orders for antibiotics are discussed in the morning meeting to ensure the medications have been started and are in the electronic record. She further stated that is the extent of what is being done with the antibiotic stewardship program at this time. and that is all that is done. She looked at the infection control book and confirmed mapping trending and surveillance of the program are not being monitored. She further stated that monthly infection control meetings are not conducted in the facility. On 2/23/2024 at 11:47 AM, DHS provided surveyor with a report from the facility's electronic medical record center. These reports titled Infection Tracker and Facility Event Summary Report for months June 2023 through January 2024 listed an infection rate for the month and a list of residents with antibiotics for the month. Review of the reports with the DHS, DHS confirmed the reports were not accurate because all residents receiving antibiotic therapy during the months were not listed on the report. In addition, all antibiotics listed on the reports (whether it met or did not meet the McGeer's criteria) were calculated into the infection rate for the month on the reports. DHS stated the reports were not accurate. During a follow-up interview on 2/24/2024 at 12:25 pm with DHS it was revealed that she is new to the position at the facility. She further stated that she had not had the opportunity to review the facility's Infection Control Policies or the Antibiotic Stewardship Program. DHS stated there was not a specific person in place monitoring the program. DHS stated that the nurses should have been tracking and trending infections, but she has been unable to locate any documentation that this had been completed. DHS stated that it is her expectation that residents should be monitored for signs and symptoms of infections, complete documentation, followed up with any labs or diagnostic test completed and followed up with the physician. XXX DONE XXX

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 45813 Based on staff interviews and a review of the facility policy titled, Infection Prevention and Control Program Surveillance Reporting, the facility failed to ensure evidence that a qualified Infection Preventionist (IP) was serving in the position at the facility. This deficient practice had the potential for creating an ineffective infection prevention program that may contribute to the spread of infections for all residents in the facility. The census was 55 residents. Findings include: A review of the facility's policy titled Infection Prevention and Control Program Surveillance Reporting, revised 11/30/2023, revealed it is the facility's policy to establish and maintain and Infection Control Program that includes detection, prevention, and control of the transmission of disease and infection among patients/residents and partners. Definitions: Infection Preventionist (IP): The person designated to carry out the daily functions of the program. The IP is responsible for collecting, analyzing, and providing infection data and trends to staff. The IP is responsible for assuring education and training is provided and assuring infection control policies and practices are followed in the facility. Interview on 2/23/2024 at 10:13 am with Director of Health Services (DHS) revealed she had just assumed the role of DHS but had worked at the facility since May 2023. The DHS stated she previously had begun to work on the infection control program but had not completed any specialized training in infection prevention and control. DHS stated no one in the facility had been educated or certified to be the IP at the facility. The DHS further revealed there had not been anyone in the role since May of 2023 and was unsure when the last certified IP was employed at the facility. The DHS stated that she and the Administrator were responsible for infection control in the facility until someone from their nursing staff received an IP certification. Interview on 2/25/2024 at 9:10 am with the Administrator confirmed there was not a certified IP employed at the facility. The administrator stated he was not sure when the last IP left, as no one was in the role when he started working at the facility a month ago. The Administrator revealed the facility had hired an Assistant Director of Health Service (ADHS) and Unit Manager to assist the DHS with the Infection control program.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on interviews, record review, and review of facility policies titled Influenza (Flu) Vaccinations for Health Care Center Residents, and Pneumococcal Vaccinations, the facility failed to provide evidence that two residents (R) (255 and 106) were offered the Influenza and Pneumococcal vaccine, and two residents (47 and 304) were administered the Influenza and Pneumococcal Vaccine after consenting to receive the vaccines. This deficient practice had the potential to put (R255), (R106), (R47), and (R304) at risk for contracting influenza and pneumococcal. Findings include: A review of the facility's policy titled Influenza (Flu) Vaccinations for Health Care Center Residents, with a revised date of [DATE]: All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. Timing of Vaccination 1. Current and newly admitted residents will be offered the influenza vaccine beginning [DATE]st of each year and it will be offered for as long as the influenza viruses are circulating, and unexpired vaccine is available. 2. Resident admitted during flu season will be offered the vaccine within two (2) weeks of the residents admission to the facility, if not previously vaccinated during the season. C. Guidance for Influenza Vaccine Use 1. An order will be obtained from the physician for those residents wishing to receive the influenza vaccine. F. Documentation 1. Each resident's immunization status will be determined prior to influenza vaccine administration and documented in the resident's medical record or Electronic Health Record (EHR). 2. Each resident's immunization will be recorded in the facility Alert Vaccination portal. 3. Prior to administering the vaccine, the resident or legal representative will be provided the vaccine information statement (VIS) and education regarding the benefits and potential side effects of the influenza vaccine. 4. The resident or legal representative will sign the Influenza (Flu) Vaccine Consent/Refusal Form upon admission, annually, and as changes are identified indicating their wishes to receive or decline the vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The resident or legal representative may refuse vaccination. Vaccination refusal and reasons why (e.g., allergic, contraindicated, etc.) should be documented in the resident's medical record or Electronic Health Record (EHR). 6. Influenza vaccine administered will be documented on the following forms: i. MAR and will include the date of administration, route, site, vaccine manufacturer, lot #, expiration date, and nurse signature. ii. Interdisciplinary Teaching Record iii. Preventive Health in HER iv. State specific immunization tracking website. Review of facility's policy titled Pneumococcal Vaccinations, with date revised [DATE]: Policy Statement - All patients/residents who reside in this healthcare center are to receive the pneumococcal vaccine(s) within the current CDC guidelines unless contraindicated by their physician or refused by the patient/resident or patient/resident's family. If the patient/resident is cognitively impaired as evidenced by scoring on the MDS, the responsible party will be contacted, and their wishes will be followed in this matter. 1.The admission process will include determining whether the patient/resident has received pneumococcal vaccine in the past. This will be the responsibility of the Director of Health Services or designee. If no reliable date of previous vaccination can be obtained, the patient/resident should be considered eligible for vaccination. 2. A Vaccination Information statement (VIS) will be provided to inform the patient/resident/family member of the side effects, benefits, and risks of the vaccine. This education will be documented on the Interdisciplinary Teaching Record. 3. Permission or refusal to receive the vaccine within the CDC guidelines will be obtained on admission using the Pneumococcal Vaccine Consent/Refusal Form. A separate consent for each type of vaccine is required. 4. An order for each vaccine will be obtained from the physician, as necessary, to assure vaccination within the CDC guidelines for those patients/residents who wish to receive the vaccine. 5. The Immunization Record will be a part of each patient/resident's clinical record and will be used to document the date of each pneumococcal vaccine previously received by the patient/resident and/or administered by the healthcare center. 6. If the vaccine is refused based on medical contraindications or side effects, there must be supporting documentation in the clinical record. 7. The Director of Health Services or designee will maintain a list of patients/residents with the date of administration of pneumococcal vaccine and make it available to state surveyors upon request. (continued on next page)

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	115529	A. Building B. Wing	02/25/2024

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Administration: Adults [AGE] years of age or older. 1. Record review of the Electronic Medical Record (EMR) for R255 revealed that the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, Cerebral Vascular disease, hemiplegia, and hemiparesis following cerebral infarction affecting the right dominant side and cognitive communication deficit. There was no evidence that the pneumonia or influenza vaccine was offered or administered to the resident. 2. Record review of the EMR for R106 revealed resident was admitted to the facility on [DATE] with diagnoses including but not limited to unspecified sequelae of cerebral infarction. There was no evidence that the pneumonia or influenza vaccine was offered or administered to the resident. 3. Record review of the clinical record for R47 revealed the resident was admitted to the facility on [DATE] with diagnoses including but not limited to depression, diabetes mellitus, osteoarthritis, and anemia. R47 signed a consent form for influenza and pneumococcal vaccines on [DATE], indicating she would like to be offered the vaccines upon admission. There was no evidence that the pneumonia or influenza vaccine was offered or administered to the resident after admission to the facility. 4. Record review of the EMR for R304 revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, Wernicke's encephalopathy, senile degeneration of the brain, and cognitive communication deficit. The resident signed a consent form for the influenza and pneumococcal vaccines on [DATE] indicating he would like to be offered the vaccines upon admission. The record does not provide evidence that the vaccines were offered or administered to the resident. During an interview on [DATE] at 11:50 am, the Director of Health Services (DHS) confirmed the above lack of consents and vaccinations. DHS stated the Admissions Director was responsible for obtaining vaccination consents and/or declinations. The DHS revealed they administer influenza and pneumococcal vaccines as the consents are received as long as they are within season. During further interview, she stated that if there are not any scanned documents for the influenza or pneumonia vaccinations in the medical records, then they don't have any. DON further stated she had not had the opportunity to audit residents' records for compliance with vaccinations and stated she did not have access to the Georgia Registry of Immunizations Transactions and Services (GRITS) system to search residents' immunization history. DHS stated the R47 and R304 vaccines failed through the cracks because she had been covering the medication carts a lot as the floor nurse. DHS further stated the breakdown also occurred because she did not do it and/or the lack of education of the nurses. DHS stated the admitting nurse failed to enter the orders into the electronic record to be administered. DHS further stated she was not aware that the consent for the vaccines had not been signed for R106 and R255. Interview on [DATE] at 11:15 am with Admission Director (AD) revealed the vaccine consents for R 255 and R106 are not in the clinical record because the admission packet had not been signed by resident's family. She stated that R255 is not cognitively able to consent to vaccines. However, R106 is cognitively intact, but she had not attempted to ask the resident to sign his own paperwork or ask for consent. The AD stated she had 48 hours from a resident's admitted to complete the Admission packet. AD further stated she had not informed the DHS or Administrator that the admission packets were not signed. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 8:21 am, the Administrator revealed that he had been made aware during the survey that there were residents in the facility who had not been offered vaccines. The Administrator further stated that it is expectation that the facility staff offer and document that vaccines were offered, administer vaccines with consents in a timely manner and document vaccine declinations in resident's records.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on staff interviews, record review, and a review of the facility policy titled COVID-19 Vaccination Clinics, the facility failed to offer and/or administer the COVID-19 vaccine to two of five residents (R) (255 and 106) reviewed for vaccines. Findings include: Review of facility's policy titled COVID-19 Vaccination Clinics, revision date [DATE]: All partners, residents, and patients who have no medical contraindications to the vaccine will be offered the updated COVID-19 vaccine per CDC recommendations to encourage and promote the benefits associated with the vaccinations against COVID-19. Administration 1. The patient or legal representative will sign the COVID-19 Vaccine Consent/Refusal Form indicating their wishes to receive or decline the vaccination. 2. All new admissions and new hires will be reviewed for consent or declination of vaccine to ensure previous doses of the vaccine have been documented, and new/next doses can be scheduled appropriately. 3. All residents and partners declining to be vaccinated will be given additional information on the benefits of immunizations and an opportunity to discuss their concerns and ask questions before signing the declination form. Timing of Vaccination 1.Partners and current unvaccinated and newly admitted residents/patients (unvaccinated or have not received the optional additional dose) will be offered the COVID-a9 updated vaccine per CDC recommendation and it will be offered as long as the COVID-19 viruses are circulating, and unexpired vaccine is available. 1. Record review of the Electronic Medical Record (EMR) for R255 revealed that the resident was admitted to the facility on [DATE] with diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction, essential hypertension, and cerebral palsy. There was no indication that the COVID-19 vaccine was offered or administered to the resident. This finding was confirmed by both the Admission Director and Director of Health Services (DHS). Record review of the EMR for R255 revealed a care plan initiated on [DATE] resident was at risk for COVID-19 and had a high risk for complications related to age and underlying conditions/co-morbidities. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the EMR for R255 revealed the data under the Preventive Health Care tab to be blank. Further review revealed that R255 did not have an Admission Packet (containing Vaccination consent and education) uploaded into the record. Record review under the Admissions tab for R255 revealed a Final Clearance Pre-Admission Checklist which indicated R255 vaccination status was partially vaccinated. Record review of the Electronic Medication Administration Record (eMAR) for R255 from [DATE] through [DATE] revealed resident had not received any COVID vaccines since admission to the facility. An interview on [DATE] at 11:50 am with the Admission Director (AD) and Director of Health Services (DHS) revealed that R255 is not cognitively intact to sign the consent. The AD further stated that R255's son had not signed any of the admission paperwork to include vaccine consent. AD also stated she had called the resident's son several times and left messages, but he still had not responded. DHS stated she was unaware the vaccine consents were not signed, and she had not made any attempts to obtain consent for vaccines. AD further revealed she had informed the corporate manager that the paperwork had not been signed but did not inform the DHS or Administrator. 2. Record review of the Electronic Medical Record for R106 revealed the resident was admitted to the facility on [DATE] with diagnoses including but not limited to unspecified sequelae of cerebral infarction. There was no indication that the COVID-19 vaccine was offered or administered to the resident. Both the AD and DHS confirmed this finding. Record review of the EMR revealed that the care plan for R106 was initiated on [DATE]. The resident was at risk for COVID-19 and had a high risk for complications related to age and underlying conditions/co-morbidities, including, but not limited to, unspecified sequelae of cerebral infarction. Record review of the EMR for R106 revealed the data under the Preventive Health Care tab to be blank. Further review revealed that R106 did not have an Admission Packet (containing Vaccination consent and education) uploaded into the record. Record review of Electronic Medication Administration Record (eMAR) for R106 from [DATE] through [DATE] revealed resident had not received any vaccines since admission to the facility. Interview on [DATE] at 11:50 am with AD and DHS revealed that the AD stated R106's Admission packet that included vaccine consent had not been signed. AD further stated she had made several attempts to contact the resident's sister to complete the required paperwork but had been unsuccessful in contacting the sister. The AD further revealed that there had not been any discussions related to vaccines since the resident's admission to the facility. The AD stated she had visited R106 to introduce herself, and the resident appeared to be cognitively intact. The AD had not attempted to discuss vaccines with him. DHS revealed that R106 is cognitively intact and able to consent to or decline vaccines himself. The DHS further revealed she was unaware that the consent for the vaccines had not been signed. An interview with the AD on [DATE] at 11:59 a.m. revealed that she is responsible for ensuring that the admission packet is completed, including the vaccine consent forms. The AD stated that she had 48 hours from a resident's admitted to complete the Admission packet. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview on [DATE] at 12:06 pm with DHS revealed she is responsible for checking to see if residents have had the immunizations. However, she did not have access to the Georgia Registry of Immunization Transactions and Services site (GRITS). The DHS stated that newly admitted residents' immunization history is usually provided before admission to the facility. DHS further stated if vaccine consents are not obtained, the nurses and social workers obtain the consent for the vaccine. The DHS further revealed once a resident consents to vaccines, the orders are entered into the electronic record, the vaccines are administered, and the consents and education are uploaded in the EMR. DHS stated that she is responsible for monitoring all newly admitted residents' records to ensure vaccines have been offered. Interview on [DATE] at 12:18 pm with Licensed Practical Nurse (LPN) Unit Manager (UM) EE revealed the admission 24-hour chart checks are started on the day of admission and completed the day after a resident is newly or readmitted to the facility. LPN UM EE further stated vaccines are included on the checklist. If the consent is not on the record, the nurses will call the resident's family and obtain verbal consent to accept or decline the vaccines.