STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115339	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Savannah	12825 White Bluff Road Savannah, GA 31419

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 resident and staff interviews, record review, and review of the facility's policy titled Involuntary Transfer and Discharges, the facility failed to ensure written bed hold policy and transfers notices were provided to the resident or resident representative (RR) for seven of seven residents (R) (R7, R66, R76, R43, R26, R57 and R45) reviewed for emergent hospital transfer out of a total sample of 28 residents. This failure had the potential to affect the resident and/or their RR by not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. This had the potential to affect all residents who resided at the facility in the event that they were transferred out of the facility. Findings include: Review of the facility's policy titled Involuntary Transfer and Discharges, dated 3/30/2023 included the following: (5) For Emergency Transfer or Discharges follow the Acute Care Transfer Reduction Plan - document in the medical record, including patient/resident's understanding of transfer or discharge and Administrator/Social Worker provide a Notice of Involuntary Transfer and Discharge form to the patient/resident, guardian or representative, and the patient/resident's physician as soon as practicable. Facility must keep a copy of the notice in the medical record. 1. Review of R7's undated admission Record located under the Resident tab in the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE]. Review of R7's Progress Note dated 1/21/2025 at 11:03 pm, located in the EMR under the Resident tab, revealed R7 was slumped over sitting on the side of his bed with his head down nurse/ writer asked resident if he was SOB [short of breath] due to symptoms of SOB increased respiratory rate at 23 and labored breathing. [The] resident stated 'I don't feel good. I'm short of breath.' [The] nurse/ writer asked [the] resident when did this start, [and] he stated after dinner. When [the] oxygen was checked he was at 82% room air. [The] resident was given oxygen at 4 liters and oxygen came up to 93%. He [was] noted to have crackles upon auscultation of lung fields. 2. Review of R66's admission Record, located in the resident's EMR under the Resident tab, revealed R66 was admitted on [DATE] and readmitted on [DATE]. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R66's Progress Note, dated 11/16/2024 at 5:05 pm, located under the Resident tab of the EMR revealed Staff found [the] resident lying on the floor on her left side from an unwitnessed fall. Staff informed NP [nurse practitioner], DHS [Director of Health Services], Family #4 (others couldn't be reached) and Facility Administrator. This writer was informed that [the resident] res [resident] could not move her left leg. [The] Res [resident] left [the] facility via stretcher with EMS [emergency medical services]. 3. Review of R76's admission Record, located under the Resident tab in the EMR, revealed R76 admitted on [DATE]. Review of R76's Progress Notes dated 6/2/2025, located under the Resident tab of the EMR, revealed R76 was observed on the floor lying on her back, in the bathroom. Moderate amount of blood noted on floor surrounding right leg, skin tear even wound edges and skin flap attached measuring 10 x 4 cm [centimeters] noted on right lateral leg. Resident states she was attempting to ambulate to restroom when she lost her balance and fell on her right side .unable to assess ROM [range of motion]to right hip d/t [due to] severe pain. R76 was transferred to the hospital. 4. During an interview on 6/17/2025 at 12:10 pm, R43 stated, I went [to the hospital] a few weeks back for breathing/lungs .they say a little pneumonia. When asked if he had received anything in writing regarding his hospital transfer (where he was going, why he was being sent, information regarding an appeal of the transfer if he desired), R43 did not remember receiving anything in writing. Review of R43's annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 5/16/2025 and located in the resident's EMR under the Resident tab, showed R43 had a Brief Interview for Mental Status (BIMS) of 14 out of a possible 15, indicative of intact cognition. Review of R43's EMR Resident - Progress Notes tab revealed: 5/8/2025 7:19 pm Resident c/o [complained of] difficulty breathing /SOB [shortness of breath]. Neb [nebulizer] treatment given, also rescue inhaler given, and resident continued to complain. NP [Nurse Practitioner] call to room to assess. NP give [sic] orders to send resident to ER [emergency room] for evaluation and treatment. Review of R43's Resident - Census, located in the resident's EMR under the Census tab, showed a hospital leave on 5/8/2025. In response to a request for evidence of the provision of a written transfer notice to R43 and his responsible party on 6/18/2025 at 5:05 pm, a written bed hold notice was provided. 5. Review of R26's Census tab in the EMR revealed R26 was originally admitted to the facility on [DATE]. Review of R26's Progress Note, dated 8/16/2024 and located under the Prog Note [Progress Note] tab in the EMR, revealed R26 was observed to be unresponsive with oxygen levels at 77% and below .R26 transported to local hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R26's EMR revealed no documented evidence of a written notice of transfer, nor was a bed hold notice issued to the resident and his representative upon his emergent transfer to the hospital. 6. Review of R57's admission Record, located in the resident's EMR under the Resident tab, revealed the resident was admitted to the facility on [DATE]. Review of R57's Progress Note, dated 4/19/2025 and located in the resident's EMR under the Resident tab, revealed R57 was found lying on the floor in front of the bathroom asking, mama to come help her off the floor. The note also revealed that R57 was assessed and found to have a laceration to her forehead that was bleeding. The resident's physician was contacted, and orders were received to send the resident to the emergency department (ED). Review of the EMR did not reveal a written notification of the transfer. 7. Review of R45's admission Record located in the resident's EMR under the Resident tab revealed the resident was admitted to the facility on [DATE]. Review of R45's Progress Note, dated 4/7/2025 and found in the resident's EMR under the Resident tab, revealed R45 was found on the floor, and per the resident's representative (RR), the resident slipped off her bed and hit her head on her trash bin. R45 indicated pain in her right temple/jaw that radiated down her neck and shoulder, which she reported to be a 9/10 on the pain scale. The RR requested that the resident be transferred to the ED. A review of R45's Census, located in the resident's EMR under the Resident tab, revealed the resident was sent to the ED and returned the same day. The census also revealed the resident was transferred to the ED on 4/12/2025 and returned on 4/14/2025. A progress note dated 4/12/2025, labeled a FALL NOTE, revealed the resident was found on the floor, sitting in urine. The resident confirmed to staff that she slipped in her urine but had no injuries. The note continued, advising that the resident's physician was notified and sent orders to send the resident to the ED. Review of the EMR did not reveal any documentation confirming that the resident and the RR were notified in writing of the transfer to the ED. During an interview on 6/18/2025 at 1:30 pm, Licensed Practical Nurse (LPN) 1 stated she had never filled out a transfer/discharge notice and was not aware one needed to be filled out and provided to the residents and their representatives. During an interview on 6/19/2025 at 2:41 pm, the Administrator stated the facility had not been providing the residents and/or their representative with a written transfer and discharge notice. He stated he was aware the facility's policy indicated the Administrator or Social Worker would provide the notice to residents and their representatives. During an interview on 6/19/2025 at 2:51 pm, the Social Worker stated she had not been providing residents or their representatives with a written transfer/discharge notice. She stated she was not aware they needed one until today, when she was shown the policy on transfer/discharge notices. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/19/2025 at 3:04 pm, the Interim Director of Health Services (IDHS) confirmed there were no transfer forms, stating, The only form they have is for the 30-day discharge, and that has not been being used for hospital transfers.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and review of the facility's policy titled Care Plans, the facility failed to review and revise residents' care plans for one of 28 sampled residents (R) (R27). The facility did not ensure care conferences occurred at least quarterly, where R27's care plan would be reviewed and/or revised. This failure placed the resident at risk for unmet care needs. Findings include: Review of the facility's policy titled Care Plans, reviewed on 7/27/2023, revealed It is the policy of the health care center for each patient/resident to have a person-centered baseline care plan followed by a comprehensive care plan developed following completion of the Minimum Data Set (MDS) and Care Area Assessment (CAA) portions of the comprehensive assessment according to the Resident Assessment Instrument (RAI) Manual and the patient/resident choice. Review of R27's admission Record, located in the resident's electronic medical record (EMR) under the Resident tab, revealed the resident was admitted to the facility on [DATE] with multiple diagnoses that included history of urinary tract infections (UTI), acute kidney failure, and generalized muscle weakness. Review of R27's Quarterly MDS with an assessment reference date (ARD) of 4/18/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident was moderately cognitively impaired. Review of R27's Care Plan, located in the residents' EMR under the Care Plan tab, revealed that the last care conference was held on 6/25/2024. During an interview on 6/20/2025 at 9:30 am, the Director of Health Services (DHS) stated he was advised that there was no documentation that R27 had a care plan conference since 6/25/2024. During an interview on 6/20/2025 at 10:20 am, the Minimum Data Set Coordinator (MDSC) confirmed that the last care conference for R27 was held on 6/25/2024. The MDSC also stated that the facility had experienced some turnover in its MDS and RAI (Resident Assessment Instrument) teams, leading to delays in completing care plan conferences.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policies titled Medication Administration - Insulin Injections and Medication Administration - General Guidelines, the facility failed to ensure insulin injection pens were used as recommended by the manufacturer and medications were administered according to physician's orders, resulting in a medication administration error rate of 13.64 percent with six errors for four residents (R) (R121, R43, R64, and R31) out of a possible 44 opportunities for error. This failure had the potential to affect the accurate dosing of insulin administered or the potential blood bioavailability of multi-dose medications administered per day to the residents. Findings include: Review of the facility policy titled Medication Administration - Insulin Injections, revised 7/18/2024, revealed: For Insulin Pens: 1. Remove the cover from the pen and swab with an alcohol swab. Screw on a new needle and remove cap. 2. Prime pen by dialing up 2 units on the pen and pressing the button on the end of the pen. Repeat priming procedure until insulin secretes from the needle. 3. Tum the knob on the end of the pen (or dial) to the number of units. 4. Insert the needle under the skin at a 90 degree angle. 5. Press the button on the end of the pen. 6. Count to 10 and remove the pen. Review of the facility policy titled Medication Administration - General Guidelines, reviewed 7/22/2024, revealed: 8. If the facility receives its medications packed with the AdvantageRx system: -The authorized personnel will compare the AdvantageRx bag to the MAR. -The authorized personnel will check off in ink on the bag the medications as they correspond to the MAR. -The authorized personnel will tum the bag over and make a final check to make sure that the actual tablet or capsule in the AdvantageRx bag corresponds to the MAR. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Medications are administered within 60 minutes before or after scheduled time, except for medications ordered to be taken with food and before or after meals, which are administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the healthcare center. 1. During the observation of medication administration on 6/19/2025 at 8:10 am, Licensed Practical Nurse (LPN) 5 removed an over-the-counter bottle of calcium with vitamin D3 500 milligrams (mg)/ 5 micrograms (mcg) and administered that along with R121's other medications. Review of R121's physician orders from the facility Resident - Orders tab showed Citrical D3 Plus Mg [magnesium] - D3 - Zn [zinc] - cop [copper] - man [manganese - [NAME] [[NAME]] tablet 250-40-125mg - mg-unit; amt [amount] 1 tabl [tablet] qd [daily] at 9a [9:00 am]. In an interview on 6/19/2025 at 9:20 am regarding the two different calcium supplements and if they were interchangeable, an Advanced Practice Registered Nurse (APRN) reviewed the two and responded, Not from my knowledge. In a follow up interview on 6/19/2025 at 9:32 am, LPN5 reviewed the bottle and confirmed 500 mg + D3, then read the back of the bottle, stating, it's 25mcg or 200 iu [international units] and 500 calcium, then read aloud the order from the medication administration record 250-40-125 and stated, It doesn't match to me. 2. During the medication administration observation on 6/19/2025 at 11:05 am, LPN3 removed the Humulin R insulin pen from the medication cart; performed a blood glucose check; dialed 40 units on the pen, applied the needle, cleaned R43's skin, placed the pen, pushed the plunger and held the pen against the skin for two seconds. During a follow-up interview on 6/19/2025 at 11:22 am regarding when a pen should be primed, LPN3 stated, Every time you use it. When asked why it was not primed (dialing two units to ensure insulin is exiting through the needle), LPN3 stated that she had forgotten. 3. During the medication administration observation on 6/19/2025 at 11:30 am, LPN6 prepared R3's medications that included Eliquis (an anticoagulant medication) 2.5mg and Nystatin 100,000/milliliters (ml), pouring out 5ml into a medication cup and administering them to R3. Review of R3's EMR Residents - Orders tab showed the Eliquis was to be given at 9:00 am and 9:00 pm, and the Nystatin was to be administered at 9:00 am, 3:00 pm, and 9:00 pm. 4. Continuing the medication administration observation with LPN6 on 6/19/2025 at 11:50 AM, LPN6 administered Eliquis 5mg to R64. Review of R64's EMR Resident - Orders tab revealed that the medication was to be administered at 9:00 am and 9:00 pm. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview on 6/20/2025 at 12:55 pm, regarding the late medication administration times, LPN6 stated, I had someone that was not doing well and they kept calling me into her room because she was not looking good, I did end up sending her out yesterday. LPN6 confirmed the meds were administered late, stating, I just got behind. 5. During medication administration observation on 6/20/2025 at 8:22 am, LPN7 was observed to check medications against a prepackaged medication pouch, placing a dot by each medication, take a bottle of cetirizine 10 mg, and pour one tablet into the medication cup. LPN7 then opened a prepackaged medication pouch that contained (as printed on the pouch) valsartan, mirabegron, metoprolol, and loratadine; then administered the medications to R31. Review of R31's Active Orders revealed an order dated 4/28/2025 for Claritin (loratadine) [OTC] tablet; 10 mg; [NAME] [amount]:1 tab [tablet]; oral once a day at 9:00 am. Further review revealed no order for cetirizine 10 mg. In a follow-up interview with LPN7 on 6/20/2025 at 10:55 am, LPN7 sorted through the opened preprinted pouches in her cart drawer to find the one for R31. LPN7 noted she did not place a dot by the loratadine but verified with the medication packet in the drawer for 6/21/2025 for R31. The LPN stated the loratadine was included in the medication in the pouch, and it would have been contained in her medication pass. LPN7 then stated, When it states OTC [on the MAR, over the counter], we always give this [showed the cetirizine bottle]. LPN7 confirmed it is a different medication than loratadine and stated, There is no OTC loratadine. LPN7 verbally confirmed R31 would have received two allergy medications and stated she would contact the APRN about it. During an interview on 6/20/2025 at 11:15 am, the Director of Health Services (DHS) stated, They need to do a pharmacy interchange for the medication, and it will be switched to the cetirizine. At 3:53 pm, the DHS stated an expectation that insulin pens would be primed before each use and that medication would be administered within one hour before or after the scheduled time.