STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and the facility's policy and procedure titled Advance Directives, the facility failed to act in accordance with Resident #1's Advance Directives and Full Code status (the desire to be resuscitated in the event of cardiac/respiratory arrest) after finding him unresponsive with no respirations. This affected one (Resident #1) of three residents reviewed for Advance Directives. The facility's failure to honor Resident #1's Advance Directives deprived him of potentially lifesaving measures. Resident #1 was not revived and expired in the facility. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 1:48 PM on [DATE]. On [DATE] at 11:40 PM, Immediate Jeopardy (IJ) began. On [DATE], at 7:00 PM, the Administrator was notified of the IJ determination, IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on [DATE]. The findings include: Cross reference F678 and F835. A medical record review revealed that Resident #1 was admitted to the facility on [DATE] and expired in the facility on [DATE]. His diagnoses included arthritis due to other bacteria - right knee, urinary tract infection, unspecified severe protein - calorie malnutrition, acute on chronic systolic (congestive heart failure), Alzheimer's disease, chronic obstructive pulmonary disease (COPD), a need for assistance with personal care, hypotension (low blood pressure), long term use of aspirin, and type 2 diabetes mellitus with diabetic chronic kidney disease. A review of the resident's physician's orders, dated [DATE], revealed Code Status: Full code. (Copy obtained) A nursing progress note dated [DATE] revealed that the Senior Care Partner, Social Services Director and Therapy Services met with Resident #1 and his daughter. The resident was alert and oriented times four (person, place, time and event). The discharge plan was to return home where the resident lived with his daughter. The care plan and all current medications were reviewed, and the resident's daughter was provided with a copy of both documents and verbalized understanding of them. All other questions were answered, and concerns were addressed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing progress note, dated [DATE], and authored by Registered Nurse (RN) E/Acting Director of Health Services (DHS), revealed that Certified Nursing Assistant (CNA) A alerted Licensed Practical Nurse (LPN) B that Resident #1 was unresponsive. LPN B verified that the resident was without a pulse or respirations and had a Full Code status. Cardiopulmonary resuscitation (CPR) was initiated, and the resident's time of death was 11:56 PM. LPN B attempted to reach the provider's answering service at 11:56 PM. The resident's daughter was notified at 12:07 AM. The Acting DHS and the Administrator were notified of the resident's passing, and the acting DHS arrived in the facility to assist/support the resident's family upon notification. The Acting DHS contacted the provider and updates were provided. Postmortem care was rendered. A care plan for Advance Directives/Full Treatment was initiated on [DATE]. Resident #1's Advance Directives were in effect, and he wished them to be carried out going forward. The interventions revealed that all staff should be made aware of the resident's wishes. The Advance Directives were to be reviewed with the resident/family quarterly. Staff were to discuss the resident's Advance Directives with the resident and/or the appointed health care representative. (Copy obtained) In a telephone interview with LPN B on [DATE] at 1:32 PM, he stated he had been employed with the facility since 2019 and was assigned to Resident #1 on [DATE]. He said that was his first day working with this resident. At the start of the shift (7:00 PM) Resident #1 was alert and oriented times 1-2 (he knew who he was and where he was) with some confusion. He stated at approximately 11:30 PM, CNA A was passing ice water and found the resident unresponsive. She notified him and both employees went to the resident's room. He assessed the resident for a carotid (neck) pulse (no pulse noted), he verified the code status (Full Code), and he started compressions. He stated he could not recall the time he initiated CPR. After approximately five minutes of compressions, he noticed the compressions were not having any effect, so he stopped. He tried to contact the provider, but the provider did not answer the phone. At approximately 12:00 AM, he contacted the resident's family. He then proceeded to the other nurses' station and notified the other nurses. When he was asked if he notified the DHS, he said the DHS was on vacation and he did not have contact information for the Acting DHS. He stated RN C notified the Acting DHS. When he was asked to explain the facility's protocol for administration of CPR, he stated when a resident was unresponsive, he should assess the resident for a pulse and respirations, verify the code status, initiate CPR, call a Code Blue (a medical emergency, specifically a resident experiencing cardiac or respiratory arrest) and 911, then continue CPR until emergency medical services (EMS) took over. He confirmed that he did not call 911 or a Code Blue. He said, I don't know why I didn't call a code or 911 because I know what do; I might have just panicked. He stated he was assigned 24 residents on [DATE]. When asked if he provided a written statement for facility management regarding the event, he stated, no. He added that the DHS and the Administrator interviewed him after the incident. He confirmed that he worked three more days after the incident and was terminated on [DATE] for not following the facility's protocol. A review of the facility assignments from [DATE] through [DATE] revealed that LPN B was assigned to 18, 16, 16 and 14 residents who had Full Code status on those days respectively. (Copies obtained) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 4:25 PM, RN E stated she was the Acting Director of Health Services (DHS) from [DATE] through [DATE] and was familiar with Resident #1. She said she assisted with his admission. He was blind, alert and oriented times 3 - 4. She stated the resident's discharge goal was to return home with his daughter. When asked about the resident's death, she stated on [DATE] at 2:00 AM, she received a telephone call from RN C who stated Resident #1 had expired and no Code Blue was called. RN C stated she and RN D were notified of the event two hours after the incident occurred. RN C continued that LPN B pronounced the resident's death, and the funeral home was on their way. The resident's family was already in the facility. RN E stated after she got off the phone, she contacted the Administrator, notified her of the incident, and went to the facility. When she arrived at 2:20 AM, the resident's family was in the resident's room and postmortem care had already been completed. After offering condolences to the family, she went to interview LPN B who provided the timeline of the event. (Copy obtained) LPN B stated he attempted CPR for five minutes. It was not successful and after pronouncing the resident's death, he attempted to contact the provider, then contacted the family. RN E stated she contacted Resident #1's Advanced Practice Registered Nurse (APRN) at 2:38 AM. The APRN was concerned that LPN B had pronounced the resident's death and could not establish the correct time of death, because RN C was not notified until two hours later when the resident's family and the funeral home had already been contacted. The APRN stated she had to consult with the resident's physician. After approximately five minutes the APRN called back and stated the resident's physician agreed to use the time that the LPN pronounced the resident's death and emphasized that it was outside of LPN B's scope of practice to pronounce the resident's death. RN E stated the DHS, who had been on leave, arrived at the facility at 6:00 AM and took over the investigation. RN E provided the DHS with the timeline of the event. During a telephone interview on [DATE] 11:44 AM, CNA A stated she had been employed at the facility for one year. When asked about Resident #1 and the [DATE] event, she stated [DATE] was the first time she had worked with Resident #1. She said she reported to work around 10:45 PM on [DATE] and at approximately 11:00 PM, she went to Resident #1's room to conduct shift rounds and the resident was in bed. Approximately 30 minutes later, she was passing ice water, and the resident was not in bed. She thought the resident was in the bathroom, but as she approached the resident's bed, she saw the resident in a kneeling position on the floor with his head resting on the bed in a praying position. He was between the bed and the window. She asked him if he was praying and he didn't respond. She tapped his shoulder and again asked if he was praying and he still did not respond. She immediately notified LPN B. LPN B and CNA A went right to the resident's room. After assessing for a pulse and respirations, LPN B walked out of the room to verify the resident's code status. Upon returning to the room a minute or so later, LPN B asked her to help him get the resident off the floor and onto the bed. She stated they placed the resident on the floor first, placed a draw sheet under the resident, and put him back in bed. She stated there were no other instructions provided by LPN B. She left the room to assist another resident who was in the bathroom and left LPN B in Resident #1's room. She stated she was not sure if LPN B administered CPR. She stated Resident #1 was warm to touch when they placed him back in bed. When asked if she provided the facility's management with a witness statement, she replied that she was interviewed by the DHS and described the event the same way she had described it during this interview. She said she was not asked to write a witness statement that day; however, on [DATE] (the date of the survey), she was asked to provide a written statement. When asked if she received any training after the incident, she said, No, they might have provided the training during the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A joint interview was conducted on [DATE] at 9:45 AM with the DHS and the Administrator. The DHS stated her responsibility was to ensure that the company's policies, process and nursing requirements were followed. She added that she ensured that the staffing requirements were met. She explained that she utilized a checklist during the morning clinical meeting to ensure that all clinical issues were addressed thoroughly and completely. During that meeting, issues such as change in condition, incidents, hospitalization and admissions were reviewed. She stated if the team found that anything had been missed, a staff member was assigned to ensure it was completed. When they were asked to review the incident involving Resident #1, the Administrator stated she was contacted by RN E on [DATE] at 2:05 AM. RN E explained that she had received a call from RN C notifying her that Resident #1 had expired and she had concerns as there was a delay in notifying her of the incident. RN E stated she was enroute to the facility to find out what happened and meet with the family. The Administrator asked RN E to gather information and call her back. Approximately 30 minutes later, the Administrator contacted RN E and asked to speak to LPN B. LPN B stated at approximately 11:40 PM, CNA A called him to Resident #1's room. The resident was unresponsive, he performed CPR for approximately five minutes, and when he was unsuccessful, he stopped. LPN B stated he could not reach the on-call provider but reached the family. The Administrator asked LPN B to write a statement and put it under the DHS' door. She also asked him not to leave the facility until DHS arrived. The Administrator contacted the DHS who had just returned from vacation and notified her of the incident. She instructed her to go to the facility and assist with the investigation. The DHS stated she arrived at the facility at approximately 5:30 AM on [DATE]. She met with RN E and was provided with a synopsis of the incident. RN E told her that she called the on-call physician who voiced concerns with the time RN C was notified of the resident's time of death (concerns determining the time of death). The DHS interviewed LPN B who confirmed the incident as it was documented by RN E. He also confirmed that he did not call a Code Blue per facility policy and conducted CPR alone and pronounced the resident's death. When asked about the facility's protocol when staff find a resident who is unresponsive, the DHS outlined the following steps: Step 1: Assess for a pulse and respirations (apical pulse (the pulse felt at the apex (bottom) of the heart, on the left side of the chest) for one minute). Step 2: Find the code status. Step 3: If the resident is a Full Code, activate Code Blue (paging overhead) and initiate CPR. She stated if there were signs of death, CPR should not be initiated. If CPR was initiated, it should not be stopped until 911/EMS (Emergency Medical Services) took over. On [DATE] at 2:03 PM, a telephone interview was conducted with the Medical Director, who confirmed that he was notified of the incident involving Resident #1 on [DATE]. He stated his expectation was that when a resident who was a Full Code was found unresponsive, CPR should be performed, unless there were signs that rigor mortis had set in. At that point, an RN could pronounce a resident's death. He stated when CPR is initiated, staff should not stop until they are told to stop by a physician or EMS upon arrival. He said he was notified that LPN B was unable to reach the provider. He said, At the very least, he should have stopped and got the RN to pronounce the death because an LPN cannot pronounce death. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on [DATE] at 2:14 PM with the Senior Nurse Consultant (SNC). She stated she had been in her role since [DATE]. She said she was contacted by the Administrator about the [DATE] incident early on the morning of [DATE]. She was told that LPN B initiated CPR and stopped when he was unsuccessful. He then pronounced the resident's death. When asked to explain the facility's policy and procedure for CPR, the SNC stated if a resident was a Full Code, the staff should initiate CPR; however, if there was enough evidence or rigor mortis was present, staff should not initiate CPR and should instead contact the provider. She confirmed that CPR should be initiated if there was evidence/likelihood of survival, and once CPR was initiated, staff should not stop until the provider asked them to or EMS arrived and took over. A review of the facility's policy titled Advance Directives: Florida (revised [DATE], reviewed [DATE]), revealed: Forms: Florida Living Will Form, Florida Healthcare Surrogate Form Policy Statement: This healthcare center recognizes the right of patients/residents to control decisions related to their medical care. Advance Directives relate to the provision of care when the patient/resident lacks the capacity to make healthcare decisions. Advance Directives executed in accordance with state law will be honored by the healthcare center. .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and the facility's policy and procedure titled Abuse Preventing and Reporting, the facility failed to 1) Ensure that alleged violations involving resident neglect were reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegation resulted in serious bodily injury (death), to the State Survey Agency in accordance with State law for one (Resident #1) of three resident incident reports reviewed. The findings include: A medical record review revealed that Resident #1 was admitted to the facility on [DATE] and expired in the facility on [DATE]. A review of the resident's physician's orders, dated [DATE], revealed Code Status: Full code. (Copy obtained) A nursing progress note, dated [DATE], and authored by Registered Nurse (RN) E/Acting Director of Health Services (DHS), revealed that Certified Nursing Assistant (CNA) A alerted Licensed Practical Nurse (LPN) B that Resident #1 was unresponsive. LPN B verified that the resident was without a pulse or respirations and had a Full Code status. Cardiopulmonary resuscitation (CPR) was initiated, and the resident's time of death was 11:56 PM. LPN B attempted to reach the provider's answering service at 11:56 PM. The resident's daughter was notified at 12:07 AM. The Acting DHS and the Administrator were notified of the resident's passing, and the acting DHS arrived in the facility to assist/support the resident's family upon notification. The Acting DHS contacted the provider and updates were provided. Postmortem care was rendered. A care plan for Advance Directives/Full Treatment was initiated on [DATE]. Resident #1's Advance Directives were in effect, and he wished them to be carried out going forward. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview with LPN B on [DATE] at 1:32 PM, he stated he had been employed with the facility since 2019 and was assigned to Resident #1 on [DATE]. He said that was his first day working with this resident. At the start of the shift (7:00 PM) Resident #1 was alert and oriented times 1-2 (he knew who he was and where he was) with some confusion. He stated at approximately 11:30 PM, CNA A was passing ice water and found the resident unresponsive. She notified him and both employees went to the resident's room. He assessed the resident for a carotid (neck) pulse (no pulse noted), he verified the code status (Full Code), and he started compressions. He stated he could not recall the time he initiated CPR. After approximately five minutes of compressions, he noticed the compressions were not having any effect, so he stopped. He tried to contact the provider, but the provider did not answer the phone. At approximately 12:00 AM, he contacted the resident's family. He then proceeded to the other nurses' station and notified the other nurses. When he was asked if he notified the DHS, he said the DHS was on vacation and he did not have contact information for the Acting DHS. He stated RN C notified the Acting DHS. When he was asked to explain the facility's protocol for administration of CPR, he stated when a resident was unresponsive, he should assess the resident for a pulse and respirations, verify the code status, initiate CPR, call a Code Blue (a medical emergency, specifically a resident experiencing cardiac or respiratory arrest) and 911, then continue CPR until emergency medical services (EMS) took over. He confirmed that he did not call 911 or a Code Blue. He said, I don't know why I didn't call a code or 911 because I know what do; I might have just panicked. He stated he was assigned 24 residents on [DATE]. When asked if he provided a written statement for facility management regarding the event, he stated, no. He added that the DHS and the Administrator interviewed him after the incident. He confirmed that he worked three more days after the incident and was terminated on [DATE] for not following the facility's protocol. During an interview on [DATE] at 3:30 PM, the Social Services Director (SSD) stated she had been employed by the facility for five years. She stated the details of the event were reviewed by the Director of Health Services (DHS), the Administrator, and the Regional Nurse Consultant to determine whether the event met reporting requirements. She confirmed that allegations of Abuse/Neglect/Misappropriation should be reported within two hours. She was asked to review the [DATE] event for Resident #1. She confirmed that the incident took place on [DATE]. She stated she was not present during the incident. She explained that she received the timeline of the incident from RN E who was the Acting DHS at the time of the incident. The SSD stated on [DATE] at 11:30 PM, CNA A found Resident #1 unresponsive and notified LPN B, who assessed the resident and initiated cardiopulmonary resuscitation (CPR) at 11:40 PM. LPN B administered CPR for approximately five minutes. Resident #1 was unable to be resuscitated by LPN B, who pronounced the resident's death at 11:56 PM, and at that time, he called the provider and the family. The SSD confirmed that the incident was reported to the appropriate agencies on [DATE], five days after the event. She explained that the Administrator had notified the corporate office about the incident and was made aware that it was not a reportable event. When asked if the corporate personnel provided the rationale, she stated LPN B reported that Resident #1 was already cold/expired when he found him. When asked for documentation from LPN B indicating that the resident was cold, she confirmed that there was no documentation, and no witness statement was obtained. She added that on [DATE] she was notified by the Administrator that a determination had been made by the corporate office that the incident was indeed reportable and that LPN B should be terminated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 4:25 PM, RN E stated she was the Acting Director of Health Services (DHS) from [DATE] through [DATE] and was familiar with Resident #1. She stated the resident's discharge goal was to return home with his daughter. When asked about the resident's death, she stated on [DATE] at 2:00 AM, she received a telephone call from RN C who stated Resident #1 had expired and no Code Blue was called. RN C stated she and RN D were notified of the event two hours after the incident occurred. RN C continued that LPN B pronounced the resident's death, and the funeral home was on their way. The resident's family was already in the facility. RN E stated after she got off the phone, she contacted the Administrator, notified her of the incident, and went to the facility. When she arrived at 2:20 AM, the resident's family was in the resident's room and postmortem care had already been completed. After offering condolences to the family, she went to interview LPN B who provided the timeline of the event. (Copy obtained) LPN B stated he attempted CPR for five minutes. It was not successful and after pronouncing the resident's death, he attempted to contact the provider, then contacted the family. RN E stated she contacted Resident #1's Advanced Practice Registered Nurse (APRN) at 2:38 AM. The APRN was concerned that LPN B had pronounced the resident's death and could not establish the correct time of death, because RN C was not notified until two hours later when the resident's family and the funeral home had already been contacted. The APRN stated she had to consult with the resident's physician. After approximately five minutes the APRN called back and stated the resident's physician agreed to use the time that the LPN pronounced the resident's death and emphasized that it was outside of LPN B's scope of practice to pronounce the resident's death. RN E stated the DHS, who had been on leave, arrived at the facility at 6:00 AM and took over the investigation. RN E provided the DHS with the timeline of the event. A joint interview was conducted on [DATE] at 9:45 AM with the DHS and the Administrator. The Administrator stated she was responsible for the oversight of the facility's operation. She stated she used different audit tools to ensure that measures were met. She added that she reported to the corporate team weekly. When asked to explain the facility's grievance/concerns process, she replied that the SSD was the grievance officer. The SSD reviewed grievances/concerns with the DHS and the Administrator. She added that incidents/grievances/concerns were also discussed during morning meetings, and the team decided whether or not an incident met the reporting requirements. All reportable incidents were also reviewed by the corporate Senior Nurse Consultant and Risk Manager. When asked to review the [DATE] incident involving Resident #1, the Administrator stated she was contacted by RN E on [DATE] at 2:05 AM and RN E explained that she had received a call from RN C informing her that Resident #1 had expired. There were concerns, as there was a delay in her having been notified of the event. RN E added that she was enroute to the facility to find out what happened and to meet with the family. The Administrator asked RN E to gather more information and call her back. Approximately 30 minutes later, the Administrator contacted RN E and asked to speak to LPN B. LPN B stated that at approximately 11:40 PM, CNA A called him to Resident #1's room. The resident was unresponsive. LPN B administered CPR for approximately five minutes, and when he was unsuccessful, he stopped. LPN B stated he could not reach the on-call provider but reached the family. When asked why the incident was not reported, the Administrator stated they felt the incident did not meet the requirement for reporting. She stated, It was an education moment because LPN B did not follow the facility's policy. She stated LPN B reported that Resident #1 was already dead. When asked if there were any progress notes documenting the incident, she replied, no. She added that she spoke to the Senior Nurse Consultant (SNC) about the incident and the SNC stated the incident did not meet reporting requirements. When asked if LPN B could pronounce a resident's death, she confirmed that LPN B acted out of his scope of practice but stated he could not reach the physician. She was then asked why LPN B was not suspended pending the investigation. She stated staff were suspended only when an incident was determined to be reportable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] 11:44 AM, CNA A stated she had been employed at the facility for one year. When asked about Resident #1 and the [DATE] event, she stated [DATE] was the first time she had worked with Resident #1. She said she reported to work around 10:45 PM on [DATE] and at approximately 11:00 PM, she went to Resident #1's room to conduct shift rounds and the resident was in bed. Approximately 30 minutes later, she was passing ice water, and the resident was not in bed. She thought the resident was in the bathroom, but as she approached the resident's bed, she saw the resident in a kneeling position on the floor with his head resting on the bed in a praying position. He was between the bed and the window. She asked him if he was praying and he didn't respond. She tapped his shoulder and again asked if he was praying and he still did not respond. She immediately notified LPN B. LPN B and CNA A went right to the resident's room. After assessing for a pulse and respirations, LPN B walked out of the room to verify the resident's code status. Upon returning to the room a minute or so later, LPN B asked her to help him get the resident off the floor and onto the bed. She stated they placed the resident on the floor first, placed a draw sheet under the resident, and put him back in bed. She stated there were no other instructions provided by LPN B. She left the room to assist another resident who was in the bathroom and left LPN B in Resident #1's room. She stated she was not sure if LPN B administered CPR. She stated Resident #1 was warm to touch when they placed him back in bed. When asked if she provided the facility's management with a witness statement, she replied that she was interviewed by the DHS and described the event the same way she had described it during this interview. She said she was not asked to write a witness statement that day; however, on [DATE] (the date of the survey), she was asked to provide a written statement. A review of the facility's policy and procedure titled Abuse Prevention and Reporting (effective [DATE], revised [DATE]) revealed: Abuse: Any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a resident, including but not limited to, assault or battery, failure to provide treatment or care, or sexual harassment of the resident. Procedure: 1. Anyone witnessing, suspecting or hearing an allegation of mental, physical, verbal or sexual abuse; neglect or exploitation of any resident will immediately report this to the Administrator whether the Administrator is on the premises or not. 2. The Administrator will immediately begin an investigation and implement measures necessary to assure the safety and protection of the residents from the actual or alleged perpetrator. 3. In the event the Administrator has knowledge that the resident has been abused, neglected or exploited while residing in the home, he/she will immediately make a report by phone or in person to the Department of Community Health. In the event that an immediate report to the Department is not possible, the Administrator shall make the report to the appropriate law enforcement agency. 4. The initial report of actual or suspected abuse shall contain at least the following: - Name and address of person making the report. - Name and address of the resident or former resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Name and address of the facility. - Nature and extent of any injuries or condition resulting from the suspected abuse, neglect or exploitation. - The suspected cause of the incident. - Any other information that the reporter believes might be helpful in determining the cause of the resident's injuries or condition and determining the identity of person or persons responsible for the incident. 5. Within 24 hours of the initial report, the Administrator shall also make a written report, using the Incident Report Form, documenting all known and relevant information, the investigation results, and any corrective or protective actions taken. 6. The written Incident Report shall be faxed to the Department of Community Health, Health Facility Regulation Department, Complaint Division. 7. The fax confirmation sheet shall be attached to the Incident Report and maintained in the central Incident Report file. 8. If the alleged perpetrator is a staff member of the home, the Administrator will place them on administrative leave until a determination of the allegation is made. Confirmed allegations shall result in termination with notification to appropriate boards, registries and agencies and the police as appropriate. .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and a review of the facility's policy and procedure titled Cardiopulmonary Resuscitation (CPR), the facility failed to administer cardiopulmonary resuscitation (CPR) to one resident who had a Full Code status (the desire to be resuscitated in the event of cardiac/respiratory arrest) after finding him unresponsive with no respirations. This affected one (Resident #1) of three residents reviewed for Advance Directives. The facility's failure to provide CPR according to Resident #1's Advance Directives deprived him of potentially lifesaving measures. Resident #1 was not revived and expired at the facility. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 1:48 PM on [DATE]. On [DATE] at 11:40 PM, Immediate Jeopardy (IJ) began. On [DATE], at 7:00 PM, the Administrator was notified of the IJ determination, IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on [DATE]. The findings include: Cross reference F578 and F835. A medical record review revealed that Resident #1 was admitted to the facility on [DATE] and expired in the facility on [DATE]. His diagnoses included arthritis due to other bacteria - right knee, urinary tract infection, unspecified severe protein - calorie malnutrition, acute on chronic systolic (congestive heart failure), Alzheimer's disease, chronic obstructive pulmonary disease (COPD), a need for assistance with personal care, hypotension (low blood pressure), long term use of aspirin, and type 2 diabetes mellitus with diabetic chronic kidney disease. A review of the resident's physician's orders, dated [DATE], revealed Code Status: Full code. (Copy obtained) A nursing progress note dated [DATE] revealed that the Senior Care Partner met with the resident to review his admission and orient him to the unit and routine. The resident was alert and oriented times four (alert to himself, his location, the time, and the circumstances), and he was blind. The initial care conference was scheduled pending family availability. A nursing progress note dated [DATE] revealed that the resident was alert and oriented times three. He had no complaints and no distress was noted. His vital signs were within normal limits, and his medications were taken without difficulty. Therapy was completed at bedside and safety precautions were in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing progress note dated [DATE] revealed that the Senior Care Partner, the Social Services Director (SSD), and Therapy Services met with Resident #1 and his daughter. The resident was alert and oriented times four. The discharge plan was to return home where the resident lived with his daughter. The care plan and all current medications were reviewed, and the daughter was provided with a copy of both documents and verbalized understanding. All other questions were answered and concerns were addressed. A nursing progress note, dated [DATE], and authored by Registered Nurse (RN) E/Acting Director of Health Services (DHS), revealed that Certified Nursing Assistant (CNA) A alerted Licensed Practical Nurse (LPN) B that Resident #1 was unresponsive. LPN B verified that the resident was without a pulse or respirations and had a Full Code status. Cardiopulmonary resuscitation (CPR) was initiated, and the resident's time of death was 11:56 PM. LPN B attempted to reach the provider's answering service at 11:56 PM. The resident's daughter was notified at 12:07 AM. The Acting DHS and the Administrator were notified of the resident's passing, and the acting DHS arrived in the facility to assist/support the resident's family upon notification. The Acting DHS contacted the provider and updates were provided. Postmortem care was rendered. A care plan for Advance Directives/Full Treatment was initiated on [DATE]. Resident #1's Advance Directives were in effect, and he wished them to be carried out going forward. The interventions revealed that all staff should be made aware of the resident's wishes. The Advance Directives were to be reviewed with the resident/family quarterly. Staff were to discuss the resident's Advance Directives with the resident and/or the appointed health care representative. (Copy obtained) In a telephone interview with LPN B on [DATE] at 1:32 PM, he stated he had been employed with the facility since 2019 and was assigned to Resident #1 on [DATE]. He said that was his first day working with this resident. At the start of the shift (7:00 PM) Resident #1 was alert and oriented times 1-2 (he knew who he was and where he was) with some confusion. He stated at approximately 11:30 PM, CNA A was passing ice water and found the resident unresponsive. She notified him and both employees went to the resident's room. He assessed the resident for a carotid (neck) pulse (no pulse noted), he verified the code status (Full Code), and he started compressions. He stated he could not recall the time he initiated CPR. After approximately five minutes of compressions, he noticed the compressions were not having any effect, so he stopped. He tried to contact the provider, but the provider did not answer the phone. At approximately 12:00 AM, he contacted the resident's family. He then proceeded to the other nurses' station and notified the other nurses. When he was asked if he notified the DHS, he said the DHS was on vacation and he did not have contact information for the Acting DHS. He stated RN C notified the Acting DHS. When he was asked to explain the facility's protocol for administration of CPR, he stated when a resident was unresponsive, he should assess the resident for a pulse and respirations, verify the code status, initiate CPR, call a Code Blue (a medical emergency, specifically a resident experiencing cardiac or respiratory arrest) and 911, then continue CPR until emergency medical services (EMS) took over. He confirmed that he did not call 911 or a Code Blue. He said, I don't know why I didn't call a code or 911 because I know what do; I might have just panicked. He stated he was assigned 24 residents on [DATE]. When asked if he provided a written statement for facility management regarding the event, he stated, no. He added that the DHS and the Administrator interviewed him after the incident. He confirmed that he worked three more days after the incident and was terminated on [DATE] for not following the facility's protocol. A review of the facility assignments from [DATE] through [DATE] revealed that LPN B was assigned to 18, 16, 16 and 14 residents who had Full Code status on those days respectively. (Copies obtained) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 4:25 PM, RN E stated she was the Acting Director of Health Services (DHS) from [DATE] through [DATE] and was familiar with Resident #1. She said she assisted with his admission. He was blind, alert and oriented times 3 - 4. She stated the resident's discharge goal was to return home with his daughter. When asked about the resident's death, she stated on [DATE] at 2:00 AM, she received a telephone call from RN C who stated Resident #1 had expired and no Code Blue was called. RN C stated she and RN D were notified of the event two hours after the incident occurred. RN C continued that LPN B pronounced the resident's death, and the funeral home was on their way. The resident's family was already in the facility. RN E stated after she got off the phone, she contacted the Administrator, notified her of the incident, and went to the facility. When she arrived at 2:20 AM, the resident's family was in the resident's room and postmortem care had already been completed. After offering condolences to the family, she went to interview LPN B who provided the timeline of the event. (Copy obtained) LPN B stated he attempted CPR for five minutes. It was not successful and after pronouncing the resident's death, he attempted to contact the provider, then contacted the family. RN E stated she contacted Resident #1's Advanced Practice Registered Nurse (APRN) at 2:38 AM. The APRN was concerned that LPN B had pronounced the resident's death and could not establish the correct time of death, because RN C was not notified until two hours later when the resident's family and the funeral home had already been contacted. The APRN stated she had to consult with the resident's physician. After approximately five minutes the APRN called back and stated the resident's physician agreed to use the time that the LPN pronounced the resident's death and emphasized that it was outside of LPN B's scope of practice to pronounce the resident's death. RN E stated the DHS, who had been on leave, arrived at the facility at 6:00 AM and took over the investigation. RN E provided the DHS with the timeline of the event. During a telephone interview on [DATE] 11:44 AM, CNA A stated she had been employed at the facility for one year. When asked about Resident #1 and the [DATE] event, she stated [DATE] was the first time she had worked with Resident #1. She said she reported to work around 10:45 PM on [DATE] and at approximately 11:00 PM, she went to Resident #1's room to conduct shift rounds and the resident was in bed. Approximately 30 minutes later, she was passing ice water, and the resident was not in bed. She thought the resident was in the bathroom, but as she approached the resident's bed, she saw the resident in a kneeling position on the floor with his head resting on the bed in a praying position. He was between the bed and the window. She asked him if he was praying and he didn't respond. She tapped his shoulder and again asked if he was praying and he still did not respond. She immediately notified LPN B. LPN B and CNA A went right to the resident's room. After assessing for a pulse and respirations, LPN B walked out of the room to verify the resident's code status. Upon returning to the room a minute or so later, LPN B asked her to help him get the resident off the floor and onto the bed. She stated they placed the resident on the floor first, placed a draw sheet under the resident, and put him back in bed. She stated there were no other instructions provided by LPN B. She left the room to assist another resident who was in the bathroom and left LPN B in Resident #1's room. She stated she was not sure if LPN B administered CPR. She stated Resident #1 was warm to touch when they placed him back in bed. When asked if she provided the facility's management with a witness statement, she replied that she was interviewed by the DHS and described the event the same way she had described it during this interview. She said she was not asked to write a witness statement that day; however, on [DATE] (the date of the survey), she was asked to provide a written statement. When asked if she received any training after the incident, she said, No, they might have provided the training during the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:30 PM, the Social Services Director (SSD) stated she had been employed by the facility for five years. She was asked to review the [DATE] event for Resident #1. She confirmed that the incident took place on [DATE]. She stated she was not present during the incident. She explained that she received the timeline of the incident from RN E who was the Acting DHS at the time of the incident. The SSD stated on [DATE] at 11:30 PM, CNA A found Resident #1 unresponsive and notified LPN B, who assessed the resident and initiated cardiopulmonary resuscitation (CPR) at 11:40 PM. LPN B administered CPR for approximately five minutes. Resident #1 was unable to be resuscitated by LPN B, who pronounced the resident's death at 11:56 PM, and at that time, he called the provider and the family. A joint interview was conducted on [DATE] at 9:45 AM with the DHS and the Administrator. When they were asked to review the incident involving Resident #1, the Administrator stated she was contacted by RN E on [DATE] at 2:05 AM. RN E explained that she had received a call from RN C notifying her that Resident #1 had expired and she had concerns as there was a delay in notifying her of the incident. RN E stated she was enroute to the facility to find out what happened and meet with the family. The Administrator asked RN E to gather information and call her back. Approximately 30 minutes later, the Administrator contacted RN E and asked to speak to LPN B. LPN B stated at approximately 11:40 PM, CNA A called him to Resident #1's room. The resident was unresponsive, he performed CPR for approximately five minutes, and when he was unsuccessful, he stopped. LPN B stated he could not reach the on-call provider but reached the family. The Administrator asked LPN B to write a statement and put it under the DHS' door. She also asked him not to leave the facility until DHS arrived. The Administrator contacted the DHS who had just returned from vacation and notified her of the incident. She instructed her to go to the facility and assist with the investigation. The DHS stated she arrived at the facility at approximately 5:30 AM on [DATE]. She met with RN E and was provided with a synopsis of the incident. RN E told her that she called the on-call physician who voiced concerns with the time RN C was notified of the resident's time of death (concerns determining the time of death). The DHS interviewed LPN B who confirmed the incident as it was documented by RN E. He also confirmed that he did not call a Code Blue per facility policy and conducted CPR alone and pronounced the resident's death. When asked about the facility's protocol when staff find a resident who is unresponsive, the DHS outlined the following steps: Step 1: Assess for a pulse and respirations (apical pulse (the pulse felt at the apex (bottom) of the heart, on the left side of the chest) for one minute). Step 2: Find the code status. Step 3: If the resident is a Full Code, activate Code Blue (paging overhead) and initiate CPR. She stated if there were signs of death, CPR should not be initiated. If CPR was initiated, it should not be stopped until 911/EMS (Emergency Medical Services) took over. On [DATE] at 2:03 PM, a telephone interview was conducted with the Medical Director, who confirmed that he was notified of the incident involving Resident #1 on [DATE]. He stated his expectation was that when a resident who was a Full Code was found unresponsive, CPR should be performed, unless there were signs that rigor mortis had set in. At that point, an RN could pronounce a resident's death. He stated when CPR is initiated, staff should not stop until they are told to stop by a physician or EMS upon arrival. He said he was notified that LPN B was unable to reach the provider. He said, At the very least, he should have stopped and got the RN to pronounce the death because an LPN cannot pronounce death. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on [DATE] at 2:14 PM with the Senior Nurse Consultant (SNC). She stated she had been in her role since [DATE]. She said she was contacted by the Administrator about the [DATE] incident early on the morning of [DATE]. She was told that LPN B initiated CPR and stopped when he was unsuccessful. He then pronounced the resident's death. When asked to explain the facility's policy and procedure for CPR, the SNC stated if a resident was a Full Code, the staff should initiate CPR; however, if there was enough evidence or rigor mortis was present, staff should not initiate CPR and should instead contact the provider. She confirmed that CPR should be initiated if there was evidence/likelihood of survival, and once CPR was initiated, staff should not stop until the provider asked them to or EMS arrived and took over. A review of the facility's policy and procedure titled Cardiopulmonary Resuscitation (CPR - effective [DATE], reviewed [DATE]), revealed: Policy Statement: Cardiopulmonary resuscitation (CPR) must be initiated on any patient/resident that has experienced cardiac arrest and does not have a Do Not Resuscitate (DNR) order. Further clarification for initiation of CPR is as follows: 1. When a patient/resident shows no signs of breathing and/or circulation. 2. The nurse will not initiate CPR, even in the absence of a DNR, if a patient/resident is obviously clinically and irretrievably dead and the death was not witnessed. Examples of signs that a patient/resident is clinically irretrievably dead include: no measurable vital signs, cool to the touch, and pupils that are fixed and dilated. 3. If there is no DNR order, and there is any question about whether or not the patient/resident is clinically and irretrievably dead, the nurse shall always initiate CPR. 4. If the death is witnessed and there is no DNR order, CPR will be initiated, even if the patient/resident is clinically and irretrievably dead. Definition: Cardiopulmonary Resuscitation is the administration of therapeutic resuscitative measures for cardiac or pulmonary arrest. These include closed chest cardiac massage and enhanced respiratory assistance. No CPR is a physician's written order not to apply or attempt resuscitation. All measures to provide therapeutic assistance and comfort will be continued. Attending Physician is the medical physician charged with ultimate responsibility for patient/resident's medical care. Procedure: When a Patient/Resident Experiences Cardiac or Respiratory Arrest and CPR is Medically Justified: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. A licensed nurse certified in CPR will be available on all shifts. One-Rescuer or Two- Rescuer CPR will be initiated as appropriate. 2. If a patient/resident is found in cardiac or respiratory arrest, the appropriate personnel will be notified and the status of the DNR determined. 3. Designated staff will immediately call emergency services. 4. All staff members certified in CPR or licensed staff should immediately go to the identified room. A designated staff person will be responsible for responding immediately with the emergency equipment. 5. If the person is medically determined to need CPR and there are three certified staff, two will take turns performing CPR per American Heart Association guidelines and the third will provide direction to all other staff and document times and actions taken. If there are only two staff members, one will perform CPR per the American Heart Association guidelines and the other will provide direction to all other staff. 6. The Charge Nurse will call the patient/resident's physician or on-call physician to inform him that emergency service has been called and then follow the physician's orders. 7. The Charge Nurse is responsible for informing the patient/resident's legal representative, responsible party, or authorized person next (as defined in the HIM Manual). 8. The Administrator or Director of Health Services will be informed. Documentation: 1. After the crisis is over, the occurrence and related information will be documented in the 1. Nurse's Notes in detail of what actions were taken and what meds were given during the code. 2. For healthcare centers with electronic charting the note will be in the nurse department notes. .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, a review of the facility's policy titled Abuse Prevention and Reporting, and a review of the Agency for Health Care Administration's Background Screening Clearinghouse website, the facility's administration failed to to administer the facility in a manner that enabled it to use its resources effectively and efficiently when it failed to immediately investigate the death of Resident #1 on [DATE]. The facility failed to ensure that measures were immediately put in place for resident safety, and thorough investigations were completed to identify system failures and facility needs. This placed the facility's 47 other residents identified as having a Full Code status at risk of suffering avoidable and untimely deaths. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 1:48 PM on [DATE]. On [DATE] at 11:40 PM, Immediate Jeopardy (IJ) began. On [DATE], at 7:00 PM, the Administrator was notified of the IJ determination, IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on [DATE]. The findings include: Cross reference F578 and F678. A medical record review revealed that Resident #1 was admitted to the facility on [DATE] and expired in the facility on [DATE]. His diagnoses included arthritis due to other bacteria - right knee, urinary tract infection, unspecified severe protein - calorie malnutrition, acute on chronic systolic (congestive heart failure), Alzheimer's disease, chronic obstructive pulmonary disease (COPD), a need for assistance with personal care, hypotension (low blood pressure), long term use of aspirin, and type 2 diabetes mellitus with diabetic chronic kidney disease. A review of the resident's physician's orders, dated [DATE], revealed Code Status: Full code. (Copy obtained) A nursing progress note dated [DATE] revealed that the Senior Care Partner, the Social Services Director (SSD), and Therapy Services met with Resident #1 and his daughter. The resident was alert and oriented times four. The discharge plan was to return home where the resident lived with his daughter. The care plan and all current medications were reviewed, and the daughter was provided with a copy of both documents and verbalized understanding. All other questions were answered and concerns were addressed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing progress note, dated [DATE], and authored by Registered Nurse (RN) E/Acting Director of Health Services (DHS), revealed that Certified Nursing Assistant (CNA) A alerted Licensed Practical Nurse (LPN) B that Resident #1 was unresponsive. LPN B verified that the resident was without a pulse or respirations and had a Full Code status. Cardiopulmonary resuscitation (CPR) was initiated, and the resident's time of death was 11:56 PM. LPN B attempted to reach the provider's answering service at 11:56 PM. The resident's daughter was notified at 12:07 AM. The Acting DHS and the Administrator were notified of the resident's passing, and the acting DHS arrived in the facility to assist/support the resident's family upon notification. The Acting DHS contacted the provider and updates were provided. Postmortem care was rendered. A care plan for Advance Directives/Full Treatment was initiated on [DATE]. Resident #1's Advance Directives were in effect, and he wished them to be carried out going forward. The interventions revealed that all staff should be made aware of the resident's wishes. The Advance Directives were to be reviewed with the resident/family quarterly. Staff were to discuss the resident's Advance Directives with the resident and/or the appointed health care representative. (Copy obtained) In a telephone interview with LPN B on [DATE] at 1:32 PM, he stated he had been employed with the facility since 2019 and was assigned to Resident #1 on [DATE]. He said that was his first day working with this resident. At the start of the shift (7:00 PM) Resident #1 was alert and oriented times 1-2 (he knew who he was and where he was) with some confusion. He stated at approximately 11:30 PM, CNA A was passing ice water and found the resident unresponsive. She notified him and both employees went to the resident's room. He assessed the resident for a carotid (neck) pulse (no pulse noted), he verified the code status (Full Code), and he started compressions. He stated he could not recall the time he initiated CPR. After approximately five minutes of compressions, he noticed the compressions were not having any effect, so he stopped. He tried to contact the provider, but the provider did not answer the phone. At approximately 12:00 AM, he contacted the resident's family. He then proceeded to the other nurses' station and notified the other nurses. When he was asked if he notified the DHS, he said the DHS was on vacation and he did not have contact information for the Acting DHS. He stated RN C notified the Acting DHS. When he was asked to explain the facility's protocol for administration of CPR, he stated when a resident was unresponsive, he should assess the resident for a pulse and respirations, verify the code status, initiate CPR, call a Code Blue (a medical emergency, specifically a resident experiencing cardiac or respiratory arrest) and 911, then continue CPR until emergency medical services (EMS) took over. He confirmed that he did not call 911 or a Code Blue. He said, I don't know why I didn't call a code or 911 because I know what do; I might have just panicked. He stated he was assigned 24 residents on [DATE]. When asked if he provided a written statement for facility management regarding the event, he stated, no. He added that the DHS and the Administrator interviewed him after the incident. He confirmed that he worked three more days after the incident and was terminated on [DATE] for not following the facility's protocol. A review of the facility assignments from [DATE] through [DATE] revealed that LPN B was assigned to 18, 16, 16 and 14 residents who had Full Code status on those days respectively. (Copies obtained) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 4:25 PM, RN E stated she was the Acting Director of Health Services (DHS) from [DATE] through [DATE] and was familiar with Resident #1. She said she assisted with his admission. He was blind, alert and oriented times 3 - 4. She stated the resident's discharge goal was to return home with his daughter. When asked about the resident's death, she stated on [DATE] at 2:00 AM, she received a telephone call from RN C who stated Resident #1 had expired and no Code Blue was called. RN C stated she and RN D were notified of the event two hours after the incident occurred. RN C continued that LPN B pronounced the resident's death, and the funeral home was on their way. The resident's family was already in the facility. RN E stated after she got off the phone, she contacted the Administrator, notified her of the incident, and went to the facility. When she arrived at 2:20 AM, the resident's family was in the resident's room and postmortem care had already been completed. After offering condolences to the family, she went to interview LPN B who provided the timeline of the event. (Copy obtained) LPN B stated he attempted CPR for five minutes. It was not successful and after pronouncing the resident's death, he attempted to contact the provider, then contacted the family. RN E stated she contacted Resident #1's Advanced Practice Registered Nurse (APRN) at 2:38 AM. The APRN was concerned that LPN B had pronounced the resident's death and could not establish the correct time of death, because RN C was not notified until two hours later when the resident's family and the funeral home had already been contacted. The APRN stated she had to consult with the resident's physician. After approximately five minutes the APRN called back and stated the resident's physician agreed to use the time that the LPN pronounced the resident's death and emphasized that it was outside of LPN B's scope of practice to pronounce the resident's death. RN E stated the DHS, who had been on leave, arrived at the facility at 6:00 AM and took over the investigation. RN E provided the DHS with the timeline of the event. During a telephone interview on [DATE] 11:44 AM, CNA A stated she had been employed at the facility for one year. When asked about Resident #1 and the [DATE] event, she stated [DATE] was the first time she had worked with Resident #1. She said she reported to work around 10:45 PM on [DATE] and at approximately 11:00 PM, she went to Resident #1's room to conduct shift rounds and the resident was in bed. Approximately 30 minutes later, she was passing ice water, and the resident was not in bed. She thought the resident was in the bathroom, but as she approached the resident's bed, she saw the resident in a kneeling position on the floor with his head resting on the bed in a praying position. He was between the bed and the window. She asked him if he was praying and he didn't respond. She tapped his shoulder and again asked if he was praying and he still did not respond. She immediately notified LPN B. LPN B and CNA A went right to the resident's room. After assessing for a pulse and respirations, LPN B walked out of the room to verify the resident's code status. Upon returning to the room a minute or so later, LPN B asked her to help him get the resident off the floor and onto the bed. She stated they placed the resident on the floor first, placed a draw sheet under the resident, and put him back in bed. She stated there were no other instructions provided by LPN B. She left the room to assist another resident who was in the bathroom and left LPN B in Resident #1's room. She stated she was not sure if LPN B administered CPR. She stated Resident #1 was warm to touch when they placed him back in bed. When asked if she provided the facility's management with a witness statement, she replied that she was interviewed by the DHS and described the event the same way she had described it during this interview. She said she was not asked to write a witness statement that day; however, on [DATE] (the date of the survey), she was asked to provide a written statement. When asked if she received any training after the incident, she said, No, they might have provided the training during the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:30 PM, the Social Services Director (SSD) stated she had been employed by the facility for five years. She stated the details of the event were reviewed by the Director of Health Services (DHS), the Administrator, and the Regional Nurse Consultant to determine whether the event met reporting requirements. She confirmed that allegations of Abuse/Neglect/Misappropriation should be reported within two hours. She was asked to review the [DATE] event for Resident #1. She confirmed that the incident took place on [DATE]. She stated she was not present during the incident. She explained that she received the timeline of the incident from RN E who was the Acting DHS at the time of the incident. The SSD stated on [DATE] at 11:30 PM, CNA A found Resident #1 unresponsive and notified LPN B, who assessed the resident and initiated cardiopulmonary resuscitation (CPR) at 11:40 PM. LPN B administered CPR for approximately five minutes. Resident #1 was unable to be resuscitated by LPN B, who pronounced the resident's death at 11:56 PM, and at that time, he called the provider and the family. The SSD confirmed that the incident was reported to the appropriate agencies on [DATE], five days after the event. She explained that the Administrator had notified the corporate office about the incident and was made aware that it was not a reportable event. When asked if the corporate personnel provided the rationale, she stated LPN B reported that Resident #1 was already cold/expired when he found him. When asked for documentation from LPN B indicating that the resident was cold, she confirmed that there was no documentation, and no witness statement was obtained. She added that on [DATE] she was notified by the Administrator that a determination had been made by the corporate office that the incident was indeed reportable and that LPN B should be terminated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A joint interview was conducted on [DATE] at 9:45 AM with DHS and the Administrator. The DHS stated her responsibility was to ensure the company's policies, process and nursing requirements were followed. She stated she ensured that the staffing requirements were met. She explained that she utilized a checklist during morning clinical meetings to ensure that all clinical issues were addressed. During the meeting, issues such as change in condition, incidents, hospitalization and admissions were reviewed. If the team identified that anything had been missed during their review, a staff member was assigned to ensure the missed task/component was addressed. When they were asked when documentation should be completed after an incident occurred, the DHS stated documentation should be completed as soon as the incident occurred. She further stated the DHS should be contacted after all incidents. The Administrator stated she was responsible for oversight of facility's operation. She used different audit tools to ensure that measures were met. She stated she reported to the corporate team weekly. When she was asked to explain the facility's grievance/concerns process, she said the SSD was the grievance officer. The SSD reviewed grievances/concerns with the Administrator and the DHS. Incidents/grievances/concerns were also discussed during morning meetings and the team decided whether or not an incident met the reporting requirements. All reportable incidents were also reviewed by the corporate Senior Nurse Consultant and Risk Manager. When asked to review the incident involving Resident #1, the Administrator stated she was contacted by RN E on [DATE] at 2:05 AM. RN E explained that she had received a call from RN C informing her that Resident #1 had expired and there were concerns, as there was a delay in her being notified of the incident. RN E stated she was enroute to the facility to find out what happened and to meet with the family. The Administrator asked RN E to gather information and call her back. Approximately 30 minutes later, the Administrator contacted RN E and asked to speak to LPN B. LPN B stated at approximately 11:40 PM, CNA A called him to Resident #1's room. The resident was unresponsive. LPN B administered CPR for approximately five minutes, and when he was unsuccessful, he stopped. LPN B stated he could not reach the on-call provider but reached the family. The Administrator asked LPN B to write a statement and put it under the DHS' door. She also asked him not to leave the facility until DHS arrived. The Administrator contacted the DHS who had just returned from vacation and notified her of the incident. She instructed her to go to the facility and assist with the investigation. The DHS stated she arrived at the facility at approximately 5:30 AM on [DATE]. She met with RN E and was provided with a synopsis of the incident. RN E told her that she called the on-call physician who voiced concerns with the time RN C was notified of the resident's time of death (concerns determining the time of death). The DHS interviewed LPN B who confirmed the incident as it was documented by RN E. He also confirmed that he did not call a Code Blue per facility policy, he conducted CPR alone and pronounced the resident's death. The DHS provided LPN B with a written warning and education on the facility's policy. The DHS confirmed that she did not obtain written statements from staff. She stated she interviewed them verbally but asked for nothing in writing. She also confirmed that LPN B failed to write a progress note after Resident #1's incident and the RN on duty at the time of the incident was not notified by LPN B until [DATE] at 1:55 AM (more than two hours later). When the Administrator was asked why the incident was not reported, she replied that they felt the incident did not meet the requirement for reporting it was an education moment because LPN B did not follow the facility's policy. She added that LPN B stated Resident #1 was already dead. When she was asked if there were any progress notes about the incident, she said no. She added that she spoke with the Senior Nurse Consultant (SNC) about the incident and she stated the incident did not meet the reporting requirements. When asked if LPNs could pronounce a resident's death, the Administrator confirmed that LPN B acted out of his scope of practice, but he could not reach the physician. She was then asked why LPN B was not suspended pending investigation of the event, and she replied that staff were suspended only when an incident was determined to be reportable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an employee personnel record review, LPN B's file revealed no evidence of a current eligible Level II background screening. A review of the Agency for Health Care Administration's Background Screening Clearinghouse website on [DATE] at 1:15 PM revealed that LPN B's status was Ineligible. His fingerprints expired on [DATE]. Facility records showed LPN B was hired on [DATE] and separated on [DATE]. LPN B was a full-time caregiver, providing direct care to residents from [DATE] through [DATE]. During an interview and employee record review with the Human Resources Manager on [DATE] at 12:15 PM, she stated LPN B was no longer listed on the facility's roster due to a recent termination, and she was unaware that LPN B's background screening status was ineligible. After reviewing the Agency for Health Care Administration's Background Screening Clearinghouse website, she confirmed that LPN B did not have a current Level II background screening, and the employee's fingerprints expired on [DATE]. On [DATE] at 2:03 PM, a telephone interview was conducted with the Medical Director, who confirmed that he was notified of the incident involving Resident #1 on [DATE]. A telephone interview was conducted on [DATE] at 2:14 PM with the Senior Nurse Consultant (SNC). She stated she had been in her role since [DATE]. She said she was contacted by the Administrator about the [DATE] incident early on the morning of [DATE]. She was told that LPN B initiated CPR and stopped when he was unsuccessful. He then pronounced the resident's death. The Administrator informed her that the investigation was ongoing, and she would update her in the morning. The following day she followed up with the Administrator and she was notified that the facility had initiated training on CPR response and started a CPR audit. She was informed by the Administrator that the team did not identify the incident as reportable because LPN B stated Resident #1 was already dead when he went to the resident's room with CNA A. Upon further investigation and after consulting with the Risk Manager, it was determined that the incident was reportable, and a report was submitted on [DATE]. When asked to explain the facility's policy and procedure for CPR, the SNC stated if a resident was a Full Code, the staff should initiate CPR; however, if there was enough evidence or rigor mortis was present, staff should not initiate CPR and should instead contact the provider. She confirmed that CPR should be initiated if there was evidence/likelihood of survival, and once CPR was initiated, staff should not stop until the provider asked them to or EMS arrived and took over. A review of the job description for LPN/Charge Nurse (modified 10/2016), revealed: Job Purpose: Directs nursing care for the patients and supervises the day-to-day nursing activities performed by assigned staff. Such supervision should be in accordance with federal, state, and local and regulations governing the nursing center. Also, as directed by the Administrator, the Medical Director, RN Charge Nurse and/or the Director of Health Services, to ensure the appropriate care for patients is provided. Key Responsibilities include: - Provide care ensuring patient/resident safety. - Supervises Certified Nurse Assistants, directs work and makes appropriate assignments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Completes documentation procedures on patients (appropriate use of forms, timelines, and Medicare documentation, etc. - Knowledge of procedures and ability to determine Advance Directives status for patients. - Responsible for ensuring Tenet Time is presented and discussed with all partners prior to and following all shifts. A review of the job description for the Administrator (created 09/08, modified 12/16), revealed: Job Purpose: To direct the day-to-day functions of the nursing center in accordance with federal, state, and local regulations that govern long-term care centers, and as may be directed by the Area [NAME] President, to provide appropriate care for our patients/residents. Key Responsibilities included: - Current knowledge of state and federal laws governing the operation of nursing facilities. - Knowledge of licensing and payment programs, general business practices, nursing practice, psychology of resident care, personal care and social services, therapeutic and supportive long-term care and services, and environmental health and safety relevant to nursing facility operation. - Ability to apply standards of professional practice to operations of nursing facility and to establish criteria to ensure that care provided meets established standards of quality. - Demonstrate knowledge of and respect for the right, dignity and individuality of each patient /resident in all interaction. Demonstrates competency in the protection and promotion of resident rights. Able to act as a role model for center and staff. A review of the facility's policy and procedure titled Abuse Prevention and Reporting (effective [DATE], revised [DATE]) revealed: Abuse: Any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a resident, including but not limited to, assault or battery, failure to provide treatment or care, or sexual harassment of the resident. Procedure: 1. Anyone witnessing, suspecting or hearing an allegation of mental, physical, verbal or sexual abuse; neglect or exploitation of any resident will immediately report this to the Administrator whether the Administrator is on the premises or not. 2. The Administrator will immediately begin an investigation and implement measures necessary to assure the safety and protection of the residents from the actual or alleged perpetrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106124	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fleming Island	2040 Town Center Blvd Fleming Island, FL 32003

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. In the event the Administrator has knowledge that the resident has been abused, neglected or exploited while residing in the home, he/she will immediately make a report by phone or in person to the Department of Community Health. In the event that an immediate report to the Department is not possible, the Administrator shall make the report to the appropriate law enforcement agency. 4. The initial report of actual or suspected abuse shall contain at least the following: - Name and address of person making the report. - Name and address of the resident or former resident. - Name and address of the facility. - Nature and extent of any injuries or condition resulting from the suspected abuse, neglect or exploitation. - The suspected cause of the incident. - Any other information that the reporter believes might be helpful in determining the cause of the resident's injuries or condition and determining the identity of person or persons responsible for the incident. 5. Within 24 hours of the initial report, the Administrator shall also make a written report, using the Incident Report Form, documenting all known and relevant information, the investigation results, and any corrective or protective actions taken. 6. The written Incident Report shall be faxed to the Department of Community Health, Health Facility Regulation Department, Complaint Division. 7. The fax confirmation sheet shall be attached to the Incident Report and maintained in the central Incident Report file. 8. If the alleged perpetrator is a staff member of the home, the Administrator will place them on administrative leave until a determination of the allegation is made. Confirmed allegations shall result in termination with notification to appropriate boards, registries and agencies and the police as appropriate. .