

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Pruitthealth - Swainsboro		STREET ADDRESS, CITY, STATE, ZIP CODE 856 Highway 1 South Swainsboro, GA 30401	
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 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the facility policy titled Freedom from Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, Mission Statement, the facility failed to ensure that one of 26 sampled residents (R) (R22) was free from involuntary seclusion when staff placed R22 in a locked shower room, unattended, for 30 minutes to one hour, without the ability to exit. As a result, R22 experienced psychosocial harm on April 11, 2026, as evidenced by expressing anger about the incident. Findings include: Review of the facility policy titled Freedom from Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, Mission Statement, revised 11/21/2016, included, . The Organization recognizes that every patient has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. Involuntary Seclusion is defined as a separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Review of the Facility Reported Incident Form, dated 04/11/2026, revealed the facility reported an incident of staff-to-resident abuse to the State Survey Agency. The report revealed that the incident occurred on 04/10/2026. The details of the reported incident included that a Certified Nurse Aide (CNA) put a resident who was hollering in the shower, turned on the hot water, and left him unattended. Nurse stated the resident did not ask to be put in the shower. The form documented that no injury was noted, and the physician, the responsible party, and the police were notified. Review of the Sheriff's Office Incident Report dated 4/11/2026 at 8:30 am revealed that a deputy was dispatched to the facility in reference to a report of elder abuse. The report documented that the complainant stated the offender left the victim in the shower for approximately one hour due to the victim hollering. Review of the facility-provided Separation Notice for CNA KK documented the period of employment as 09/05/2023 through 04/10/2026. The documented circumstance of the separation was Terminated due to serious rules violations. Review of the Face Sheet for R22 revealed the resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, generalized anxiety disorder, bipolar disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment, for R22, with an Assessment Reference Date (ARD) of 02/12/2026, revealed that Section C (Cognitive Patterns) documented a Brief Interview Mental Status Score (BIMS) of 12, which indicates cognitive awareness with little to no periods of confusion. Section E (Behaviors) documented that behaviors were not exhibited. Section GG (Functional Abilities and Goals) documented R22 was non-ambulatory, and required substantial assistance to was dependent for Activities of Daily Living (ADLs). Review of the progress note, for R22, revealed an entry by Licensed Practical Nurse (LPN) DD and dated 04/11/2026, of Resident has been brought back to room and assisted back in bed. breath and lung sounds are clear and unlabored. skin assessed. no injuries observed. resident denies pain. will continue to monitor. {sic} Review of a facility-provided handwritten statement, signed by LPN DD and dated 04/11/2026, documented that (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 0603 Level of Harm - Actual harm Residents Affected - Few	R22 . was removed from his room by CNA KK, placed in the shower room, and left unattended. The resident had been inside for approximately 30 minutes to an hour. The resident reported he was having trouble breathing. I subsequently questioned the CNA who had placed the resident in the shower room and asked whether a shower had been provided. He (CNA KK) responded, No. I just put him in there so that he would hush. I informed [name of] CNA KK that his action was inappropriate and constitutes a form of abuse. {sic}In a telephone interview on 04/24/2026 at 11:01 AM, CNA KK confirmed that he placed R22 in the shower room and left him unattended because the resident was yelling out. CNA KK stated that his intention was to allow the R22 to quieten down and prevent him from disturbing his roommate and other residents with his yelling out. CNA KK reported that the estimated time the resident remained in the shower room was almost an hour. In an interview on 04/22/2026 at 12:01 PM, R22 confirmed that CNA KK locked him in the shower room. R22 identified CNA KK by his first name. He stated, I did not want to be in the shower room. I told him that I did not want to go in there, but he still did it. He left me in there against my will. I was in there for a long time. Don't know how long. When asked if he was having any stress or concerns that were affecting him. R22 reported being angry that night when the incident first happened. R22 denied any physical abuse from CNA KK. In an interview on 04/22/2026 at 3:10 PM, LPN DD confirmed that on 04/11/2026 at a few minutes past 1:00 AM, she observed CNA KK push R22, seated in a geriatric chair, into the shower room, and stated R22 was yelling. She further stated that she went to check on the resident a few minutes before 2:00 PM and found R22 alone in the shower room, locked in. LPN DD stated R22's face was pink in color, and he was having difficulty breathing. She continued to state that she returned the resident to his room and assessed him. She stated that CNA KK confirmed to her that he had placed R22 unattended in the shower room. In an interview on 04/23/2026 at 9:11 AM, CNA BB reported that on 04/11/2026, she entered the shower room with LPN DD and observed R22 in the shower room stating, Please get me out of here and Thank you. She stated R22 was in a geriatric chair in the reclined position. In an interview on 04/22/2026 at 12:03 PM, the Social Services Director (SSD) stated she provided services to R22 on 04/13/2026. The SSD stated that R22 stated he was angry about CNA KK placing him in the shower room and leaving him alone. He stated he told CNA KK that he didn't want to be left in the shower room. The SSD stated the psychiatric therapist was at the building on 04/13/2026 to see other residents, and the therapist stated another therapist would see the resident as soon as possible. She further stated she visited R22 on 04/13/2026, 04/14/2026, and 04/15/2026. In an interview on 04/22/2026 at 10:25 AM, the Administrator reported being made aware of the incident on 04/11/2026 by Unit Manager CC around 7:30 AM. She confirmed that staff reported R22 was locked in the shower room for 30 minutes to an hour. The Administrator stated that CNA KK was terminated on the same date as the incident. The Administrator stated that yelling out was normal behavior for R22, that staff should check on him to assess his needs, and that he should not have been locked alone in the shower room. The Administrator further stated she considered being locked in the shower room to be seclusion and abuse. R22 was seen by psychiatric services on 4/23/2026. The facility implemented the following:1. On 4/11/2026, the facility submitted an incident report to the State Survey Agency (SSA) and reported to the State CNA Registry. 2. On 4/11/2026, a police report was completed at 9:05 AM. Case number: 2026-04-00053.3. On 04/11/2026, CNA KK was terminated from employment. 4. On 04/11/2026, a skin assessment was completed for R22. 5. From 04/11/2026 through 04/14/2026, the facility completed skin assessments on the residents who were assigned to CNA KK. The results revealed no abuse concerns.6. On 04/11/2026, the facility conducted an Abuse Questionnaire with residents who were assigned to CNA KK. The results revealed no abuse concerns.7. On 4/13/2026, 4/14/2026, and 4/15/2026, Social Services provided services to R22.8. On 04/13/2026, Social Services offered a hospital emergency room visit or immediate psychiatric services to R22, and he declined. 9. On 04/13/2026, an education titled Abuse: Identifying, Reporting, Types, Seclusion, was conducted with all staff. Review of the sign-in sheet revealed 94 unique names. 10. On 04/13/2026, the facility conducted a Quality Assurance and Performance Improvement (continued on next page)		

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F 0603 Level of Harm - Actual harm Residents Affected - Few	(QAPI) meeting to address the incident. The attendees included the Medical Director, Administrator, and DON.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled Care Plans, the facility failed to develop or implement a comprehensive person-centered care plan for one of 26 sampled residents (R) (R84). This deficient practice had the potential to place R84 at risk of unmet needs, medical complications, and diminished quality of life. Findings include: Review of the facility's policy titled Care Plans, revised 10/21/2025, revealed the admission Comprehensive Care Plan of Care section included, . 3. The comprehensive person-centered care plan is developed to include measurable goals and time frames to meet a patient/resident's medical, nursing, and psychosocial needs, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial needs that are identified in the comprehensive assessment. Review of the Face Sheet for R84 revealed the resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, pneumonitis due to inhalation of food and vomit, dysphagia following cerebral infarction, and gastrostomy status. Review of the annual Minimum Data Set (MDS) assessment for R84, dated 01/28/2026, revealed that section K (Swallowing/Nutritional Status) documented the resident had a feeding tube and received 51 percent or more of total calories and 501 cubic centimeters (cc) through the feeding tube. Review of the care plan for R84, dated 04/8/2026, revealed that R84 had a feeding tube and was at risk of aspiration. The goal was for R84 to maintain nutritional stability through the next 90 days. Interventions included tube feeding as ordered, flushing as ordered, notifying the MD (Medical Doctor) of any problems, and elevating the head of the bed per protocol. Review of the physician orders for R84 revealed an order dated 01/28/2026 for Jevity 1.5 feeding at a rate of 60 milliliters (ml) per hour from 10:00 PM through 6:00 AM, with a water flush at 50 ml per hour from 10:00 PM through 6:00 AM. Observations on 04/21/2026 at 10:56 AM and 3:03 PM revealed that Jevity 1.5 was infusing via a feeding pump at 60 ml per hour. In an interview on 04/23/2026 at 10:07 AM, Licensed Practical Nurse (LPN) EE confirmed that the feeding pump should be turned off at 6:00 AM and not infused during the day. He confirmed that the physician's order was to turn off the feeding pump at 6:00 AM. In an interview on 04/23/2026 at 12:39 PM, Case Mix Director HH confirmed the care plan interventions for R84 included administering the tube feeding as ordered. She further stated that the care plan should always be followed.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident representative and staff interviews, record review, and review of the facility policy titled Enteral Nutrition (Tube Feeding), the facility failed to follow the prescribed enteral feeding order for one of five residents (R) (R84) with prescribed enteral feedings. This deficient practice had the potential to place R84 at risk of enteral feeding complications. Findings include: Review of facility policy titled Enteral Nutrition (Tube Feeding), reviewed 10/21/2025, revealed the Procedure section included, . 2. The physician will write orders prescribing the formula rate, route of administration, and flush orders for the individual patient/resident. Review of the Face Sheet for R84 revealed the resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, pneumonitis due to inhalation of food and vomit, dysphagia following cerebral infarction, and gastrostomy status. Review of the annual Minimal Data Set (MDS) assessment for R84, dated 01/28/2026, revealed that section K (Swallowing/Nutritional Status) documented the resident had a feeding tube and received 51 percent or more of total calories and 501 cubic centimeters (cc) through the feeding tube. Review of the physician orders for R84 revealed an order dated 01/28/2026 for Jevity 1.5 feeding at a rate of 60 milliliters (ml) per hour from 10:00 PM through 6:00 AM, with a water flush at 50 ml per hour from 10:00 PM through 6:00 AM. Observation on 04/21/2026 at 10:56 AM revealed that Jevity 1.5 was infusing through a feeding pump at 60 ml per hour. Observation on 04/21/2026 at 3:03 PM revealed that Jevity 1.5 was infusing through a feeding pump at 60 ml per hour. In an interview on 04/23/2026 at 10:07 AM, Licensed Practical Nurse (LPN) EE confirmed that the feeding pump should be turned off at 6:00 AM and not infused during the day. He confirmed that the physician's order was to turn off the feeding pump at 6:00 AM. In an interview on 04/23/2026 at 10:36 AM, LPN/Unit Manager GG confirmed that the formula was infusing and the physician's order was to turn off the feeding pump at 6:00 AM. In an interview on 04/23/2026 at 1:07 PM, the Director of Health Services (DHS) revealed that the nurse should follow the physician's order for administering the feeding tube formula. The DHS stated that the night-shift nurse was responsible for turning off the feeding at the time ordered to end it. The DHS further stated that if the night shift nurse did not stop the infusion, the day shift nurse was responsible for following the orders.		