STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106140	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Southwood	2301 Bluff Oak Way Tallahassee, FL 32311

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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. (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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to assure accuracy of billing, by charging a resident's account for services covered by insurance after winning an appeal, for 1 out 3 records reviewed. (Resident #2) The findings include:A review of Resident #2's medical record revealed the resident was admitted on [DATE] to the facility under skilled nursing care after hospitalization. Resident #2's record had a Notice of Medicare Non-Coverage (NOMNC) dated [DATE], ending services on [DATE]. A review of Resident #2's medical record revealed an Expedited Appeal Documentation Request dated [DATE]. The request was reviewed and required the facility to upload the necessary documentation to the Quality Improvement Organization (QIO) (beneficiary and family centered care quality improvement organization authorized by the Medicare program to review inpatient services provided to Medicare patients) website by close of business. Resident #2's record revealed an appeal decision from the QIO dated [DATE]. The decision stated that ending services was not appropriate due to the facility's failure to provide sufficient medical records or other required documentation within the mandated timeframe. Resident #2's record revealed a completed financial responsibility statement for post skilled services dated [DATE], indicating the last covered date as [DATE]. Documentation showed that, effective [DATE], Resident #2 will transition to Private Pay/Medicaid Pending status. The noted private pay rate was $399 a day. A review of an email correspondence dated [DATE] at 3:38 PM between the Business Office Manager and the corporate Care Management Team revealed Resident #2 had active insurance coverage as supported by email documentation. However, the system deleted the email confirming this coverage. A review of an email correspondence dated [DATE] at 4:28 PM between the insurance company's Lead Clinical Review Nurse and the corporate Care Management team revealed that the resident's authorization listed [DATE] as the last covered day. Resident #2 remained in the facility under long term care status beginning [DATE]. A communication note was documented indicating that a member of the corporate Care Management team sent a secure email conveying this information. Resident #2's billing record revealed an account balance of $19,215.18 as of [DATE]. On [DATE] at approximately 9:50 AM, a phone interview was conducted with the representative for Resident #2. She stated that the facility informed her on [DATE] that, as of [DATE], the resident was not approved, therefore covered under his insurance. However, she was under the impression that her appeal was approved. She recalled receiving a phone call from the facility's Business Office Manager at 7:30 PM, informing her that she needed to come immediately to remove the resident due to an outstanding bill. She stated she was told that, because his insurance had not approved of his stay, the balance had increased to around $10,000 at a rate of $399 per day. On [DATE] at approximately 10:00 AM, an interview was conducted with the facility's Business Office Manager. She explained that she had discussed with the resident and family that Resident #2 had the option to apply for long-term care (LTC) Medicaid, which they declined. However, the resident remained on private pay Medicaid pending status, and his outstanding balance upon discharge was $19,215.18. She stated that the billing error was the result of corporate oversight. She clarified that as of [DATE], the payer was changed to Medicaid private pending, and this is when the resident began being billed in error. She recognized the lack of communication, as the resident was authorized for stay and services the whole time under his insurance. On [DATE] at approximately 3:00 PM, a phone interview was conducted with the Consultant Regional Business Office. After reviewing the Notice of Medicare Non-Coverage (NOMNC) and the appeal documents, she confirmed that the resident won the appeal and should not have been removed from services. She explained that, because the insurance coverage was not active as of [DATE] due to the facility failure to submit required documentation timely, a second NOMNC should have been issued for technical denial. As of [DATE], the Resident status should have been classified as technical overturn (that refers to the successful appeal and reversal of a claim denial that was initially rejected due to a procedural or administrative error) instead of Private Pay-Medicaid pending, which was incorrect. The resident should have remained covered without authorization lapse. She reported that the change of payer source was not communicated to the corporate Care Manager Team and reiterated that the failure was on the facility, not the resident. She added that staff did not read properly the QIO documentation. On [DATE] at 9:58 AM, a phone interview was conducted with the Care Management Manager Supervisor. She explained that after the appeal was won with the resident, due to the facility failure to submit paperwork in a timely matter, a second NOMNC should have been issued. This resulted in the resident being billed in error. She explained that

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and facility policy, the facility failed to communicate the need for dialysis to the receiving provider, resulting in the resident missing dialysis treatment, for 1 of 3 residents reviewed. (Resident #3)The findings include:Record reviews revealed Resident #3 was admitted on [DATE] with a diagnosis of Dependence of Renal Dialysis related to End Stage Renal Disease. The resident's medication orders revealed dialysis treatment on Tuesday and Saturday with next treatment after discharge being 11/1/25. However, this appointment was missed because there was no communication to the dialysis center that Resident #3 was discharged from the nursing home on [DATE]On 12/9/25 at approximately 2:55 PM, an interview was conducted with Director of Health Services (DHS). The DHS indicated that the residents' dialysis centers are responsible for coordinating change of facilities for dialysis treatments.On 12/10/25 at approximately 11:15 AM, an interview was conducted with the Social Service Director. The Social Service Director revealed the resident's family is responsible for notifying the need to change dialysis centers when the resident is discharged from the nursing home.On 12/10/25 at approximately 1:30 PM, an interview was conducted with Director of Nursing (DON). The DON indicated the residents discharge plan done by social services should have a continuous care plan for dialysis.On 12/10/25 at approximately 2:00 PM a telephone interview was conducted with previous dialysis center staff. The staff member from this facility stated, the nursing home is responsible of notifying the current dialysis center of the resident discharge date and plan to ensure the resident is transferred to the dialysis center needed close to where the resident will be residing. On 12/10/25 at approximately 3:30 PM an interview was conducted with Case Mix Director. The Case Mix Director stated, if the resident has a planned discharge, then we would notify the dialysis center of the discharge and the need to transfer services, however this resident advised social services on 10/29/25 that she planned to discharge on [DATE] therefore was not a 3-day planned discharge, and dialysis was not notified. The Case Mix Director reviewed the facility discharge policy that revealed the discharge planning will begin with each patient/resident and patient/resident's representative upon admission. The process is coordinated by Social Services/Senior Care Partner or designee. The patient/resident, patient/resident representative and Interdisciplinary Team (IDT) are involved in the planning process. The post-discharge plan of care is developed with the participation of the patient/resident and/or the patient/resident's representative with the patent/resident's consent. The discharge plan will be monitored and revised as necessary. The discharge summary is initiated by the Social Service Director, Senior Care Partner, or Administrator Designee upon admission. The Discharge Planning policy also included Social Services, or the designee will contact community resource providers to schedule care and services that will be needed at the time of the discharge. Case Mix Director indicated the nursing home should have notified the dialysis center of the discharge on [DATE].On 12/11/25 at approximately 11:30 AM a telephone interview was conducted with a representative from the resident's current outpatient dialysis center and they stated, resident #3 resumed dialysis on 11/3/25 and missed scheduled dialysis on 11/1/25.