STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115391	A. Building B. Wing	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Eastside	2795 Finney Circle Macon, GA 31217

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on interviews and record review, the facility failed to notify the Medical Director (MD), who was the physician, and responsible party when one of 40 sampled residents (Resident (R) 29) returned from the hospital. Findings include: Review of R29's Face Sheet, located in the electronic medical record (EMR) under the Face Sheet tab, revealed R29 was admitted to the facility on [DATE] with diagnoses that included heart failure, diabetes mellitus (DM), and end stage renal disease (ESRD). Review of R29's Progress Notes dated 11/2/21 and located the EMR under the Progress Notes tab, revealed alert and verbal, unable to make needs known. 0 S/SX [no signs and symptoms] of pain or discomfort. BS [blood sugar] 74. LOA [leave of absence] to appointment at [heart clinic]. Ensure [liquid supplement] sent with resident. 0 [no] distress noted. Review of R29's Progress Notes dated 11/2/21 and located in the EMR under the Progress Notes tab, revealed writer informed by escort that resident was sent to ER [emergency room] from [heart clinic]. Review of R29's Progress Notes dated 11/2/21 and located in the EMR under the Progress Notes tab, revealed returned from ER [emergency room] with Dx [diagnosis] of hypoglycemia [low blood sugar]. BS [blood sugar] 120. Lunch tray set up for resident. 0 [no] distress at this time. Interview on 1/20/22 at 1:03 p.m. with R29's physician revealed he was not notified when R29 returned from the hospital due to hypoglycemia. Continued interview revealed that the physician expected staff to inform him the same day because he needs to be aware of these things to prevent reoccurring hospitalization s. Interview on 1/20/22 at 1:39 p.m., Licensed Practical Nurse (LPN)2 revealed she was not aware that she should have contacted R29's physician and guardian when R29 returned from the hospital on 11/2/21. LPN2 confirmed that she didn't notify R29's physician or guardian after R29 returned to the facility. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/20/22 at 1:42 p.m. with the Nurse Consultant revealed nurses must notify the physician and responsible party, guardian for R29, when residents have a change in condition. Interview on 1/20/22 at 1:47 p.m. with the Director of Nursing (DON) revealed LPN2 should have called R29's physician and guardian to keep them informed of R29's change in condition. The DON stated that the facility did not have a change of condition policy.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on interview, record review, facility document review, and review of the facility's policy titled, Prevention of Patient, Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to ensure residents were free from physical abuse from Resident (R) (#79) for three of seven sampled residents reviewed for abuse (R13, R19, and R6). An altercation between R79 and R13 resulted in actual harm to R13 when he sustained an eyebrow laceration requiring repair and an orbital floor closed fracture. Findings include: Review of the facility's policy titled, Prevention of Patient, Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, revised 10/27/20, indicated, It is the policy . to actively preserve each patient's right to be free from verbal, sexual, physical and mental abuse . 1. Review of the Face Sheet found in the electronic medical record (EMR) revealed R79 was admitted to the facility on [DATE] with diagnoses including schizophrenia, bipolar, fetal alcohol syndrome, and traumatic subdural hemorrhage (bleeding into the brain) with loss of consciousness of 30 minutes or less. Review of the Against Medical Advice [AMA] Release from Responsibility for Discharge indicated R79 left the facility AMA on 12/29/21. Review of R79'S Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/15/21 revealed R79 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. The MDS indicated R79 exhibited physical behavioral symptoms toward others that occurred one to three days in the assessment period. Review of the Care Plan, located in EMR under the Care Plan tab, revealed a Psychosocial Wellbeing care plan with a start date of 6/11/21 that indicated, Monitor for psychosocial changes. Observe and report any changes in mental status, mood, behavior, caused by situational stressor. A Behavioral Symptoms care plan with a start date on 9/9/21 indicated, Encourage [R79] to utilize acceptable coping mechanisms if feeling stressed. [R79] will accept medication as ordered . [R79] will verbalize his frustration to staff when feeling frustrated . An update to the Behavioral Symptoms care plan with a start date of 12/3/21 indicated, Resident exhibited socially inappropriate disruptive behavioral symptoms. 12/2/21- physical altercation with another resident, hitting head against wall, refusing care . Approaches indicated, Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Divert resident's behavior. When resident becomes physically abusive, keep distance between resident and others. When resident becomes physically abusive, move resident to a quiet, calm, environment. 2. Review of R13's Face Sheet, located under the Face Sheet tab in the EMR revealed an admitted [DATE] with diagnoses of blindness in both eyes, diabetes mellitus, seizure disorder, major depression, and schizophrenia. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of R13's Quarterly MDS with an ARD of 10/8/21 revealed R13 had a BIMS score of 11 out of 15, which indicated the resident was moderately cognitively impaired. The MDS indicated R13 didn't exhibit any physical or verbal behavioral symptoms toward others. Review of the facility's Incident Report Form, dated 9/9/21 and provided by the facility, revealed On 9/9/21 at 11:50 a.m., [R13] pushed [R79] because he was talking bad about some of the female residents. In the process of [R79] being pushed, [R79] took a swing and hit [R13] by his eye. [R13] was sent to the ER [emergency room] for stitches. Review of the Situation Background Communication Form dated 9/9/21 revealed the physician was notified that R13 was involved in an altercation with another resident and sustained a laceration above the left eye that may require suturing. Emergency medical transport was initiated. Review of the Emergency Department Provider Report dated 9/9/21 revealed chief complaint: assault victim, nursing home pt (patient) was punched by another resident, lac (laceration) above left eye. Clinical impression included closed injury of head, eyebrow laceration (with repair), and orbital floor (blow-out) closed fracture. Interview with R13 on 1/17/22 at 11:29 a.m. revealed R79 hit him in the face in the day room which resulted in a laceration over his left eye after he stood up to tell R79 to stop talking about his girlfriend. R13 also stated he was sent to the ER and stitches were placed above his left eye. R13 indicated R79 no longer resided in the facility. 3. Review of the Resident Face Sheet, undated and located in the EMR under the Home tab, revealed R19 was admitted to the facility on [DATE]. R19's diagnoses included unspecified psychosis, dementia, paranoid schizophrenia, major depressive disorder, and schizoaffective disorder. Review of the MDS with an ARD of 10/13/21 revealed R19 was moderately impaired in cognition with a BIMS of eight out of 15 (score of eight - 12 indicates moderate cognitive impairment). R19 exhibited verbal behavioral symptoms towards others four to six days out of the seven-day assessment period. R19 required extensive assistance of one person for transfers, dressing, and hygiene. R19 had not walked during the assessment period and used a wheelchair for mobility. Review of the Care Plan, dated 11/27/19 and located in the EMR under the Resident Assessment Instrument (RAI) tab, revealed a problem of, Behavioral Symptoms. [R19] has verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) . verbal altercation leading to physical aggression with injury from another resident on 12/3/21. The goal was for R19 to not threaten, scream at, or curse at other residents, visitors, and/or staff . Interventions included, Notify the MD [Medical Doctor] as needed . psych services . Assess whether the behavior endangers the resident and/or others. Intervene if necessary . Convey an attitude of acceptance toward the resident . Follow familiar routines with resident . Maintain a calm environment and approach to the resident . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurse's Note, dated 12/3/21 at 1:10 p.m. and located in the EMR under the Progress Notes tab, revealed Resident was involved in altercation in the day room. Resident [R19] was attacked by another resident [R79] after a verbal altercation. The other resident [R79] punched him [R19] in the head and neck area several times. He [R19] was knocked out of his wheelchair and landed on the floor on his right side. Staff assisted resident [R19] off floor. Resident [R19] assessed for pain and injuries. Resident [R19] had a skin tear to right lower leg. Bleeding stopped, and dressing applied. 911 and MD [Medical Doctor] notified. [R19's family] called and aware. Review of the Follow-up for [number of incident], undated paper document provided by the facility, revealed The incident on 12/3/21 took place between [R19] . male age 57 BIMS score of 8 and [R79] [AGE] year-old . male who has a BIMS of 13 . [R19] rolled his wheelchair by [R79] and asked him what time smoke break was. [R79] replied it's the same time it is every day why are you asking me that. [R19] replied back it's just a stupid f (---) ing question cracker. This upset [R79] and he stood up and took a swing at [R19] and pushed him out of his wheelchair. There was some commotion and yelling in the common ground until staff rushed in and separated the two men. [R79] was standing over ([19] on the ground in an attack like position and was separated, the [name] sheriff's office was notified, the physician notified and both responsible parties . The decision was made to 1013 [initiate transportation to an emergency receiving mental health facility due to imminent risk] [R79] . He [R79] was sent to a behavior health center for stabilization (resident was hospitalized from 12/3/21 through 12/14/21 at inpatient psychiatric facility) . [R19] was evaluated for any injuries and had none to report. [R19] has returned back to his normal baseline routine. During an interview on 1/18/22 at 6:56 p.m., the Administrator stated R79 was sent out on a 1013 after he punched R19 in the head and neck. The Administrator stated R79 hit R19 after R19 called R79 a cracker. During an interview on 1/19/22 at 10:31 a.m., the Social Services Director (SSD) stated R19 was sporadically verbally aggressive towards residents and staff. She stated there were no patterns to this behavior and indicated the incident between R19 and R79 was started by R19. The SSD indicated R19 had used a derogatory name towards R79 on 12/3/21; R79 then punched R19 in the face two or three times. The SSD stated R19 had a history of sustaining a head injury when he was in prison prior to admission and indicated his cognition was delayed. The SSD stated R19 did not have a history of being physically abusive towards other residents. During an interview on 1/20/22 at 12:53 p.m., Licensed Practical Nurse (LPN) 9 stated R19 upset other residents by cussing and fussing at them. R19 had to be redirected by staff. LPN9 stated anything could tick R19 off. During an interview on 1/20/22 at 1:34 p.m., the Medical Director, also R19's physician, stated R19 had dementia. He stated R19 was usually calm, he had not witnessed any verbally aggressive behaviors, and in general R19 was doing well. The Medical Director stated he was notified of the incident on 12/3/21. He stated staff should be monitoring residents on a one-to-one basis after aggressive behaviors were exhibited for 24 to 48 hours. He stated residents were sent on a 1013 if they were at risk of harming themselves or others. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	4. Review of R6's Face Sheet, located under the Face Sheet tab in the electronic medical record (EMR) revealed an admitted [DATE] with diagnoses that included cerebrovascular accident (CVA-stroke), aphasia (difficulty speaking), vascular dementia with behavioral disturbance, depression, bipolar disease, and anxiety disorder. Review of R6's Quarterly MDS with an ARD of 10/8/21 revealed a BIMS score of 10 out of 15, which indicated R6 was moderately cognitively impaired. The MDS indicated R6 exhibited verbal behavioral symptoms toward others that occurred one to three days during the assessment period. Review of the facility's Incident Report Form, dated 12/27/21 and provided by the facility, revealed On 12/27/21 at 5:00 p.m., [R6] was rolling by in her wheelchair and mumbled something to [R79] calling him a bastard and [R79] called [R6] a whore then according to witnesses stood up and kicked [R6] and [R6] fell out of her wheelchair. Staff were notified [and] separated the two and did an injury assessment on [R6]. The police department was called for assistance. They called back after an hour saying they couldn't do anything and to call back to dispatch if further assistance was needed. Review of the facility's Follow Up Report, undated and provided by the facility revealed The incident that took place on 12/27/21 between [R6 and R79] .[R79] was watching [television] and [R6] who is verbally impaired rolled by [R79] who was blocking the view of the TV [television]. [R6] mumbled to [R79] get out of the way you bastard. [R79] proceeded to stand up and yelled back at [R6] shut up your [sic] whore. Then [R79] kicked [R6's] wheelchair and [R6] slid out of the chair. Staff rushed in and separated the residents and cleared out the common area. A pain assessment was done on [R6] and the physician and family was [sic] notified. After the incident took place [R79] went and spoke with the social services director and told them he wanted to leave the facility and go back to his brother's home in [city]. [R79's] brother was working on finding a room for him to rent prior to this incident. Later that evening an uber was called and [R79] signed himself out AMA [against medical advice] to return back to his home in [city] GA. [R6] has since returned back to her normal routine. Interview with R6 on 1/18/22 at 9:49 a.m. revealed R79 kicked her wheelchair and she slid out of it in the dayroom. R6 also stated staff assessed her and she didn't have any injuries. R6 indicated that R79 didn't reside in the facility any longer. Interview with the Administrator on 1/20/22 at 5:34 p.m. revealed he protected the residents from abuse per the facility's abuse policy by clearing the common area where the incident took place, sending R6 and R79 to their rooms. The Administrator also stated he paused the smoke break temporarily and R79 signed out AMA on 12/29/21. Interview with the Nurse Consultant, along with the Administrator, Director of Nursing (DON), and Social Worker on 1/18/22 at 6:00 p.m. revealed the facility would not accept the resident back if he wanted to come back. The Nurse Consultant stated the resident was not a good fit for the facility and that he was danger to himself and others. Interview with the Administrator on 1/18/22 at 6:44 p.m. revealed that he didn't know R79's medical history and would not have admitted him if had known about his violence. Regarding R79, the facility got a referral from the hospital, prior history of behaviors was not known. The Administrator stated after admission they learned R79 had been living with his brother in the past and the brother kicked him out due to drug abuse. R79 had been shot multiple times and had a history of fighting. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review for R79, R13, R19, and R6 from 9/9/21 through 1/20/22 revealed residents were receiving appropriate behavioral health services when indicated.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on observation, interview, record review, and review of facility's policy titled Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to implement their abuse policy to complete a thorough investigation for one of seven residents (Resident (R) 29) reviewed for abuse, when an injury of unknown origin was reported to the Director of Nursing (DON) by Registered Nurse (RN) 11 on 5/13/21. Findings include: Review of the facility's policy titled Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, revised 10/9/20, revealed Procedure: 1. The Administrator of the provider is responsible for assuring that an accurate and timely investigation is completed. If there is an occurrence of or allegation involving patient abuse (including injuries of unknown source), neglect, exploitation, mistreatment or misappropriation of patient property, the following investigation and reporting procedures will be followed: The provider should assure that precautions are taken to protect the health and safety of the resident during the course of and following the investigation. The provider should utilize the appropriate forms dependent on the specific situation: If an actual injury has occurred, including an injury of unknown origin, or abuse, neglect, exploitation, mistreatment, or misappropriation of property is observed, an occurrence report with supervisory investigation should be completed. 2. Investigation of injuries of un-known source to health care center (skilled nursing facilities) and intermediate care facilities for individuals with intellectual disabilities (ICF/IDD) patients. In accordance with applicable federal and state regulations, a health care center and ICF/IDD must investigate all injuries of unknown origin and other occurrences that may constitute abuse or neglect, but if a health care center, ICF/IDD determines that the situation does not appear to a reasonable person to be an incident of abuse or neglect, the health care center is not required to report the occurrence to the State. The health care center and ICF/IDD should be able to demonstrate that it investigated the injury, even if it subsequently determined that no violation of resident rights regarding abuse or neglect occurred. If it appears to a reasonable person that injury of unknown cause has occurred, interviews should be conducted. Signed statements should be gathered from: staff who cared for patient just prior to and just after injury; other reliable patients in the vicinity nearby area; and family or visitors who may have noticed anything. Once an injury of unknown source has been identified, staff should observe the patient and watch his or her behavior to see if the source of injury can be identified based on the patient's behavior (e.g., how the patient moves his or her arms, walks, pushes a wheelchair, behaves). A written report of the investigation and follow-up should be submitted to the appropriate agency within five working days of the occurrence, unless otherwise if indicated. The patient (if appropriate), the legal representative, and/or responsible party, should be notified of the investigation results. If indicated, the Ombudsman and the law enforcement agency should also be notified. Review of R29's Face Sheet, located in the electronic medical record (EMR) under the Face Sheet tab, revealed R29 was admitted to the facility on [DATE] with diagnoses that included history of falling, difficulty in walking, unsteady on feet, osteoarthritis, end stage renal disease (ESRD), vascular dementia with behavioral disturbance, and heart failure. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R29's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/21/21 revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicated R29 was unable to complete the interview. Facility staff accessed R29 as moderately impaired in making decisions. The MDS also indicated that R29 required extensive assistance of two persons with transfers and extensive assistance with one-person physical assistance with bed mobility, walking in room, eating, dressing, personal hygiene, and toileting. The MDS revealed R29 had not had a fall since admission or the prior assessment. Observation on 1/17/22 at 10:32 a.m. revealed R29 was sitting in a wheelchair drinking Ensure from the bedside table. Observation on 1/19/22 at 3:30 p.m. revealed R29 lying in bed low to the floor with his eyes closed. Observation on 1/20/22 at 8:30 a.m. revealed a staff member feeding R29 breakfast in his room. Review of the R29's Medication Administration Record (MAR), dated 5/13/21 and located in R29's EMR under the Reports tab revealed RN11 assessed R29 for pain which was rated a 6 (moderate pain) out of 10 and was administered methocarbamol (a muscle relaxant) 500 milligrams (mg) tablet. Review of the R29's Nursing Progress Notes, dated 5/13/21 and located in the Progress Notes tab in the EMR, revealed RN11 documented received call from dialysis center stating that resident's hip was red and swollen. [Dialysis] Nurse wanted to know if resident had fallen recently. I explained to nurse that there is no report of resident falling. I spoke with DON and verified no recent falls on resident. Dialysis nurse stated that patient was being sent to the hospital for evaluation of possible fractured hip. Review of the facility's Incident Report Form, dated 5/19/21 and provided by the facility, documented an injury of unknown source was reported to the State Agency (SA) by the DON as follows: Resident [R29] was transferred to the hospital from dialysis center due to right redness and swelling; later found out resident [R29] had to have surgery of right hip due to fracture of unknown origin. Review of the facility's Follow Up Report, dated 5/26/21 and provided by the facility, revealed the Administrator documented[R29] is a dialysis patient and had an appointment on 5/13/21. His primary diagnosis [sic] is [sic] history of falling, difficulty in walking, unsteady on feet, unspecified fracture of sacrum, vascular dementia with behavior disturbances, ESRD, and muscle weakness. He has a BIMS score of 10. The dialysis center called the facility and stated that [R29] has some redness and swelling on his right hip. The dialysis center asked us if he had a fall recently and we told him no, a fall was not reported to any of the nurses. [R29] can make his needs known. The dialysis center informed the nursing home that [R29] would be sent to the hospital to be evaluated and treated if treatment would be required. The hospital did x-rays and did surgery to repair a broken hip. The resident is in good spirits and in recovery free of pain. Upon arrival, he did not reveal any new details on if he had a fall or not before his dialysis appointment. He was readmitted on [DATE]. Interview on 1/17/22 at 2:13 p.m. with the Social Worker (SW) at the dialysis center revealed that [upon arrival to the dialysis center] when R29 was transferred from the stretcher to the wheelchair he moaned in pain, so the [dialysis] Charge Nurse assessed R29. The SW stated the Charge Nurse documented that R29's right hip was swollen, warm to the touch, right leg was rotated and shorter than the left leg, and that his pain level was a 9 out of 10. The SW indicated an ambulance was called and R29 was transported to the hospital. The SW stated the ambulance drivers stated R29 was in pain when they picked him up from the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/18/22 at 4:49 p.m. with Ambulance Transportation Driver 1 revealed when he arrived to R29's room with the stretcher, R29 was not ready yet and when asked why he was not ready the Certified Nursing Assistant (CNA) stated R29 had complained of pain. The Ambulance Transportation Driver 1 also stated R29 moaned when he transferred him from the stretcher to the chair at the dialysis center then he informed the nurse. Interview on 1/18/22 at 5:43 p.m. with RN11 revealed the dialysis center called and stated that R29 was transferred to the hospital due to a hip fracture. RN11 stated she didn't recall if R29 complained of pain prior to going to the dialysis center, if she treated him for pain, or if she conducted a skin assessment. Continued interview with RN11 revealed that she reported the injury to the DON, but she was not interviewed about the incident by the DON or the Administrator. Interview on 1/19/22 at 5:41 p.m. with the DON revealed she became aware of the injury of unknown source on 5/13/21 when RN11 reported that the dialysis center contacted the facility and reported they sent R29 to the hospital due to a right hip fracture. The DON stated she asked staff if R29 had fallen, staff had no knowledge of him having a fall, however, she didn't document the interviews or ask for written statements. The DON also stated review of R29's x-ray results from 11/2020 which revealed R29 had moderate osteoarthritis in his right hip. The DON stated that based on his transfer and mobility capacity he wouldn't have been able to get off the floor or transfer back to the bed without assistance of two or more people. Interview on 1/19/22 at 5:54 p.m. with the Administrator revealed he was the Abuse Coordinator for the facility and the DON conducted the investigation of the injury of unknown origin and submitted the initial report to the SA. The Administrator also stated he submitted the follow up report to the SA. The Administrator indicated that one of CNAs that cared for R29 no longer worked at the facility and the other CNA worked PRN [as needed].

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, record review, and review of facility policy titled Involuntary Transfers and Discharges, the facility failed to involve a physician in determining if the safety of individuals was endangered prior to an attempt to involuntarily discharge to a homeless shelter for one of two residents (Resident (R) 128) reviewed for discharges. Findings include: Review of the document titled Admission Packet - Skilled Nursing Facility, undated and provided by the facility, revealed Transfer and Discharge . Facility Initiated - The Facility may terminate this Agreement and transfer or discharge the Resident if: An emergency situation arises where the resident or other residents are subject to an imminent and substantial danger that only transfer, or discharge will relieve. Review of the Involuntary Transfers and Discharges policy, dated 6/30/18 and provided by the facility revealed, It is the policy of this healthcare center to permit each patient to remain in the healthcare center and not transfer or discharge them involuntarily unless it is necessary and for appropriate reason. Permitted reasons for discharge included: The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident . The health of individuals in the building would otherwise be endangered. Review of the Resident Face Sheet undated and located in the electronic medical record (EMR) under the Home tab, revealed R128 was admitted to the facility on [DATE]; diagnoses included end stage renal disease (ESRD) with hemodialysis (three times a week), chronic pain, mood disorder, right below the knee amputation (BKA), hypertension, right finger amputation, peripheral vascular disease (PVD), congestive heart failure (CHF), hyperparathyroidism, unsteadiness on feet, and muscle weakness. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/4/21 revealed R128 was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. R128 exhibited verbal behavioral symptoms towards others one to three days during the assessment period. R128 required supervision and set up with bed mobility, transfers, locomotion on the unit, and eating. R128 required limited one-person physical assistance with walking in the room, walking in the corridor, and dressing. R128 was not steady and was only able to stabilize with staff assistance for walking and turning around. He was also unsteady but was able to stabilize without staff assistance with moving from a seated to standing position, moving on and off the toilet, and surface-to-surface transfers. R128 was impaired in ROM to the lower extremity on one side. R128 used a wheelchair for locomotion; he was identified as having a medically complex condition. Review of a Nurse's Note, dated 7/26/21 and located in the EMR under the Progress Notes tab, revealed R128 was being discharged to a homeless shelter. The note read, Resident was discharged to a [homeless shelter name] . Spoke with [staff name] at [dialysis facility name] in regard to resident discharging and setting up transportation for new location; address and phone number given to [staff name at dialysis center]. [Resident's physician] made aware of resident discharging . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Social Services Note, dated 7/26/21 revealed, Resident discharged at 12:24 p.m. to [homeless shelter name]. Resident, departed with his medications and his personal belongings. During an interview on 1/18/22 at 10:28 a.m., the Ombudsman stated R128 called her three times during the discharge process and did not want to be discharged . The resident did not stay at the homeless shelter and was transferred to the hospital. During an interview on 1/18/22 at 11:05 a.m., the homeless shelter staff stated R128 was not admitted to the shelter; there was no record of him. During an interview with the Administrator and (Director of Nursing) DON on 1/19/22 at 9:48 a.m., the Administrator stated R128 was discharged due to threatening behavior towards staff. The Administrator confirmed it was an involuntary discharge due to the resident being dangerous to others. The Administrator stated R128 threatened to find out where a CNA lived and that he would hurt her. The Administrator stated a police report was filed. The Administrator stated another CNA, who lived within eyesight of the building, was threatened by R128 who stated he would take care of her husband. The Administrator stated, in addition, they also obtained statements from residents of financial exploitation. R128 ordered food and charged residents extra and then kept the cash. During a follow up interview with the Administrator and DON on 1/19/22 at 10:07 a.m. they stated they set up the discharge to the homeless shelter. R128 wanted to stay at the facility and did not want to go to the homeless shelter. R128 refused to stay at the homeless shelter once he arrived and that was why he was then transported to the hospital. The Administrator stated they had tried to find other placement prior to discharging him to the homeless shelter; however, stated, No one else would take him. The Administrator stated R128 was now living in another nursing home in the area. Review of MDS data revealed R#128 has resided in two additional long-term care facilities in the area, one from 9/22/21 through 11/6/21 and another from 11/16/21 through current. During an interview on 1/19/22 at 10:55 a.m., the Social Services Director (SSD) stated there were allegations of financial exploitation by R128 from residents. She further stated a CNA reported sexual statements were made by R128 towards her (a few days prior to the resident's discharge). The SSD stated this happened to another CNA as well. One of the CNAs called the police. Neither of the CNAs involved in the incidents were currently employed by the facility. The SSD reported a situation with the resident wanting to sit in the parking lot and that it was a safety issue due to him being in a wheelchair and the presence of rocks (not paved). The SSD stated the resident wanted to sit outside but did not want to sit in the smoking area. The SSD stated, prior to his discharge, R128 no longer wanted to be in the facility, and he started to refuse therapy and care and that a therapist was verbally assaulted by him. The SSD stated the homeless shelter had a bed and they would accept him. The SSD stated it was an involuntary discharge. The SSD stated R128 was mentally competent and could decide whether he wanted to stay at the homeless shelter. The SSD stated the resident's physician was aware of the discharge, but she did not think the physician wrote an order or documented the rationale for the involuntary discharge. During an interview on 1/20/22 at 1:28 p.m., the Medical Director, who was also R128's physician, stated he was informed after the fact of R128's discharge. The Medical Director stated he was told it was due to criminal activity and that it was a corporate decision. The Medical Director verified he had not determined the resident was a danger to other residents prior to discharge. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R#128 signed a typed statement on 7/16/21 that he would not speak to staff in derogatory terms or use sexually inappropriate language or curse words to caregivers. He also agreed to stay on the westside of the building where his room is located due to allegations of sexual harassment from a female CNA. Any violations of the agreement would lead to discharge. Review of Progress Notes and multiple witness statements from 1/1/21 through 7/26/21 (including a police report dated 7/22/21) revealed documented verbally aggressive and threatening behavior towards staff and others.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, record review, and review of facility policy titled Involuntary Transfers and Discharges, the facility failed to issue a written discharge notice with the reasons for the discharge to one of two residents reviewed for discharges (Resident (R)128). The facility failed to notify R128 and the resident's representative of the facility-initiated discharge in writing and subsequently failed to send a copy of the notice to the Office of the State Long Term Care Ombudsman. This failure increased the risk of residents and representatives not being aware of their appeal rights and/or the role of the Ombudsman as a resident advocate. Findings include: Review of the document Involuntary Transfers and Discharges policy, dated 6/30/18 and provided by the facility, revealed It is the policy of this healthcare center to permit each patient to remain in the healthcare center and not transfer or discharge them involuntarily unless it is necessary and for appropriate reason. Permitted reasons for discharge included: 3) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident . 4) The health of individuals in the building would otherwise be endangered. Further review of the policy revealed under the heading of Required Notice Before Involuntary Discharge the policy indicated, The healthcare center must provide notice to the patient, guardian or representative, and the patient's physician in writing and language that they understand. The facility must send a copy of the notice to the Office of the State Long-Term Care Ombudsman. Facility must keep a copy of the notice in the medical record . Notice of involuntary transfer or discharge includes: -Reason for transfer or discharge. -Effective date of transfer or discharge. -Location to which patient will be transferred or discharged . -Notice of the patient's right to appeal and right to counsel. -Contact information for the long-term care Ombudsman and State agencies for the protection of the developmentally and mentally disabled. Under the heading of Timing of the notice, the policy read, For any involuntary transfer or discharge made pursuant to reasons (2), (3), and (4), the facility must provide notice as soon as practicable. Review of the Resident Face Sheet, updated and located in the electronic medical record (EMR) under the Home tab, revealed R128 was admitted to the facility on [DATE]; diagnoses included end stage renal disease (ESRD) with hemodialysis (three times a week), chronic pain, mood disorder, right below the knee amputation (BKA), hypertension, right finger amputation, peripheral vascular disease (PVD), congestive heart failure (CHF), hyperparathyroidism, unsteadiness on feet, and muscle weakness. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/4/21 revealed R128 was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Review of a Nurse's Note, dated 7/26/21 and located in the EMR under the Progress Notes tab, revealed R128 was being discharged to a homeless shelter . The note read, Resident was discharged to [homeless shelter name] . [Resident's physician] made aware of resident discharging to new facility. Review of a Social Services Note dated 7/26/21 revealed, Resident, discharged at 12:24 p.m. to [homeless shelter name]. Resident, departed with his medications and his personal belongings. During an interview on 1/18/22 at 10:28 a.m., the Ombudsman stated R128 called her three times during the discharge process. The Ombudsman verified R128 was not notified with a discharge notice prior to the transfer. During an interview with the Administrator and DON on 1/19/22 at 9:48 a.m., the Administrator stated R128 was discharged due to threatening behavior towards staff. The Administrator confirmed it was an involuntary discharge due to the resident being dangerous to others. During a follow up interview with the Administrator and DON on 1/19/22 at 10:07 a.m. they stated they set up the discharge to the homeless shelter. R128 wanted to stay at the facility and did not want to go to the homeless shelter. R128 refused to stay at the homeless shelter once he arrived and that was why he was then transported to the hospital. The Administrator stated R128 was now living in another nursing home in the area. During an interview on 1/19/22 at 10:55 a.m., the Social Services Director (SSD) stated typically the business office issued a discharge notice, which was signed and provided to the resident and sent to the Ombudsman. The SSD stated she had looked but could not find any evidence this was done for R128's discharge. During an interview on 1/19/22 at 6:09 p.m., the Administrator and Director of Nursing (DON) verified no discharge notice was provided to the resident or representative prior to discharge and notice to the Long-Term Care State Ombudsman was not provided. The EMR was reviewed, and no discharge notice was found. Cross refer to F622.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on interview, record review, and review of the facility's policy titled Care Plans, the facility failed to develop a comprehensive person-centered dialysis care plan for one of four residents (Resident (R) 27) reviewed for dialysis. Findings include: Review of the facility's policy titled Care Plans, dated 12/31/96, revealed . Admission Comprehensive Plan of Care . 2. A comprehensive person-centered care plan will be developed by the interdisciplinary team for each patient/resident within seven days after the completion of the comprehensive assessment . 3. The comprehensive person-centered care plan is developed to include measurable goals and timeframes to meet a patient/resident's medical, nursing, and psychosocial needs, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan should describe the following- The services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .4. The care plan will contain 4 [four] main components: Problem, Goal, Approaches and Role or Accountability. Review of R27's Face Sheet, located under the Face Sheet tab in the electronic medical record (EMR) revealed an admitted [DATE] with a diagnosis of End Stage Renal Disease (ESRD). Review of R27's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/21 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R27 was moderately cognitively impaired. The MDS also revealed R27 had a diagnosis of ESRD and received dialysis. Review of R27's Physician's Orders, dated 1/19/22 and located in the EMR under the Orders tab, revealed an order for dialysis two times per week at [dialysis center] on Mondays and Fridays. Review of R27's comprehensive Care Plan, dated 11/7/21 and located in the EMR under the Care Plan tab, revealed dialysis was not addressed on the care plan. Interview on 1/20/22 at 3:47 p.m., the Interim MDS Coordinator stated that the MDS Coordinator should have added dialysis to the care plan with interventions such as the type of dialysis received, how often, location of the dialysis center, assess thrill and bruit [assessment of the dialysis site], and make transportation arrangements for dialysis. The Interim MDS Coordinator stated that the care plan should have been developed to address dialysis after the MDS was completed on 10/21/21.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, and record review, the facility failed to provide services to address a contracture of the right hand and an exercise program to prevent further declines in range of motion (ROM) as directed in the care plan for one of two residents (Resident (R)1) reviewed for restorative/range of motion/therapy. R1 was at risk for further declines in range of motion (ROM). Findings include: Review of the Resident Face Sheet, undated and located in the electronic medical record (EMR) under the Home tab, revealed R1 was readmitted to the facility on [DATE] following a hospital stay. R1's original admission was on 9/23/20. Pertinent diagnoses included difficulty walking, hemiparesis, and hemiplegia [weakness and paralysis on one side of the body] following cerebrovascular disease affecting the right dominant side, and contracture [fixed shortening of a muscle or tendon resulting in deformity of the joint] of the right hand. Review of the Annual Minimum Data Set (MDS), dated [DATE] and located in the EMR revealed R1 was unimpaired in cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (score of 13 - 15 indicates intact cognition). R1 was documented with verbal behaviors towards others; however, no other behaviors such as refusal of care were noted. R1 required extensive assistance of one person for bed mobility, dressing, toilet use; he required extensive assistance from two staff for transfers. R1 was impaired in ROM to the upper extremity on one side and to the lower extremities on both sides. R1 utilized a wheelchair for mobility. Review of the restorative plan dated 12/7/21 revealed to Place resident in restorative nursing program: active range of motion through all planes of motion daily, 3 sets of 10 reps (repetitions). Transfers: sit to stand as tolerated from bed; stand to bed. From bed to wheelchair\from wheelchair to bed daily X (for) 15 minutes. Report any concerns to clinical staff. Give positive feedback to resident. Flowsheet: Restorative Nursing Once a Day; Days 07:00 a.m. - 04:00 p.m. Review of the document OT (Occupational Therapy) Therapist Progress & Discharge Summary, dated 8/23/21 and provided by the facility, revealed R1 received OT services from 7/30/21 through 8/23/21 to address ADL self-care deficits. R1 received ROM to his right hand with a goal of increasing flexion from 45 degrees to 100 degrees to maintain joint integrity and avoid further deformity and risk of skin breakdown. The resident achieved 80 degrees flexion with minimal complaints of pain, but due to the new onset of blisters, did not progress further. The long-term goal was for the caregiver to appropriately don and doff the resting hand splint/grip splint orthotic to the right upper extremity and monitor skin condition for effective joint protection for six to eight hours or as tolerated. Caregiver education was provided. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the document Physical Therapy Evaluation, dated 11/24/21 and provided by the facility, revealed Patient presenting today significantly below baseline with balance deficits, ambulation deficits, activity tolerance deficits, med mobility deficits, coordination . deficits, mobility deficits, muscle weakness, transfer deficits. Based on clinical findings patient will benefit from skilled physical therapy services to address stated impairments, with goal of improving activity limitations and overall function. Review of the document General Order, dated 12/7/21 and provided by the facility, revealed Physical Therapy to be provided (daily or twice daily), (3) times per week, for (3) weeks, for medical condition . and treatment diagnosis . Treatment might include therapeutic exercise, therapeutic activities, neuromuscular reeducation wheelchair management, manual therapy and [estim Electrical Muscle Stimulation-treatment for muscle pain] . During an interview on 1/17/22 at 1:04 p.m., R1 stated he came to the facility to receive therapy. R1 stated he had recently been receiving physical therapy (PT) but was taken off and currently was not provided with any type of exercise program. R1 stated, All I do is lay in bed . R1 stated he was withering away and he needed help to get out of bed. R1 held his right hand up to the surveyor and stated he could not straighten the last three fingers on his hand. Observation revealed his last three fingers were curled towards his palm. R1 stated he had previously been provided a splint for his right hand but had not worn it since the summer and did not have it anymore. He stated he developed blisters on his right hand during the summer after application of a wrap and after that point, the splint was not applied. R1 stated the blisters healed months ago. During an interview on 1/18/22 at 5:41 p.m., Certified Nursing Assistant (CNA) 9 stated she did not provide restorative nursing (such as exercise programs, ROM, and splints) to residents. CNA9 stated the facility had specific restorative staff who did that. During an interview on 1/19/22 at 3:10 p.m., Licensed Practical Nurse (LPN)10 stated R1 was not currently receiving therapy, but had previously been on physical therapy (PT) case load from 12/07/21 through 12/12/21. During an interview on 1/19/22 at 6:25 p.m., the Administrator and Director of Nursing (DON) stated the facility was transitioning to a new restorative nursing model. The Administrator stated the facility used to have (but no longer had) restorative program aides who provided the restorative care to residents. The new plan was to have all CNAs, who would be signed off as being qualified, providing restorative as part of their care. CNAs were to document in the EMR the provision of restorative. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/20/22 at 10:25 a.m., Therapy Outcomes Coordinator (an occupational therapy assistant) stated R1 was not currently on the therapy caseload; he had been discharged on [DATE]. The Therapy Outcomes Coordinator stated therapy set up the restorative programs for residents when they were discharged from therapy and put the restorative plan on the care plan. Then nursing staff was then trained and the information went onto the dashboard in the EMR. Nursing was then responsible to implement and document the program. The Therapy Outcomes Coordinator stated there was no designated person in the nursing department who oversees the restorative program at this time; the previous person in charge had been gone from the facility for about six months. The Therapy Outcomes Coordinator stated R1 had been hospitalized and when he returned to the facility, he received physical and occupational therapy. She stated R1 had pertinent diagnoses of osteoarthritis, spinal stenosis [narrowing of the spinal column], spondylosis [degenerative changes in the vertebrae of the spine], and hemiplegia affecting the right dominant side. The Therapy Outcomes Coordinator stated R1 was seen on 7/30/21 for splinting of his right-hand to address contracture management of the right hand. She stated the resident should be currently wearing a right-hand splint six to eight hours a day. The Therapy Outcomes Coordinator verified R1 developed blisters to his right hand (in August 2021) so he could not don the splint until the blisters had healed. She stated if the blisters had resolved, he should be wearing the splint. The Therapy Outcomes Coordinator stated that part of restorative program including putting splints on, stating therapy educated CNAs and nurses how to do it and when it should be worn. The surveyor and Therapy Outcomes Coordinator went to R1's room on 1/20/22 at approximately 10:45 a.m. The Therapy Outcomes Coordinator observed R1's hand and stated R1 needed to wear a splint to address his contracted hand and to prevent further closing of his fist. R1 stated he did not have a splint; he stated he needed one. R1 attempted but was not able to straighten his last three fingers. No blisters were visible on the resident's right hand. During an interview on 1/20/22 at 1:02 p.m. LPN9 stated R1 had not worn a splint recently; however, she remembered he had previously worn a splint. LPN9 was unable to state exactly when she had last seen it used but indicated it was prior to the resident being hospitalized . During an interview on 1/20/22 at 4:02 p.m., the Administrator stated there were no restorative records (requested any records from October 2021 through 01/20/22) because R1 had not been receiving restorative services.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 28270 Based on observation, interview, and facility policy review, the facility failed to ensure current nurse staffing data was posted at the beginning of each shift. Specifically, the staff posting observed on 1/20/22 was dated 1/12/22 indicating the posting had not been updated for eight days. This had the potential to affect all residents of the facility. Findings include: Observation on 1/20/22 at 10:59 a.m. with the Director of Nursing (DON) revealed the Nursing Staffing form located in front of the DON's office on the facility's information bulletin board, was dated 1/12/22. Interview with the DON at the time of the observation confirmed the posting on the bulletin board on 1/20/22 was dated 1/12/22. Review of the facility's policy titled, State Minimum Staffing for Healthcare Centers, reviewed 10/25/18, indicated, .2. The facility will post the nurse staffing data on a daily basis by the beginning of each shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115391	A. Building B. Wing	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Eastside	2795 Finney Circle Macon, GA 31217

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and review of policy titled Monitoring of Anxiolytics, the facility failed to ensure one of five residents (Resident (R) 49) reviewed for unnecessary medications had an attempt at a gradual dose reduction (GDR) and behavior monitoring for an antianxiety medication. Findings include: Review of the document Monitoring of Anxiolytics policy, dated 7/23/19 and provided by the facility, revealed Patients/residents receive anxiolytic [antianxiety] medication only when medically necessary. Every effort is made for patients/resident who use anxiolytics to receive the intended benefit of the medications and to minimize the unwanted effects of the anxiolytic medications . Patients/residents receive an anxiolytic medication if designated medically necessary by the responsible physician and only for the shortest time possible. The reason for the medication is documented in the patient/resident's medical record . Every patient/resident on a psychotropic medication will have a behavior monitoring guide printed on the MAR (Medication Administration Record). This must be filled out by the nurse every shift and must spell out what behaviors occurred on that shift. This must be filled out as accurately as possible as it will be used in the assessment of gradual dose reduction of the psychotropic medication . Review of the Annual Minimum Data Set (MDS) with an Assessment Reference date of 11/10/21 revealed R49 was admitted to the facility on [DATE]; her diagnoses included congestive heart failure (CHF), Diabetes Mellitus Type 2, and anxiety disorder. R49 was moderately impaired in cognition with a Brief Interview for Mental Status Score (BIMS) of 12 out of 15 (score of eight through 12 indicates moderate cognitive impairment). No behaviors were exhibited during the assessment period. R49 was prescribed antianxiety and antidepressant medication all seven days of the assessment period. Review of the Physician Order, located in the electronic medical record (EMR) under the Orders tab, revealed R49 was prescribed buspirone five mg (milligrams), one tab, three times a day (TID) with an initiation date of 7/5/21 for anxiety disorder. Review of the document Consultant Pharmacist Communication to Physician, dated 7/20/21 and provided by the facility, revealed a recommendation for a GDR for Buspar (brand name for buspirone) to five mg twice daily (BID) from TID. The narrative read, Resident is due for an anxiolytic drug evaluation per CMS (Center for Medicare/Medicaid) guidelines pertaining to use in elderly. Please consider a trial reduction to Buspar 5 mg BID at this time. The box was checked to show the rationale An attempted GDR is likely to result in impairment of function or increased behavior. The physician declined the dose reduction. No further recommendations regarding Buspar had been made by the Pharmacist. No behaviors were observed, or concerns expressed to the surveyor by R49 during the survey: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115391	A. Building B. Wing	01/20/2022

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Pruitthealth - Eastside	2795 Finney Circle Macon, GA 31217

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/22 at 11:57 a.m., R49 was fully dressed, lying on her bed with oxygen on watching television. R49 resided in a private room. The surveyor and R49 chatted and set up a time for an interview. The resident was pleasant. On 1/17/22 at 3:42 p.m., R49 was interviewed. R49 was lying on her bed with oxygen on watching television. She stated she was on continuous oxygen and at times she waited for assistance to get up or to be changed. R49 did not have concerns with her medications or other aspects of her care. R49 was pleasant during the interview. On 1/18/22 at 9:46 a.m., R49 was fully dressed, lying in bed watching television with oxygen on. During an interview on 1/19/22 at 3:54 p.m., Registered Nurse (RN)1 stated R49 did not exhibit any behaviors. RN 1 stated R49 had complained of being depressed. RN1 stated when a resident received a new order for an antianxiety medication, a three-day behavior monitoring record was generated. After that, a physician's order was obtained to monitor behaviors every shift and the behaviors were documented on the MAR by the nurses. During an interview on 1/19/22 at 10:52 a.m., the Social Service Director (SSD) stated R49 had exhibited mood changes. The SSD stated R49 previously had a roommate, and the television was loud; R49 was moody related to this. The SSD stated R49 was sweet and pleasant; however, if R49 felt something was not working, she will let you know. During an interview on 1/20/22 at 1:31 p.m., the Medical Director who was R49's Physician, stated R49 had previous issues with anxiety and depression. He stated R49 was on Lexapro (antidepressant) and later he added Buspar (antianxiety). The Medical Director stated he received calls previously from the staff about R49's mood/behavior. The Medical Director stated he declined the pharmacist's recommendation for a dose reduction of the Buspar because the medication was effective i.e., the resident was not exhibiting behaviors, and he did not want to make any adjustments. He stated that usually after a few months he would do a dose reduction. The Medical Director verified there should be physician's orders for monitoring behaviors for residents on psychotropic medications. The Medical Director stated the nurses should be monitoring R49's behaviors on the MAR. During an interview on 1/20/22 at 6:03 p.m., the Director of Nursing (DON) stated R49's behaviors should be documented on the MAR. She stated there should also be a physician's order directing the nurses to monitor the resident's behaviors. Review of the MAR dated 1/1/22 through 1/19/22 and located in the EMR under the Orders tab, revealed R49 received buspirone five mg TID at 9:00 a.m., 1:00 p.m., and 5:00 p.m. No behavior monitoring was found on the MAR. During an interview on 1/20/22 at 8:05 p.m., the Nurse Consultant stated residents started on new psychoactive medications should have an initial order for three days of behavior monitoring. The Nurse Consultant stated that for R49, after three days, the behavior monitoring dropped off the MAR. The Nurse Consultant stated nursing should have followed up with the physician to ensure behavior monitoring was added to the MAR. The Nurse Consultant verified after the three days of initial behavior monitoring; behaviors had not been monitored.