STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115658	A. Building B. Wing	10/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Greenville	99 Hillhaven Rd. Greenville, GA 30222

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 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 observation, staff interview and a review of the facility policy titled Cleaning Procedure-Kitchen area the facility failed to ensure a clean sanitary environment in the kitchen. The census was 66 of 67 residents will be affected. Findings include: A review of the facility policy titled It is policy of [NAME] Health to maintain a clean and sanitary environment to prepare patient/resident meals revealed that the policy applies to all dietary staff, housekeeping , and maintenance partners scheduled to assist in cleaning/sanitizing procedures, All soiled, dirty, dusty, surfaces and /or areas within the kitchen should be cleaned and /or sanitized (as needed) immediately upon identification. During initial walk thru of the kitchen on 10/27/2023 at 08:00 am the surveyor observed the ceiling had dust mites hanging out from the ceiling. Observation of greasy burnt food debris inside the oven and the burner. During a follow up visit of the kitchen on 10/28/2023 at 8:35 am with the Dietary Manager (DM) , The surveyor observed confirmed the dust mites and greasy burnt food debris inside the oven and the burner with the DM. The DM stated that the Maintenance Director is responsible for keeping the kitchen ceiling free of dust mites. The DM further revealed that the staff has schedule for cleaning kitchen equipment. During a follow up visit of the kitchen on 10/29/2023 at 8:39 am observation of the dust mites were still hanging on the ceiling. During an interview on 10/29/2023 at 8:26 am with the facility Administrator regarding her expectation of dietary staff and she revealed that she expects the DM to make sure the dietary staff complete daily and monthly cleaning of the kitchen . During an interview on 10/29/2023 at 8:40 am with the DM regarding his expectation of the dietary staff he revealed that he expects the dietary staff to keep the kitchen clean . During an interview on 10/29/2023 at 10:17 am with the Administrator, she confirmed that she saw the dust mites in the kitchen ceiling and stated that after meal the diet staff will clean it (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up visit in the kitchen on 10/29/2023 at 11:42 am with facility consultant, Administrator and DM, confirmed that the oven and the burner were not clean.

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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. 38997 Based on record review, staff interviews, and review of the policies titled Infection Prevention Control Plan and Infection Prevention and Control Program Surveillance Reporting the facility failed to provide evidence that infection control surveillance data was collected ten out of fifteen months reviewed (July 2022 through September 2023). Findings include: Review of the policy titled Infection Prevention and Control Program Surveillance Reporting review date 1/24/2023 indicated: Policy Statement-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. The Administrator of the Healthcare Center is responsible for the Infection Control Program. All infection prevention and control practices reflect current Centers for Disease Control (CDC) guidelines. Procedure: 1. Patient/resident infection cases are monitored and documented by the IP. The IP reviews cases of infections, including tracking and analysis of the findings and develops an action plan to resolve identified concerns. 2. A report of resident infections, Epidemiology Report and monthly Tuberculosis (TB) reports are submitted monthly to the Administrator and Director of Health Services (DHS). Review of the policy titled Infection Prevention Control Plan review date 6/23/2023 indicated Policy Statement- This Infection Prevention and Control Plan outlines the framework by which all ___ facilities will assess, implement, and evaluate an active, effective, comprehensive facility-wide Infection Prevention and Control program. The Medical Director and Director of Health Services are responsible for the identification of appropriate resources and/or resource allocation that supports the Infection Prevention and Control Program. The goals of the program are to decrease morbidity/mortality attributable to infections in residents; prevent and control outbreaks of infection in residents; prevent acquisition of infection by staff members; maintain resident functional status; maintain optimal social environment for residents; and limit costs of care attributable to infections. The Infection Prevention and Control Program will incorporate risk assessments, surveillance activities, evidence-based prevention practices, communication to mitigate risks and decrease adverse outcomes related to Infection Prevention and Control. Review of the infection control binder provided by the Infection Preventionist (IP) on 10/28/2023 at 9:30 a.m. revealed no data was obtained for July 2022, August 2022, September 2022, October 2022, November 2022, December 2022, February 2023, March 2023, April 2023, and July2023. An interview on 10/28/2023 at 9:44 a.m. with the Director of Health Services (DHS) and the IP stated the infection control binder that contains the required information that includes the Monthly Healthcare Associated Infection Summary Report, line listing, mapping, Epidemiology Report Form, and Monthly Surveillance for Tuberculosis Form for 7/2022-12/2022 could not be located. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 10/28/2023 at 12:10 p.m. with the Director of Health Services confirmed that there were no data collection February 2023, March 2023, April 2023, and July 2023. The DHS stated it is her responsibility to make sure that the data is collected to complete the Monthly Healthcare Associated Infection Summary Report, Line Listing, Mapping, Epidemiology Report Form, and Monthly Surveillance for Tuberculosis Form.

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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. 38997 Based on record review, staff interviews, and review of the policy titled Antibiotic Stewardship Program, the facility failed to provide evidence of a monitoring system to track and trend antibiotic use for ten out of fifteen months of the infection control data reviewed (July 2022 through September 2023). Findings include: Review of the policy titled Antibiotic Stewardship Program review date 2/8/2023 indicated: Policy Statement-As part of the Infection Prevention and Control Program, ____ will implement and maintain an Antibiotic Stewardship Program (ASP). Under the direction of the Medical Director and Director of Health Services (DHS) the ASP is designed to promote appropriate use of antibiotics and improve patient health outcomes. The goal of ASP is to promote appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. Each month the Antibiotic Stewardship Pharmacist will monitor, document, and provide each facility the following antibiotic use information on the Monthly Healthcare Associated Infection Summary Report: Percent of residents receiving antibiotics, Percent of new admissions receiving antibiotics, New Antibiotics Starts, Rate of Antibiotic Days of Therapy, New Antibiotics Starts, Rate of Antibiotic Days of Therapy (DOT), and Antibiotic Utilization Ratio. Review of the infection control binder provided by the Infection Preventionist (IP) on 10/28/2023 at 9:30 a.m. revealed no evidence of antibiotic surveillance data, analysis, documentation of follow up in response to the data or monthly antibiotic reporting for ten months. The ten months included July 2022, August 2022, September 2022, October 2022, November 2022, December 2022, February 2023, March 2023, April 2023, and July2023. An interview on 10/28/2023 at 12:10 p.m. the Director of Health Services (DHS) stated the facility has had problems with keeping an infection preventionist. She stated since May 2023 the facility has had three different people in the infection preventionist role. The facility hired a Registered Nurse on 10/2/2023 that will be fulfilling the IP role. An interview on 10/29/2023 at 10:15 a.m. with the Administrator and DHS. The Administrator stated the previous IP was not providing her with the monthly Healthcare Associated Infection Summary Report She stated her expectation is that the facility's policy and procedure are followed. She stated the infection control surveillance will be placed Performance Improvement Project and discuss in Quality Assurance and Performance Improvement (QAPI). The Administrator stated she will ensure all staff involved are doing their work. The DHS stated she has been reporting to the Physician based on the lab results and culture sensitivities and the physician will order the appropriate antibiotics based on the information given. She stated the pharmacy consultant has not provided the facility with the Antibiotic Stewardship Report. An interview on 10/29/2023 at 10:52 a.m. with the Senior Nurse Consultant stated the newly hired IP will be in-service on the infection control policy and procedure. She stated herself and the corporate IP will work closely with her to ensure that the HAI and ASP are completed monthly per policy and CMS guidelines. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post exit telephone interview on 10/30/2023 at 10:30 a.m. with the facility's Consultant Pharmacist BB stated he visits the facility monthly. During the visit to the facility, he will review the residents that have an order for antibiotics and look for a start date, stop date, and diagnosis. In the event he encounters a problem it is addressed with the Director of Health Services. The Pharmacy Consultant stated he is not responsible for generating the Antibiotic Stewardship Report for the facility. He is not part of the ASP but does participate in the quarterly QAPI meetings. Post exit telephone interview on 10/30/2023 at 1:59 p.m. with the facility's Pharmacist CC stated the Antibiotic Stewardship Report for the facility is auto generated every month between the third-sixth of the month. She uploads the report to Teams to each facility. The facility is responsible for accessing the folder and reviewing the antibiotics that are used for the month. She stated no one from the facility has ever communicated to her that the facility was unable to access the report. She stated her responsibility is to review the report before uploading it to Teams and the report is reviewed by herself. The Pharmacist stated she looks for anything that doesn't have a stop date, antibiotic that doesn't have a diagnosis, any antibiotic that stands out that is not normally used. She stated anything that is concerning she will reach out to the facility. She stated the pharmacy will also look to make sure the required information is in the order before sending the antibiotic to the facility. The pharmacist provided the surveyor with a copy of the facility's report from last month for review.