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	07/24/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interviews, record review, and policy review, the facility failed to immediately identify and report allegations of abuse to the state survey agency for 1 of 1 sampled residents. (Resident #9)The findings include:On 7/22/25, a review of the facility's federal report incident on 9/2/24 concerning the allegation of assault made by Resident #9's representative on 9/2/24 was conducted. A summary of the facility's interview with the participants states bruising was noted on the day shift (7:00 am-3:00 pm). The bruising was noticed by the assigned Certified Nursing Assistant (CNA) K and documented by the day shift assigned Nurse J on 8/31/24.On 7/22/25 a review of the nurse's notes was conducted. No nurses' notes were documented on 8/31/24. However, a late entry note was entered on 9/2/24 at 11:01 am stating, Upon entering on 8/31/24 at 8:15 am during medication administration, noticed black and blue bruise under the right eye. Unknown cause, resident unable to verbally express the cause. Order to monitor area daily until healed. Will continue to monitor.On 7/23/25 at approximately 5:00 PM, an interview was conducted with the Risk Manager (RM). She confirmed the expectation is for all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are to be reported immediately but not later than two hours, and the results of all investigations of alleged violations should be reported within five working days of the incident.On 7/24/25 at approximately 11:30 am, an interview was conducted with the Director of Nursing (DON). The DON stated the nurse did not submit a federal report because she did not view it as abuse since she called the doctor and his order was to monitor until healed. The DON confirmed an injury of an unknown source is required to be reported within two hours. She further stated she was notified on 9/1/24. The Federal report was filed on 9/2/25 when Resident #9's representative observed bruise and contacted law enforcement.The facility's policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property (dated 12/02/2001, revised 11/15/2024) revealed, It is the policy of PruittHealth to actively preserve each patient's right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, mistreatment, and misappropriation of patient property, (referred to collectively in this policy as abuse, neglect, mistreatment, and exploitation). The Organization and its partners should assure that best efforts are made to prevent any occurrences of any form of abuse, neglect, and exploitation.The facility's policy titled Occurrences (dated 7/1/2012, revised 1/11/2024), revealed Occurrence hazards are physical features in the healthcare center environment which may pose a risk to a residentts safety, including but not limited to: Unexplained injury to a patient/resident where no specific or actual incident was observed; yet the patient/resident exhibits evidence of an injury, such as a bruise or skin tear. Reporting Occurrences: 1. Occurrences are to be reported to the Charge Nurse immediately, no matter how minor they may appear. 2. Patient/resident care software incident entry must be completed on the shift the occurrence took place. 3. If occurrence is noted without direct staff observation, the incident entry must be completed in the software system on the shift the occurrence was reported. 4. Partners witnessing an occurrence involving a patient/resident must report details of occurrence to his/her Charge Nurse as soon as possible. Do not leave an occurrence victim unattended unless it is necessary to summon assistance. Occurrence Documentation: I. The licensed nurse will be responsible for completing the following occurrence documentation requirements prior to the end of the shift when the occurrence took place. This documentation will be noted in the patient/resident's clinical record and in the occurrence reporting software program. The Administrator or designee will complete the supervisor investigation on all occurrences, and report to the appropriate state agency and/or other external agencies according to law. This documentation is to be typed on the patient/resident care software occurrence report follow up section. The Administrator's findings will include, but not limited to: Interview findings, Was abuse ruled out, if abuse was noted list in detail type of abuse and who was involved, date of when report was completed, date external agencies were notified, etc. Was abuse ruled out, if abuse was noted list in detail type of abuse and who was involved, date of when report was completed, date external agencies were notified, etc. When the physician and responsible party was notified. List any education and/or corrective action related to the occurrence.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 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 observations, interviews and record reviews, the facility failed to implement the baseline care plan for 1 of 2 individuals reviewed for care plans. (Resident #35) The findings include:On 07/22/25 at approximately 9:50 AM during a visit with Resident #35, the resident was observed lying in bed wearing only a shirt and a brief. The Director of Nursing (DON) and Staff B from Physical Therapy (PT) entered the room to respond to the resident's complaint earlier that day. The resident was upset and tearful. She verbally expressed frustration regarding her perceived lack of progress in therapy and a decline in her ability to perform functional tasks independently. She specifically voiced a desire to regain the ability to use the bathroom independently and shared concerns that she is not receiving sufficient therapy. She reported that she had been waiting in bed for someone to assist her with getting up, using the bathroom, and performing hand hygiene. The resident stated that she is at the facility to improve and return to her independent living situation and expressed concerns over the current level of support. On 07/22/25 at approximately 9:55 AM, an interview was conducted with Resident #35. She expressed feelings of frustration regarding a perceived delay in her physical progress and continued dependence on staff for mobility and personal care. She reported that she is still in bed at the time of the interview and has not yet had assistance to get up or attend therapy, which she believes should have already begun. She feels strongly about going back to her independent living and being able to walk to the bathroom independently. She further explained that she was continent but currently wears a brief, explaining that this is due to her inability to independently access the bathroom.On 07/22/25 at approximately 3:25 PM, an interview was conducted with Staff C, Certified Nursing Assistant (CNA). She is the sole caregiver assigned to the 100 and 200 halls, which currently house a total of 11 residents. When asked about bladder training, she stated that nursing restorative provides that service. Regarding incontinence care, she acknowledges that the facility's expectation is to conduct rounds every two hours, or more frequently if needed, to meet the residents' needs.On 07/23/25 at approximately 9:49 AM, an interview was conducted with the DON. She confirmed that the goal is to return Resident #35 to her highest level of functioning and agreed that the resident, though not currently on a toileting program, would benefit from one. The DON also acknowledged Resident #35's strong motivation to participate in therapy and her goal of returning home to her prior level of functioning. She confirms that it is the facility's expectation to provide the necessary services to support the residents in achieving these goals.On 07/23/25 at approximately 4:02 PM, an interview was conducted with the Physical Therapy Outcome Coordinator. According to their documentation, Resident #35 ambulated distances of 80 feet, 90 feet and 150 feet with supervision or touching assistance. Transfers from sit to stand were performed with partial/moderate assistance, requiring approximately 50% assistance. Resident #35 is a one person assist for mobility and transfers.On 07/23/25 at approximately 5:00 PM, an interview was conducted with Staff E (CNA). When asked about the level of assistance she provides Resident #35 for toileting needs, she explained that she has not yet assisted with toileting since the resident's readmission on [DATE], despite having worked five shifts with her, stating that the resident is incontinent. Additionally, she mentioned that therapy staff take Resident #35 to the bathroom, but that she only provides incontinent care and does not offer her toileting. She added that the resident is a limited transfer when she assists her to bed.On 07/23/25 at approximately 5:15 PM, an interview was conducted with the DON. She describes the facility's expectations to check and assist residents with toileting and incontinence care every 2 hours. She reviewed Resident #35's care plan dated 07/14/25, which stated: ADL needs will be met and independence potential maximized and Improve ADL function to maintain independence through next review. She recognized that since the documentation of the resident being continent on 06/27/25, toileting the resident should be an intervention to meet the goal of the care plan and optimize the potential for the resident to regain bladder control and her prior level of independence. A recent Physical Therapy (PT) note dated 07/22/25 was reviewed that indicates Resident #35 was ambulating in therapy with touch assistance. A review of progress notes from 06/25/2025, 06/27/2025, 06/28/2025 indicated the resident is alert and oriented and able to communicate needs, continent of bowel and bladder and requires one person assist with all transfers. A review of a progress note from 07/18/2025 indicated the resident requires one person assist for Activities of Daily Living. A review of the discharge plan dated 07/23/2025 reveals resident plan to return to Independent Living.On 07/23/25, the Minimum Data Set, dated [DATE] was reviewed. It stated that the resident is using a wheelchair and walker for mobility device

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews and facility policy review, the facility failed to develop a care plan for 2 of 2 residents sampled for Gerichair use (Residents #42 and #45) and 1 of 1 resident sampled for Hoyer lift use (Resident #4).The findings include:Resident #4 On 07/21/2025 at 4:34 PM, Resident #4 was observed inside his room in a wheelchair waiting to be assisted to bed. A few minutes later, Staff A, a Certified Nurse Assistant (CNA), was observed assisting the resident from the wheelchair to the bed via Hoyer Lift. There was no other staff assisting during this transfer. On 07/21/2025 at 4:47 PM, an interview was conducted with Staff A, CNA. She stated she knew there were supposed to be two staff members assisting with the Hoyer lift. She further stated the reason she was doing it alone was because the resident had used the call light three times, and she could not find anyone to help her. A medical record review of Resident #4 was conducted. Resident #4 was admitted on [DATE] with diagnoses including metabolic encephalopathy, sepsis, rhabdomyolysis, encounter for change or removal of surgical wound dressing, local infection of the skin and subcutaneous tissue, open wound left hip, chronic systolic heart failure, unsteadiness on feet, atrial fibrillation, cognitive communication deficit, hypertension, type 2 diabetes mellitus, cerebral palsy, and adult failure to thrive. The plan of care included risk for falls and impaired mobility with requiring assistance with transfers. The plan of care did not include use of Hoyer lift. On 7/22/25 at 12:37 PM, an interview was conducted with Director of Nursing (DON). She was made aware that the CNA was using the Hoyer lift alone. She stated it was facility policy to have two staff members using the Hoyer lift. She confirmed Resident #4 had been using a Hoyer lift since admission because he was unable to stand safely. She was asked how the staff would know the resident would need to be transferred via Hoyer lift and she stated the resident would be care planned for it. She reviewed the plan of care for Resident #4 and verified that the Hoyer lift was not included as intervention, but it should had been included. She further stated she would add it immediately. Resident #42: On 7/21/25 at approximately 1:58 PM, an observation was made of resident #42 in her room sitting up in a Geri-chair (a chair that reclines) with a Hoyer lift sling noted underneath the resident (a device used to transfer the resident from bed to chair). A review of Resident #42’s medical record revealed there was no physical or occupational therapy evaluation for the use of a Geri-chair. Further review of the resident’s medical record revealed that there was no physician order for the Geri-chair, nor a care plan for the use of the Geri-chair in the record. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/25 at approximately 1:00 PM an interview was conducted with Staff Member F, a Certified Nursing Assistant, (CNA) who indicated that she had been getting the resident up in a Geri-chair as long as the resident had been in the facility and further indicated that she was not sure who made the decision that the Geri-chair is appropriate for the residents. CNA F further indicated that she was instructed to get the resident up today in a regular wheelchair. On 7/22/25 at approximately 1:15 PM an interview was conducted with Nurse G, Registered Nurse Unit manager, and Nurse H, Licensed Practical Nurse. Both Nurse G and H confirmed that there was no care plan, physician order, or therapy evaluation for the use of the Geri-Chair for resident #42. On 7/22/25 at approximately 2:40 PM an interview was conducted with the Physical Therapist B, who indicated that she did do an evaluation of resident #42 for wheelchair versus Geri-chair for positioning today, and recommended that resident #42 was appropriate for wheelchair. The Physical therapist B further indicated that she did not have resident #42 when she was on therapy case load, so she was not aware of why the resident was in the Geri-chair, however she does tend to lean forward and to the side when the resident is tired, so I did recommend that the resident be laid down for a rest period in bed when tired. Resident #45: On 7/22/25 at approximately 1:00 PM an observation was made of Resident #45 sitting in a Geri-chair in the dayroom area of the 600 hall. Resident #45 stated “I wish they would let my legs down; I do not like sitting like this.” On 7/22/25 at approximately 1:10 PM an interview was conducted with CNA I, who indicated that Resident #45 was in the Geri-chair because he keeps trying to get up and falls, and he messes with the other residents, that the Geri-chair was for his safety. On 7/22/25 at approximately 1:15 PM an interview was conducted with Nurse G, Registered Nurse Unit manager, and Nurse H, Licensed Practical Nurse. Both Nurse G and H confirmed that there was no Care plan, physician order, or therapy evaluation for the use of the Geri-Chair for Resident #45. Nurse H indicated that the resident had been in the Geri-chair for the 3 weeks that Nurse H had been working at the facility. On 7/22/25 at approximately 2:15 PM, an observation was made of the resident being evaluated by the Physical Therapist for a high back wheelchair. Resident #45 was observed to be able to propel himself about the dayroom during the observation. On 7/22/25 at approximately 2:40 PM an interview was conducted with the Physical Therapist, who indicated that she did the evaluation of Resident #45. She recommended that the resident was appropriate for the high back wheelchair instead of the Geri-chair and further indicated that the resident was able to propel himself 10 feet during the evaluation. The Physical Therapist indicated that she was not sure why the resident was in a Geri-chair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/25 at approximately 2:45 PM an interview was conducted with the Risk Manager (RM) and Director of Nursing (DON) concerning the use of Geri-chairs for resident #42 and #45. Both the RM and DON indicated that neither of them was aware that Geri-chairs could be considered a physical restraint. The RM stated after contacting the regional nurse for the facility and confirming that the Geri-chair could be considered a physical restraint, the residents were referred to therapy for an evaluation for positioning. The DON indicated that it was her understanding that Resident #45 used the Geri-chair for comfort due to being on hospice, but confirmed no documentation was available to indicate the reasoning for the Geri-chair. The DON further indicated that they have started a performance improvement plan on the use of Geri-chairs and that they make sure the staff are trained and that the residents receive evaluations for appropriate positioning.