STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115628	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Palmyra	1904 Palmyra Road Albany, GA 31702

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on resident interviews and staff interviews, the facility failed to ensure that three residents (R) (R14, R28, R29) of six residents who wanted to vote were assisted with obtaining absentee ballots or was registered to vote in the November 2024 election. Findings include 1. Review of the medical record revealed Resident 14 was admitted to the facility with the following diagnoses that include but are not limited to absence of right and left leg above the knee, malignant neoplasm of the prostate and generalized weakness and a Brief Interview Mental Status score (BIMS) of 14 which indicated intact cognition. An interview on 5/19/2025 at 2:37 pm with R14 revealed he wanted to vote in November 2024 election and needed help to renew his state identification card and no one assisted him. 2. Review of the medical record revealed R28 was admitted to the facility with the following diagnoses that include but are not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, atherosclerotic heart disease of native coronary artery and seasonal allergic rhinitis and BIMS score was 15 indicating intact cognition. An interview on 5/19/2025 at 3:00 pm, with R28 revealed that she has her identification to vote, but no one assisted her nor provided her an absentee ballot to vote. She reported that she wanted to vote and would have voted if she had assistance. 3. Review of the medical record revealed R29 was admitted to the facility with the following diagnoses that include but are not limited to syncope, gastro-esophageal reflux, epilepticus, anxiety disorder and hypoglycemia. Interview on 5/19/2025 at 2:58 pm, R29 revealed that he is a registered voter but did not receive an absentee ballot to vote. He continued to state that he wanted to vote. A telephone interview on 5/19/2025 at 1:12 pm, with the County voter registers revealed that the facility can reference the informative links on the county's voter's registers and elections web page to assist with voter enrollment requirements and verify if residents are a registered vote. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 5/19/2025 at 3:32 pm, the Social Worker Master of Social Work (MSW) revealed she will do a survey with residents who have a BIMS greater than 10 to see if they want to vote. She continued to state that she will follow up to make sure residents have a valid state identification card if needed. She further reported that she was not employed in the facility during November 2024 election. An interview on 5/22/2025 at 11:13 am, Social Worker Bachelor of Social Work (BSW) revealed that a group of voter registrars had come to the facility for residents who wanted to vote but he did not assist or follow up on nor did he know which residents wanted to vote in the November 2024 election.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the physician was notified of abnormal vital signs for one resident (R)(R5) and failed to notify the responsible party of diagnostic test results and impaired skin for R17 of 29 sampled residents. Findings include: Review of the policy provided by the facility titled Changes in a Resident's Condition, with a revision date of 8/18/23 noted the following policy: In case of an accident or sudden adverse change in a resident's condition or adjustment, a center will immediately take actions appropriate to the specific circumstances to meet the resident's needs, including notification of the resident's authorized representative or legal surrogate and the resident's physician. R5 was admitted to the facility on [DATE] with the following but not limited to diagnoses: atherosclerotic heart disease, hypertension, unsteadiness on feet, atrial fibrillation, abdominal aortic aneurysm, difficulty walking, hypotension, iron deficiency anemia and muscle weakness. Review of the 11/20/2024 Physical Therapy Treatment Encounter Note revealed the resident's blood pressure (BP) was assessed while in the supine position and was documented as 103/48 millimeters of mercury (mmHg). When the resident was transferred from supine to the sitting position the BP was 68/46 mmHg. The resident was returned to the supine position to perform therapeutic exercises. The 11/21/2024 Physical Therapy Treatment Encounter Note documented the resident was in bed and supine BP was 115/53 mmHg, heart rate 50, the sitting BP was 88/57 mmHg, and the heart rate was 52. The documentation further noted when the resident stood, staff was unable to get a BP, just stated Low and resident partially passed out. After three minutes in supine position the BP was 138/61 mmHg. The resident was then transferred to the wheelchair was unable to get a BP and the resident completely passed out. The resident was placed back in the bed and BP was 107/58 mmHg. The nurse was informed of all the BP's. The Certified Medication Aide (CMA) reported the resident had his BP medication this morning. The Physical Therapist asked if the physician could be contacted for parameters for BP and medication regimen. Review of the 11/21/2024 Occupational Therapy Treatment Encounter Note documented the resident's BP in supine position was 115/53 mmHg. The resident's BP sitting was 88/57 mmHg. The resident's standing BP was Lo and resident became faint. The therapist lowered the resident to the bed and returned to supine position. Resident's BP in supine was 92/46 and then approximately three minutes later the BP was 138/68. The resident was then assisted with transfer to the wheelchair. The resident passed out in the wheelchair and was unable to tolerate sitting. The resident was returned to supine with bilateral lower extremities elevated and was alert and oriented immediately after laying back down. Nurse notified of orthostatic hypotension. Review of the clinical record revealed there was no documentation the physician or the Nurse Practitioner (NP) was notified of the low BP until 11/25/2024. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 11/25/24 Nursing Progress Note revealed new orders were obtained from the NP to discontinue the atenolol (blood pressure medication), monitor BP twice a day for five days then daily. During an interview with the Administrator on 4/16/2025 at 4:00 pm, she confirmed staff did not notify the NP of the resident's low blood pressure until 11/25/24. Review of the medical records revealed R17 was admitted with the following diagnoses that include but not limited to dementia, type 2 diabetes mellitus, gastrostomy status, abnormal posture, and hypertension. Review of the progress notes dated 4/18/2025 through 5/15/2025 revealed entry dated 4/28/2025 that R17 had a diagnostic procedure for verification placement of gastrostomy. There was no evidence that the responsible party was notified. Review of the diagnostic test dated 4/28/2025 revealed gastrostomy tube tip in stomach. An interview on 5/14/2025 at 10:11 am, the family member revealed visiting R17 on 5/7/2025 saw vomit on her gown and had the nurse to assess the resident. Family member reported being told that R17 was going to have a diagnostic test and the family member would be called with the results. The family member further reported seeing a pink dressing on R17's lower right leg and denied being made aware of any skin issue on R17's leg. R17's family member reported no followup communication related to being informed of the diagnostic test results or the reason for the dressing on R17's leg. An observation on 5/15/2025 at 2:06 pm with Registered Nurse (RN) YY skin integrity nurse, RN FFFFF skin integrity nurse and Certified Nursing Assistant (CNA) ZZ who provided a body audit for R17. This observation confirmed that there is a pink dressing without a date on the right leg. An interview on 5/15/2025 at 3:02 pm, RN YY skin integrity nurse revealed that the wound on the right lower leg was new, and she was unaware of the wound before today's observation. RN YY further reported that the person who placed the dressing on the opened area should have gotten orders.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review, and the facility policy Grievances: Healthcare Centers, the facility failed to ensure the grievances from resident council meetings were addressed with resolutions for four of seven months reviewed. Findings include Review of the facility policy Grievances: Healthcare Center Policy Statement: The Administrator of each healthcare center serves as its grievance official and is responsible for the following: overseeing the grievance proves; receiving and tracking grievances through to the conclusion; leading necessary investigations; maintaining confidentiality of all information associated with grievances (for example, the identity of the patient for those grievances submitted anonymously); issuing written grievance decisions to the person who filed the grievance (if known); and coordinating with state and federal agencies as necessary in light specific allegations. Procedures: 1. If the patient or family member requires assistance with writing the grievance, the staff person receiving the information will assist with completing the appropriated section of the Grievance/Complaint Form: Healthcare Centers. 2. The Administrator will be responsible for overseeing the grievance process: The Administrator or designee will track the grievance on the Greivance/Complaint Log Form: Healthcare Centers. This will provide a central place for all grievances. 5. The Grievance/Complaint should be resolved withing three business days. 1. Review of the Patient/Resident Council Minutes/Report Form dated 11/18/2024 revealed no tea, late meals; form dated 1/20/2025 multiple issues with meals to include not being able to eat in dining room on weekends due to time and timing of evening meals; form dated 2/17/2025 revealed no coffee in the building; form dated 3/17/2025 revealed kitchen coffee pot is broken and food is still cold. There was no evidence that resolutions to grievances were put in place or addressed. An interview on 5/22/2025 at 10:59 am, with the Activity Director who revealed that she writes residents' complaints voiced during the resident council meeting and the concerns are then given to the department head related to the concern. It was further reported that there is a food committee with dietary, but the Activity Director acknowledged that she does not follow back up with the residents related to follow up on the grievances that they have filed. An interview on 5/22/2025 at 11:13 am, with Social Worker, Bachelor of Social Work (BSW) who acknowledged that the Activity Director would bring the grievances to the morning meetings and the grievances were discussed and addressed to the department head of those concerns. Social Worker BSW reported that he was not a part of the process for getting resolutions or addressing the concerns. An interview on 5/22/2025 at 11:17 am, Social Worker, Master of Social Work (MSW) revealed that she had never reviewed any grievances from the Patient/Resident Council Minutes/Report Form because the forms were not given to her but moving forward, she will begin to keep a record of them. An interview on 5/22/2025 at 3:38 pm, with the Administrator revealed that staff should be educated on completing a grievance form and anyone (staff) in the facility can write a grievance. The Social worker is to get the forms, then the form goes to the department head that related to the concerns.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 observation, record review, the facility failed to implement the care plan for weekly skin inspections for two residents (R)(R9 and R12) and failed to develop care plan interventions for routine weekly skin assessments for residents (R1, R3, R8 and R11) who were at risk for skin breakdown from a sample of eight residents with pressure ulcers. On May 20, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Nurse Consultant and the Area [NAME] President were informed of the Immediate Jeopardy on May 20, 2025, at 2:49 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 24, 2024. The survey team validated the implementation of the removal plan through observations, staff interviews, and review of resident records. The immediacy of IJ was removed on May 23, 2025. Findings include: Review of the facility policy and procedure titled Care Plans with a revision date of 7/23/2023 revealed the following policy statement: It is the policy of the health care center for each 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 Instrument Manual and the resident choice. The policy also noted the comprehensive person-centered care plan is developed to include measurable goals and timeframes to meet a resident's medical, nursing and psychosocial needs, the services that are to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial needs that are identified in the comprehensive assessment. It further noted care plans will be updated by nurses, Case Mix Directors, or any other interdisciplinary team member so that the care plan will reflect the resident's needs at any given moment. 1. R1 was admitted to the facility on [DATE] with the following but not limited to diagnoses: end stage renal disease, dependence on renal dialysis, neuropathy, pressure ulcer sacral region Stage 4, chronic ischemic heart disease, iron deficiency anemia, diabetes, peripheral vascular angioplasty and morbid obesity. Review of the Braden Scale (a tool used to assess a resident's risk of developing a pressure ulcer) form dated 4/15/2025 revealed the resident had a pressure ulcer risk score of 15 indicating the resident was at risk for skin breakdown. Review of the resident's care plan with a review/revision date of 8/30/2024 revealed the resident was at risk for skin breakdown related to physical limitations and disease process with a goal the resident's skin would remain intact until next review. Interventions for nursing staff included keep skin clean and dry as possible, pressure relieving device to bed, provide incontinence care and report any signs of skin breakdown (sore, tender, red, or broken areas). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Although the resident had a care plan in place for being at risk for skin breakdown, there were no interventions in place to perform routine weekly skin assessments to identify skin breakdown timely per facility policy. Review of the Skin Notes in the resident's electronic record revealed that no weekly skin assessments were done for the month of January 2025, skin assessments were done three out of four weeks in February 2025, and although the resident was in the hospital from [DATE] to 3/25/2025, there was no documentation a skin assessment was performed on 3/25/2025 when she returned from the hospital. Further review of the record revealed there were no skin assessments in April 2025 until 4/16/2025 when a staff identified a Stage II to the right thigh and a re-opened Stage IV to the sacrum. 2. R3 (closed record) was admitted to the facility on [DATE] with the following but not limited to diagnoses: malignant neoplasm of the prostate, multiple myeloma, iron deficiency anemia, moderate protein calorie malnutrition, polyneuropathy, paraplegia, Stage IV pressure ulcers. Review of the resident's 12/31/2024 Quarterly Minimum Data Set revealed the resident's Brief Interview of Mental Status (BIMS) score was a 4 indicating severe cognitive impairment, required partial/moderate assistance with bed mobility, non-ambulatory, had three Stage III and two Stage IV pressure ulcers that were present on admit. The resident had a Braden Scale assessment completed on 9/25/2024 that indicated the resident had a pressure ulcer risk score of 9 indicating the resident was at very high risk for developing pressure ulcers. Review of the resident's care plan with a reviewed/revised date of 10/1/2024 revealed the resident was at risk for skin breakdown related to resident has multiple pressure ulcers with interventions to keep skin clean and dry as possible, minimize skin exposure to moisture, pressure relieving device to bed, provide incontinence care and report any signs of skin breakdown (sore, tender, red, or broken areas). Although the resident had a care plan in place for being at risk for skin breakdown, there were no interventions in place to perform routine weekly skin assessments to identify skin breakdown timely per facility policy. Review of the Skin Notes in the resident's electronic record revealed that weekly skin assessments were only done on 12/21/2024 and 1/18/2025. 3. R8 was admitted to the facility on [DATE] with the following but not limited to diagnoses: muscle weakness, heart failure, pulmonary hypertension, bullous pemphigoid, acute kidney failure, iron deficiency anemia, gout and diarrhea. Review of the resident's 3/21/2025 Significant Change MDS revealed he had BIMS score of 15 indicating he was cognitively intact and was at risk of developing pressure ulcers. Review of the Braden Scale form dated 2/8/2025 revealed the resident had a pressure ulcer risk score of 16 indicating the resident was at risk for skin breakdown. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the resident's 2/4/2025 care plan revealed the resident was at risk for impaired skin integrity with an approach to see skin risk analysis for interventions. During an interview with the DHS on 4/22/2025 at 3:07 pm, when asked to clarify the intervention to see skin risk analysis for interventions, she stated that was the Braden Scale. However, review of the Braden scale revealed there were no interventions in that assessment. Although the resident was at risk of developing pressure ulcers, the resident had one skin assessment on 3/22/2025 and there were no skin assessments in April 2025 until 4/16/2025 when the staff identified an unstageable pressure ulcer to the left heel. Review of the Wound Management Detail Report dated 4/17/2025 documented the date the wound to the left heel was identified as 4/17/2025. It further noted the resident had an unstageable pressure ulcer to the left heel measuring 2.5 cm x 5 cm with eschar noted, light serous drainage, no odor noted, and edges attached. 4. R9 was admitted to the facility on [DATE] with the following but not limited to diagnoses: anemia, chronic kidney disease, contractures to the right hand, left hand and left elbow, unspecified dementia with anxiety, heart failure, chronic obstructive pulmonary disease and abnormal posture. Review of the Braden Scale form dated 4/16/25 revealed the resident had a pressure ulcer risk score of 12 indicating the resident was at high risk for skin breakdown. Review of the 3/30/2025 Quarterly MDS revealed the resident had severely impaired cognition, was dependent on staff for activities of daily living (ADL) and bed mobility and was at risk of developing pressure ulcers. Review of the resident's care plan revealed the resident was at risk for additional pressure ulcers related to disease process, incontinence, impaired mobility and admitted with pressure ulcer to the sacrum. There was an approach for nursing staff to conduct systematic skin inspection weekly and report signs of further breakdown. Review of the Skin Notes in the Electronic Health Record revealed skin assessments were done 1/16/2025, 1/30/2025, 2/13/2025 and 2/27/2025. There were no skin assessments documented as done in March 2025 and none in April 2025 until 4/16/2025 during the facility wide skin sweep when staff identified an unstageable pressure ulcer to the resident's left elbow. Review of the 4/17/2025 Nursing Notes revealed documentation that as of 4/16/2025 nurse performing skin assessment to gather information and observed concern to the left elbow. Cleansed and dressing applied. Provider made aware. The 4/18/2025 Nursing Note documented the resident had an unstageable to the left elbow measuring 1.5 cm x 0.8 cm with slough noted. 5. R11 was admitted to the facility on [DATE] with the following but not limited to diagnoses: cognitive communication deficit, abnormal posture, anemia, muscle weakness, severe protein calorie malnutrition, intellectual disabilities and unspecified dementia. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Braden Scale form dated 3/7/2025 revealed the resident had a pressure ulcer risk score of 14 indicating the resident was at moderate risk for skin breakdown. Review of the 3/25/2025 Annual MDS revealed the resident had cognitive impairment, dependent on staff for activities of daily living, dependent for bed mobility, at risk for developing pressure ulcers and had one Stage III pressure ulcer present on admit. Review of the resident's care plan revealed the resident had impaired skin integrity which noted an open area to the coccyx. There was an approach to see skin risk analysis for interventions, report any signs of skin breakdown (sore, tender, red, or broken areas). Review of the Skin Notes in the EHR revealed weekly skin assessments had not been done in March 2025 and April 2025 until 4/16/2025 during a facility wide skin sweep and identified a Stage III pressure ulcer to the resident's coccyx. However, review of the EHR revealed the resident has had this pressure ulcer since 9/17/2024. Review of the 9/17/2024 Wound Observation History form indicated the resident had a Stage III to the coccyx that measured 0.7 cm x 0.7 cm x 0.3 cm with granulation tissue. There was also a 4/14/2025 progress note from the wound care NP who noted the Stage III pressure ulcer to the coccyx continued to improve. It further noted the wound measured 0.6 cm x 0.6 cm x 0.2 cm with 5% yellow necrotic tissue, 50% granulation tissue and 45% intact. The plan was to continue current treatment of calcium alginate with silver 6. R12 was admitted to the facility on [DATE] with the following but not limited to diagnoses: chronic obstructive pulmonary disease, contracture left and right knee, cognitive communication deficit, abnormal posture, polyneuropathy, morbid obesity, stress incontinence, and iron deficiency anemia. Review of the Braden Scale form dated 4/15/2025 revealed the resident had a pressure ulcer risk score of 13 indicating the resident was at moderate risk for skin breakdown. Review of the 3/21/2025 Quarterly MDS revealed the resident had severely impaired cognitive skills, she was dependent on staff for ADL's, and at risk for developing pressure ulcers. Review of the resident's 10/23/2021 care plan revealed the resident was at risk for pressure ulcers related to disease process, incontinence and impaired mobility with an approach to conduct a systematic skin inspection (weekly, daily, etc). Pay particular attention to the bony prominences. Review of the weekly Skin Notes revealed a skin assessment was done 2/8/2025 and no skin assessments were done in March 2025 and April 2025 until 4/16/25 during a facility wide skin sweep when two unstageable pressure ulcers were identified to the sacrum and left knee. Review of the 4/17/2025 Wound Management Report revealed a 1.3 cm x 1.0 cm unstageable sacral wound with slough noted to the wound bed, attached reddened edges and a 9 cm x 3 cm unstageable left knee pressure ulcer with black necrotic tissue present. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a post survey interview with the Administrator on 6/24/2025 at 5:24 pm it was stated that any nurse could complete or update a care plan. It was reported that the care plans identified as missing for the residents was an oversight. She explained that nursing staff educated about being able to create and revise care plans during their orientation. She also reported that residents with wounds are followed in the Patients At Risk (PAR) meetings and care plans are reviewed at that time as well. Cross Refer to F686

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, and review of facility policy titled Documentation of Skin and Wound Care, the facility failed to perform consistent weekly skin assessments for residents at high risk for skin breakdown in order to identify breakdown timely for six residents (R) (R1, R3, R8, R9, R11 and R12) and failed to perform treatments as ordered by the physician and/or recommended by the Wound Care Nurse Practitioner for three residents (R3, R11 and R12) of seven residents reviewed for pressure ulcers. The total sample size was 27. On May 20, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Nurse Consultant and the Area [NAME] President were informed of the Immediate Jeopardy on May 20, 2025, at 2:49 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 24, 2024. The survey team validated the implementation of the removal plan through observations, staff interviews, and review of resident records. The immediacy of IJ was removed on May 23, 2025. Findings include: Review of the facility policy and procedure titled Documentation of Skin and Wound Care (revised 6/14/24), revealed the following Policy Statement: It is the policy of the Healthcare center to complete documentation that reflects the current resident status as related to skin/wound care. Documentation will provide current and timely documentation on resident's condition related to skin/wound care, accurate information on resident's status as it pertains to skin/wound care, record care rendered and interventions in place and provide a detailed history of the wound assessments that have occurred in the healthcare center. The procedure noted documentation regarding wound observations and care should be completed on pressure ulcers weekly and as needed, per clinical judgement. Daily documentation of treatments is done by signing the ETAR that the dressing was completed. Weekly documentation of treatments will be completed on Wound Manager in the Electronic Health Record (EHR) and Focus Observation to include Skin observation. Further review of the policy revealed as an integral part of the pressure ulcer prevention program, an audit of all residents will be completed on admission and readmission, prior to any discharge or transfer and a minimum of every week. It further noted the Director of Health Service (DHS) or RN supervisor will develop a schedule of when each resident is to have the skin audit completed by the assigned charge nurse each week. This procedure is in addition to the responsibility of each partner to notify the Skin Integrity Coordinator (SIC) or designee when an area of altered skin integrity is identified. Wound assessment and documentation are completed weekly and when there is a significant change using the Documentation of Wound Observation and Assessment form. Wound assessments are completed weekly by the SIC RN. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115628	A. Building B. Wing	05/29/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the Regional Nurse Consultant OOOOOO on 4/17/2025 at 9:45 am, he stated the staff conducted a facility wide skin sweep on all the residents due to concerns identified with R1 on 4/16/2025. He provided a list of residents with new wounds found from the skin sweep on 4/16/2025. The list identified five residents with previously unidentified wounds. Three residents (R8, R9 and R12) were identified with unstageable pressure ulcers, one resident (R11) was identified with a Stage III pressure ulcer and one resident (R27) had a Stage I pressure ulcer. 1. R1 was admitted to the facility on [DATE] with the following but not limited to diagnoses: end stage renal disease, dependence on renal dialysis, neuropathy, pressure ulcer sacral region Stage 4, chronic ischemic heart disease, iron deficiency anemia, diabetes, peripheral vascular angioplasty and morbid obesity. Review of the resident's Quarterly Minimum Data Set, dated [DATE] revealed she had Brief Interview for Mental Status (BIMS) score of 15 indicating she was cognitively intact, required partial to moderate assistance with hygiene and bathing, independent with bed mobility, she was non-ambulatory and had one Stage IV present on admit. Review of the Braden Scale (a tool used to assess a resident's risk of developing a pressure ulcer) form dated 4/15/2025 revealed the resident had a pressure ulcer risk score of 15 indicating the resident was at risk for skin breakdown. Review of the 1/15/2025 wound care provider Progress Note indicated the resident had Stage IV pressure ulcer to the sacrum since 6/7/2023. This progress note further indicated the sacral ulcer appeared to be healed at that time. Review of the Skin Notes in the resident's electronic record revealed that no weekly skin assessments were done for the month of January 2025, skin assessments were done three out of four weeks in February 2025, and although the resident was in the hospital from [DATE] to 3/25/2025, there was no documentation a skin assessment was performed on 3/25/2025 when she returned from the hospital. Further review of the record revealed there were no skin assessments in April 2025 until 4/16/2025 when a staff identified a Stage II to the right thigh and a re-opened Stage IV to the sacrum. During an interview with the resident on 4/16/2025 at 9:10 am, she complained of her bottom hurting. She also stated that she had complained of her bottom hurting to her daughter the other day and made her look at it but she did not know if she saw anything. During an observation of wound care on 4/16/2025 at 11:45 am with the Nurse Practitioner (NP), DHS and the Skin Integrity Nurse FFF, the resident had dressing to the sacrum and right thigh dated 4/15/25. The resident's right thigh was a Stage II that measured 1.5 centimeters (cm) x 1.4 cm x 0.1 cm. The sacrum measured 1.5 cm x 1.2 cm x 0.3 cm. The NP stated at that time the sacrum was a Stage III and the right thigh was a Stage II. During an interview with Licensed Practical Nurse Unit Manager IIII on 4/16/2025 at 10:35 am, she stated the resident does complain of her bottom hurting, so the other day she did a skin assessment on the resident and did not see any open areas, only old scar tissue. She stated they went ahead and placed a dressing on it to provide some cushion. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the Regional Nurse Consultant OOOOOO on 4/16/2025 at 4:15 pm, he stated he was only able to find skin assessments for February 2025. He stated since the surveyor was looking at the resident and after the areas were found on the resident on 4/16/2025, they looked at the resident's documentation and knew they had a problem. He stated they knew they had a problem with wounds but not to this extent. He further stated as of 4/16/2025 they started doing a 100% skin sweep on all the residents that would be completed that night and have started educating the staff. 2. R3 (closed record) was admitted to the facility on [DATE] with the following but not limited to diagnoses: malignant neoplasm of the prostate, multiple myeloma, iron deficiency anemia, moderate protein calorie malnutrition, polyneuropathy, paraplegia, Stage IV pressure ulcers. Review of the resident's 12/31/2024 Quarterly Minimum Data Set revealed the resident's BIMS score was a 4 indicating severe cognitive impairment, required partial/moderate assistance with bed mobility, non-ambulatory, had three Stage III and two Stage IV pressure ulcers that were present on admission. The resident had a Braden Scale assessment completed on 9/25/2024 that indicated the resident had a pressure ulcer risk score of 9 indicating the resident was at very high risk for developing pressure ulcers. Review of the physician's orders revealed the following wound care order with a start date of 12/3/2024 and end date of 2/7/2025 to pack lower back at 10 O'clock- 12 O' Clock with Opticell AG, cover wound bed with calcium alginate, finish with adhesive foam dressing once a day on Monday, Wednesday and Friday. Review of the January 2025 Medication Administration Record revealed the following missing treatments to the lower back on 1/17/2025, 1/20/2025, 1/24/25 and 1/27/2025 as indicated with no initials. Review of the Skin Notes in the resident's electronic record revealed that weekly skin assessments were only done on 12/21/2024 and 1/18/2025. 3. R8 was admitted to the facility on [DATE] with the following but not limited to diagnoses: muscle weakness, heart failure, pulmonary hypertension, bullous pemphigoid, acute kidney failure, iron deficiency anemia, gout and diarrhea. Review of the resident's 3/21/2025 Significant Change MDS revealed he had BIMS score of 15 indicating he was cognitively intact and was at risk of developing pressure ulcers. Review of the Braden Scale form dated 2/8/2025 revealed the resident had a pressure ulcer risk score of 16 indicating the resident was at risk for skin breakdown. Although the resident was at risk of developing pressure ulcers, the resident had one skin assessment on 3/22/2025 and there were no skin assessments in April 2025 until 4/16/2025 when the staff identified an unstageable pressure ulcer to the left heel. Review of the 4/17/2025 Nursing note indicated on 4/16/2025, nurse performing skin assessment and noted area of concern to resident's left heel. Wound care made aware and Hospice representative, dressing applied and heel boot in place. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Wound Management Detail Report dated 4/17/2025 documented the date the wound to the left heel was identified as 4/17/2025. It further noted the resident had an unstageable pressure ulcer to the left heel measuring 2.5 cm x 5 cm with eschar noted, light serous drainage, no odor noted, and edges attached. Although the unstageable pressure ulcer was initially identified on 4/16/2025, a physician's order for treatment was not obtained until 4/18/2025 to cleanse the left heel with wound cleanser, apt dry, apply Betadine-soaked gauze and dry 4x4 gauze and protective dressing every Monday, Wednesday and Friday. Review of the April 2025 Medication Administration Record (MAR) revealed the treatment to the left heel was not started until 4/18/2025. The resident was evaluated by the wound care NP on 4/21/2025 who noted the resident had an unstageable pressure ulcer to the left heel that measured 8 cm x 8 cm with 100% black necrotic tissue. During an observation of the resident's left heel on 4/23/2025 at 11:18 am with the DHS and Skin Integrity RN FFF, the resident had an unstageable pressure ulcer to the left heel. The wound had approximately 60% black eschar and 40% pink granulation. 4. R9 was admitted to the facility on [DATE] with the following but not limited to diagnoses: anemia, chronic kidney disease, contractures to the right hand, left hand and left elbow, unspecified dementia with anxiety, heart failure, chronic obstructive pulmonary disease and abnormal posture. Review of the Braden Scale form dated 4/16/2025 revealed the resident had a pressure ulcer risk score of 12 indicating the resident was at high risk for skin breakdown. Further review of the record revealed the 4/16/2025 Braden Scale was the only Braden Scale done in 2025 and there were no Braden Scale assessments completed in 2024. Review of the 3/30/2025 Quarterly MDS revealed the resident had severely impaired cognition, was dependent on staff for activities of daily living (ADL) and bed mobility and was at risk of developing pressure ulcers. Review of the Skin Notes in the Electronic Health Record revealed skin assessments were done 1/16/2025, 1/30/2025, 2/13/2025 and 2/27/2025. There were no skin assessments documented as done in March 2025 and none in April 2025 until 4/16/2025 during the facility wide skin sweep when staff identified an unstageable pressure ulcer to the resident's left elbow. Review of the 4/17/2025 Nursing Notes revealed that as of 4/16/2025 there was documentation of nurse performing skin assessment to gather information and observed concern to the left elbow. Cleansed and dressing applied. Provider made aware. The 4/18/2025 Nursing Note documented the resident had an unstageable to the left elbow measuring 1.5 cm x 0.8 cm with slough noted. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the 4/2025 MAR revealed treatment was started on 4/16/2025 with cleansing the left elbow with normal saline, pat dry, apply calcium alginate and Medihoney with 4x4 gauze and cover with dressing every Tuesday, Thursday and Saturday. The resident was evaluated by the wound care NP on 4/21/2025 who noted the left elbow was a recurrent Stage IV pressure wound that as of 4/21/2025 the area was scabbed with no drainage and no open area. The area measured 2 cm x 2 cm. The NP noted the plan was to use Skin Prep and bordered foam dressing. Review of the Physician's orders revealed a new order on 4/22/2025 to cleanse the left elbow with normal saline, pat dry and apply Skin Prep every Tuesday, Thursday and Saturday. During an observation on 4/23/2025 at 11:02 am with the DHS and the Skin Integrity RN FFF, the resident was observed with two small, scabbed areas to the left elbow. 5. R11 was admitted to the facility on [DATE] with the following but not limited to diagnoses: cognitive communication deficit, abnormal posture, anemia, muscle weakness, severe protein calorie malnutrition, intellectual disabilities and unspecified dementia. Review of the Braden Scale form dated 3/7/2025 revealed the resident had a pressure ulcer risk score of 14 indicating the resident was at moderate risk for skin breakdown. Review of the 3/25/2025 Annual MDS revealed the resident had cognitive impairment, dependent on staff for activities of daily living, dependent for bed mobility, at risk for developing pressure ulcers and had one Stage III pressure ulcer present on admit. Review of the Skin Notes in the EHR revealed weekly skin assessments had not been done in March 2025 and April 2025 until 4/16/2025 during a facility wide skin sweep and identified a Stage III pressure ulcer to the resident's coccyx. During an observation of the resident on 4/23/2025 at 10:25 am with the DHS and the Skin Integrity RN FFF, the resident was observed to have a Stage III to the coccyx with 100% pink granulation tissue. However, review of the EHR revealed the resident has had this pressure ulcer since 9/17/2024. Review of the 9/17/2024 Wound Observation History form indicated the resident had a Stage III to the coccyx that measured 0.7 cm x 0.7 cm x 0.3 cm with granulation tissue. There was also a 4/14/2025 progress note from the wound care NP who noted the Stage III pressure ulcer to the coccyx continued to improve. It further noted the wound measured 0.6 cm x 0.6 cm x 0.2 cm with 5% yellow necrotic tissue, 50% granulation tissue and 45% intact. The plan was to continue current treatment of calcium alginate with silver. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Physician's Orders revealed there was an order dated 10/28/2024 through 3/4/2025 to cleanse the sacral area(coccyx) with sterile normal saline, pat dry, pack wound with iodoform and cover with adhesive dressing every Monday, Wednesday and Friday. However, review of the MARs for March 2025 and April 2025, there was no documentation the treatment had been done as ordered until 4/18/2025 when a physician's order was obtained to cleanse the coccyx with normal saline, apply purachol and 4x4 gauze covered with adhesive dressing every Monday, Wednesday and Friday. During an interview and review of the EHR with the DHS on 4/23/2025 at 3:45 pm, she confirmed the resident was in the hospital from [DATE]-[DATE]. When the resident returned to the facility on 3/7/2025, the wound care orders were not restarted, and wound care was not done from 3/7/2025 through 4/17/2025. After they did the facility skin sweep on 4/16/2025 and identified the resident's Stage III pressure ulcer, physician orders were obtained for treatment on 4/16/2025. 6. R12 was admitted to the facility on [DATE] with the following but not limited to diagnoses: chronic obstructive pulmonary disease, contracture left and right knee, cognitive communication deficit, abnormal posture, polyneuropathy, morbid obesity, stress incontinence, and iron deficiency anemia. Review of the Braden Scale form dated 4/15/2025 revealed the resident had a pressure ulcer risk score of 13 indicating the resident was at moderate risk for skin breakdown. Review of the 3/21/2025 Quarterly MDS revealed the resident had severely impaired cognitive skills, she was dependent on staff for ADL's, and at risk for developing pressure ulcers. Review of the weekly Skin Notes revealed a skin assessment was done 2/8/2025 and no skin assessments were done in March 2025 and April 2025 until 4/16/2025 during a facility wide skin sweep when two unstageable pressure ulcers were identified to the sacrum and left knee. Review of the 4/17/2025 Wound Management Report revealed a 1.3 cm x 1.0 cm unstageable sacral wound with slough noted to the wound bed, attached reddened edges and a 9 cm x 3 cm unstageable left knee pressure ulcer with black necrotic tissue present. The wound care NP noted on 4/14/2025 a new unstageable pressure ulcer to the left knee measuring 3 cm x 3 cm x 1 cm with 100% black necrotic tissue. The NP noted a primary dressing of Betadine and a dry protective dressing three times a week. The 4/18/2025 Nursing Progress Note documented a 1.3 cm x 1.0 cm unstageable sacral wound with slough noted to wound bed and a 9 cm x 3 cm left knee pressure ulcer with black necrotic tissue. The 4/21/2025 wound care NP progress note documented the pressure ulcer to the sacrum as unstageable, measuring 1.2 cm x 1.2 cm x 1.0 cm with 100% yellow necrotic tissue with orders to apply honey, dry protective dressing three times a week. Review of the April 2025 MAR revealed a 4/14/2025 physician's order to cleanse wound to left knee with wound cleanser, paint wound with Betadine to wound bed and secure with dry protective dressing every Monday, Wednesday and Friday. However, further review of the April 2025 MAR indicated the wound care was only provided on 4/21/2025 and 4/25/2025. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the DHS on 4/29/2025 at 12:15 pm, she stated the nurses on the floor are responsible for doing the weekly skin assessments on all of the residents. Each unit has a schedule to go by and if new areas are identified they are reported to the wound nurse. During an interview with Unit Manager DDDD on 4/30/2025 at 12:40 pm, she stated the charge nurses were responsible for doing the weekly focused skin assessments on everybody each week and they have a schedule to go by. During an interview with the Administrator and the DHS on 5/6/2025 at 9:45 am, they stated from August 2024 to April 2025 they have had a total five treatment nurses. Stated there was one treatment nurse until a Registered Nurse was hired on 3/26/2025 and a third nurse was hired on 5/7/2025. They stated that at one time there was only one treatment nurse, and it was hard for them to document on wounds, such as weekly documentation and there were holes in the MAR's. Stated residents with wounds get a weekly Braden scale and those residents who don't have wounds get quarterly Braden scales, but they were not being done. When asked who was responsible for monitoring the skin integrity program, they stated the wounds would be discussed in weekly meetings. During an interview with Unit Manager IIII on 5/7/2025 at 10:15 am, she stated the charge nurses were responsible for doing the weekly skin assessments, but they were not doing them. Stated she did not know why they were not doing them. She stated those nurses have since resigned. When surveyor asked if she reported this to management, she stated that everybody knew about it. During an interview with the Wound Care NP on 5/20/2025 at 9:37 am, she stated the biggest issue was keeping a consistent wound care nurse. She stated that RN YY was good about calling her anytime and would give RN YY recommendations at that time until she could see the resident during her next visit which is weekly. Stated when she visits, she gives orders for the resident's wounds and leaves a copy of the order to both of the Skin Integrity Nurses and the DHS. She also confirmed that necrotic tissue does not develop overnight.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of policy titled Procedure: Indwelling Urinary Catheter the facility failed to obtain a physician's order to continue an indwelling catheter for one resident (R) (R3) who was admitted from the hospital with an indwelling urinary catheter from a sample of 29 residents. Findings include: Review a procedure provided by the facility titled Procedure: Indwelling Urinary Catheter dated 2019 revealed under the section titled Procedure step 2 was to verify orders. R3 was admitted to the facility on [DATE] with the following but not limited diagnoses: malignant neoplasm of prostate, Stage IV pressure ulcer, multiple myeloma not achieving remission, paraplegia and colostomy. Review of the 9/24/2024 admission orders from the hospital and all orders up to 2/7/2025 lacked a physician's order for an indwelling urinary catheter. Review of the 9/24/2024 admission Nursing Progress Note indicated the resident arrived to the facility from (Hospital Name) with a Foley catheter intact. The 10/8/2024 Nursing Progress note documented a 24 French Foley catheter was removed with 250 cubic centimeters (cc) of urine in bag. Inserted a new 24 French Foley catheter using sterile technique. Review of the 12/31/2024 Quarterly Minimum Data Set revealed the resident had the presence of an indwelling catheter. During an interview with Unit Manager DDDD on 4/30/2025 at 12:40 pm, she confirmed R3 had a Foley catheter. During an interview with Regional Nurse Consultant OOOOOO on 5/21/25 at 12:35 pm, he confirmed there was not a physician's order for the Foley catheter for R3.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, staff interviews, and review of the job description titled Position Description Dietary Manager, the facility failed to ensure the kitchen had a Certified Dietary Manager to oversee the duties and responsibilities of the kitchen staff; and failed to ensure the Dietitian assumed responsibility and accountable for the Dietary Services Department. The facility has 184 of 203 resident that receive oral meals. Findings include: Review of the facility Position Description Dietitian Job Purpose: Responsible for assuming professional responsibility and accountability for the Dietary Services Department in; the provision of nourishing, palatable, well-balanced diets to meet the daily nutritional and special dietary needs of each resident. Key Responsibilities: 12. Conducts regular meal observations, record reviews, and resident interviews for adherence to prescribed diet orders and nutrition interventions. 13. Conducts quality assurance functions that include regular compliance rounds of the Dietary Department's food preparation and storage areas for adherence to regulator guidelines. 14. Directs staff in improving the quality of foods served and the dining experience. Review of the facility Position Description Dietary Manager: Job Purpose: Plans, organizes, develops, and directs the overall operation of the Dietary Department in accordance with current federal, state and local regulations governing the center and as directed by the Administrator. Responsible for maintaining the Dietary Department in a clean, safe, and sanitary manner and prove nutritionally adequal meals in accordance with regulatory guidelines. Key Responsibilities: 8. Maintains the proper storage, preparation, distribution and serving of food under sanitary conditions in accordance with regulatory guidelines. 10. Follows procedures for serving partner meals to comply with company policies and procedures. 11. Supervises proper procedures for cleaning all kitchen equipment to include but not limited do carts, tables, counters, ice machine, buckets, blender, mixer, mat slicer, freezer, refrigerator, stove, oven steamer, garbage disposal, dish machine, coffee/tee maker, and steam table. 12. Supervises the operation of all major equipment to include but not limited to the dish machine, garbage disposal, blender, mixer steamer, meat slicer, fry, steamer, oven and coffee/tee maker. An observation on 5/1/2025 at 11:26 am, upon entrance into the kitchen, observed and met with Dietary Supervisor/Cook as there was no Certified Dietary Manager (CDM) available. An observation on 5/13/2025 at 2:09 pm, observed a Certified Dietary Manager (CDM) from an affiliated facility overseeing the duties and responsibilities of the kitchen. Review of the separation notice revealed the former CDM last day was 3/31/2025. Review of the List of Key Personnel provided by the facility revealed that the facility has a Registered Dietitian AA, Dietary Manager DDD and a Dietary Supervisor BB. However, the Dietary Manager DDD was responsible for other duties in the facility. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the kitchen staff dated 5/14/2025 that was provided by the facility revealed no CDM on the staff list. An interview on 5/15/2025 at 4:13 pm, Registered Dietitian AA revealed she was working with the former CDM about the cleanliness of the kitchen which was a concern. Registered Dietitian AA reported that she did help the dietary supervisor as much as possible. An interview on 5/19/2025 at 12:34 pm Dietary Supervisor BB revealed that the former CDM was the person to make cleaning schedules and duty assignments for each person. Dietary Supervisor BB acknowledged that she had not made any schedules. Further reporting that the kitchen staff were winging it meaning if they saw something that needed to be cleaned, they cleaned it. There were no assigned names for the kitchen duties. An interview with the Administrator on 5/19/2025 at 3:38 pm, revealed the former Certified Dietary Manager's (CDM) last workday was 3/31/2025.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview and policy Nutritional Screening and Assessments/Food Preferences, the facility failed to ensure food preference was honored for one resident (R14) of three sample residents. Findings include Review of the policy titled, Nutritional Screening and Assessments/Food Preferences (revised date of 3/28/2024): Procedure: 4. Patient/resident food preferences and choices will be honored within reason according to the patient/resident's diet order and menu selections available. Review medical record revealed R14 had a Minimum Data Set (MDS) Quarterly assessment dated [DATE] which indicated R14 had a Brief Interview Mental Status (BMIS) score of 14 which indicated intact cognition. Review of the Diet Review/Food & Beverage Preference List revealed R14 has a dislike for broccoli. An observation and interview on 5/5/2025 at 2:55 pm, of R14's lunch meal tray had the following food items: rice, broccoli, pear slices, carrots, dinner roll, fruit, and a glass of water. R14 revealed that he is never asked what he wants off the menu and they always serve him things that he does not like such as the broccoli. An interview on 5/22/2025 at 3:38 pm, the Administrator revealed that the plan is to print the menu and have the residents to let us know what they want to eat.

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	115628	A. Building B. Wing	05/29/2025

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, staff interview, and record review, the facility failed to ensure that resident meals were served in a timely manner. This deficient practice had the potential to affect 184 of 203 residents that received an oral diet. Findings include: The following was observed during kitchen visits: 1. On 5/1/2025 at 11:37 am, the dishwasher area had breakfast dishes in the sink. 2. On 5/3/2025 at 11:21 am, five carts of dirty breakfast dishes at entry of the dishwasher door waiting to be place in the dishwasher. 3. On 5/5/2025 at 11:52 am, observed a backlog of breakfast dishes waiting to wash. Observation on 5/5/2025 at 2:38 pm, of Licensed Practical Nurse (LPN) OOOO on 600 Hall assisting with the delivery of the lunch meal trays. An interview on 5/5/2025 at 2:55 pm with R14 revealed that his dinner is always late with dinner arriving between 6:30 pm to 8 pm. Observation of lunch trays being delivered to 600 hall on 5/13/2025 at 2:01 pm revealed the lunch was being served in Styrofoam containers. CNA UUUU confirmed that the meal trays had just been delivered for lunch. Observation of 500 hall revealed lunch meal trays being delivered on 5/15/2025 at 1:35 pm. Review of posted mealtimes for residents revealed breakfast is served at 7:00 am, lunch is served at 11:15 am, and supper is served at 4:30 pm. During an in interview with the Dietary Supervisor on 5/19/2025 at 12:34 pm revealed his responsibility is staffing assignment, ensuring that the kitchen is cleaned, making sure food is palatable, and making sure residents' meals are on time. Dietary Supervisor reported that the facility has purchased an additional 121 dinner plates. However, meals have been late because of the dishwasher and plates being wet for the next meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews the facility failed to ensure that the ice machine was free from black and pink substances; failed to ensure the dishwasher maintained proper water temperature; failed to follow manufactures recommendations regarding sanitation of pots and pans in the three compartment sink; failed to ensure food on steam table maintained food temperature; failed to ensure opened food items were properly dated, labeled, and stored; failed to ensure cleanliness of the kitchen floors; failed to ensure a no touch trash can was near the sink and failed to ensure clean dishes were stored on a clean surface. This deficient practice had the potential to increase the spread of food borne illness for 184 of 203 residents that received an oral diet. Findings include: Observation 5/1/2025 at 11:26 am, revealed there is no touchless trash can near the sink. The staff were observed using a 50-gallon trash with a lid and several staff seen sliding the lid over with a paper towel or dropping the used paper towel in a narrow opening. Observation on 5/1/2025 at 11:28 observed on the stainless counter next to the coffee pot and a plastic container, two rolls of plastic trash bag and a can of uncapped stainless stain cleaner on the stainless stain counter next to the meat and vegetable sink. Observation on 5/1/2025 at 11:33 am, observed the inside of the ice machine inside on a white plastic chute black substance on the right and on the left side of the chute is a pinkish slime substance. The ice bin was full of ice and the ice door chute was open to air. The outside of the ice bin had debris and needed cleaning. Observation on 5/1/2025 at 11:35 am, of Supervisor [NAME] BB wiping the ice machine chute with a white towel and the cloth having a visible black and pinkish substance from the ice machine. An observation on 5/1/2025 at 11:37 am, observed in the dishwasher area breakfast dishes in the sink. On the floor on the right as standing facing the dishwasher area. There is a white wet blanket on the floor. There is also another white wet blanket with black substances on it. And on the left side of the floor near the drain on the floor is another white wet blanket. The floor in this area has food debris. In the rinse sink prior to the dishwasher there are multiple food covers and small glasses from the breakfast meal. On the wall above the water sprayer there is black substance on the wall. The kitchen floor has multiple areas throughout the kitchen with food particles, dirt and dried spills. An observation on 5/1/2025 at 11:51 am, observed on near the steam table a pile of stacked white plates. On the top plate, there is dried food particles. An observation on 5/1/2025 at 11:53 am, observed in storage room the floor bin has the scoop without a bag on top with scattered floor on the lid of the bin. The cornmeal bin and sugar bin have the scoops inside of the bin. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of Dietary Aide (DA) EE on 5/1/2025 at 2:19 pm, revealed him at the three compartment sink washing pots and pans. The first sink had soap and water below the water line, there was no rinse water in the second sink, and there was no sanitizer solution in the third sink. Each sink had instructional posters for operational use of each sink which included the title label of each sink and a measurement line drawing of the water level (to show the water filled line for each sink). The first sink was labeled wash sink and displayed waterline. The second sink was labeled rinse sink and displayed the waterline level. The display for the third sink (sanitizer step) indicated to merge items in the water for at least 30 seconds to allow complete sanitizing. DA EE was observed rinsing the pot under running water using the water faucet and missing the sanitizer step. During an observation and interview on 5/1/2025 at 2:23 pm with Dietary Supervisor the dish washer revealed the wash cycle hot water temperature was 117 degrees F and the rinse temperature was 142 degrees F. It was reported that the dishwasher had chlorine for sanitation. An observation on 5/1/2025 at 2:31 pm, observed the dishwasher pre-rinse sink sprayer, being used and water is sprayed on the ceiling, running on the floor onto the white dirty blanket under the sink. There is black substance on the wall behind the water knobs. An observation on 5/3/2025 at 11:20 am, observed the three-compartment sink with cookware below water line with pots in the sink. The first sink with soap and water below the water line, there is no rinse water in the second sink; and there is no sanitizer solution in the third sink. DA EE was observed rinsing the pot under a running water using the water faucet and missing the sanitizer step. He was observed drying a pan with cloth towel instead of allowing the pan to air dry. An observation on 5/3/2025 at 11:51 am, observed with Dietary Aide EE in the walk-in refrigerator. There was a package of turkey breast slices wrapped in clear plastic, a five-pound bag of cheddar wrapped in clear plastic, and a bag of liquid egg that did not have an open date. There was also cornbread wrapped in clear plastic, and it did not have a preparation date or a use by date. During an observation on 5/3/2025 at 12:02 pm, [NAME] DD obtained food temperatures from the steam table and the following items had a holding temperature below 135 degrees Fahrenheit (F): green beans 119. 2 degrees F, onion rings 105.5 degrees F, and cheeseburger 113.5 degrees F. An observation on 5/5/2025 at 12:43 pm, observed with the Territory Representative for (named company) the high temperature dishwasher which was modified temporarily to a chlorine sanitizer on 4/21/2025. The first cycle of dishes washed reveal the wash water temperature was 128 degrees F and the rinse cycle 165 degrees F. The second cycle of dishes washed the water temperature was 120 degrees F and rinse cycle was 145 degrees F. The third cycle of dishes washed the wash water was 115 degrees F and rinse cycle was 138 degrees F. The fourth cycle of dishes washed the water temperature was 118 degrees F and rinse cycle was 130 degrees F. The fifth cycle of dishes washed the wash temperature was 115 degrees F and rinse cycle was 145 degrees F. An observation on 5/5/2025 at 12:57 pm, with the (named company) Territory Representative the first sink of the three-compartment sink with a pot and a pan in the first sink water. The Territory Representative obtained water temperatures for the sink and the water temperature was 106 degrees F and was below the recommended 110 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/7/2025 at 1:55 pm, with Central Supplies staff it was revealed that he has never ordered the cleaning solution for the ice machine and that the Maintenance Director may be the one who orders the solution to clean the ice machine. An interview on 5/7/2025 at 2:16 pm, with the Maintenance Director revealed that to his knowledge the ice machine has never been sanitized using the cleaning solution because the facility has never had the cleaning solution. Lastly, it was reported that ice machine was purchased August 2023. A telephone interview on 5/5/2025 at 11:52 am with Territory Representative revealed that the dishwasher needs to be replaced because it is the smallest dishwasher. He continued to say that on 4/21/2025 that he came to the facility and temporarily converted the high temperature dishwasher to a chlorine sanitizer until the facility could get their hot water issue resolved. The hot water after continuous cycling water, the water temperatures is 130-135 degrees F. The chlorine wash is 120 F. During a subsequence interview at 1:04 pm, the Territory Representative revealed that the facility must get the hot water issues resolved before the high temperature dishwasher can be used as a regular high temperature dishwasher. An interview on 5/15/2025 at 11:43 am, Dietary Aide III revealed the dishwasher has had problems and that sometimes they can wash five loads and other days they can barely wash three loads. It was reported that hot water is taken away when the laundry department is washing the residents' laundry, and the kitchen then has to wait for the water to heat again. An interview on 5/19/2025 at 1:00 pm, Dietary Aide NNN revealed that the sprayer for the dishwasher area was always leaking water and blankets were on the floor. An interview on 5/15/2025 at 10:39 am, with Dietary Aide EE revealed that the 3 Compartment Sink in the first sink is the wash sink with water and soap, the second sink is the rinse water, and the third sink is for sanitizing. Dietary EE reported that line on the outside of the sink is for the water level in the sinks. It was further reported that the second sink is the rinse sink and when the sink is empty, he just rinses the pots from the faucet because he is close to getting off work. He reported the third sink's (sanitizer) purpose is to keep the bacteria off the dishes the pots are supposed to air dry. Dietary Aide EE denied using the cloth to dry a flat pan. During an interview with the Dietary Supervisor on 5/19/2025 at 12:34 pm he revealed his responsibilities are to make staffing assignments, ensure the kitchen is cleaned, palatability of food, and to ensure resident food is delivered on time. He continued to state that the dietary aides are to make sure that they put dates on the opened food items. The Dietary Supervisor reported that it could be lack of education or lack of knowledge as to why there was no dates placed on the food items. It was also confirmed that the scoops should be bagged when not in use and stored in a scoop holder on the wall. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/19/2025 at 3:38 pm, the Administrator revealed that the ice machine has been contracted out for services for 90 days and then the kitchen staff will clean twice a week. The contracted company will educate the Maintenance Director on how to perform the maintenance for the ice machine. The kitchen staff are to make sure the water line is met and that all three sinks are properly filled when cleaning cookware in the three-compartment sink. The Administrator further confirmed that no scoops should be stored in the dry goods bins. It was reported that any opened food items are to be dated and those that are not dated must be discarded. The dirty kitchen floors should be mopped, and the Administrator did not have an answer for why this was not done. It was further reported that dietary staff should not have been using the 55-gallown trashcan and blankets should not have been placed on the floor when the dish sprayer was not working appropriately.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review, staff interviews and review of the Administrator Job Description and the Director of Health Services Position Description, administration failed to ensure staff were performing weekly skin assessments and wound treatments as ordered and failed to provide oversight and monitoring of the skin integrity program. This deficient practice impacted six residents (R) (R1, R3, R8, R9, R11 and R12) of 29 sampled residents. On May 20, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Nurse Consultant and the Area [NAME] President were informed of the Immediate Jeopardy (IJ) on May 20, 2025, at 2:49 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 24, 2024. The survey team validated the implementation of the removal plan through observations, staff interviews, and review of resident records. The immediacy of IJ was removed on May 23, 2025. Findings include: Review of the facility Administrator Position Description revealed: Directs 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: -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 operations. -Ability to apply standards of professional practice to operations of nursing facility and to establish criteria to assure that care provided meets established standards of quality. -Ability to develop and implement administrative policies and procedures that reflect the center's philosophy and mission in compliance with federal and state laws and regulations. -Carries out all duties in accord with the center's mission and philosophy. Review of the Director of Health Services Position Description revealed: Job purpose to plan, organizes, develops and directs the overall operation of our Nursing Services Department in accordance with current federal, state, and local regulations governing our nursing center, and as may be directed by the Administrator and the Medical Director, to provide appropriate care. Key Responsibilities: -Maintain knowledge of documentation procedures including appropriate use of forms, timelines, and Medicare documentation etc. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Maintain working knowledge of current licensure standards and the survey process. -Perform other related duties as necessary and as directed by supervisor. The facility failed to provide effective oversight and monitoring of the Skin Management Program. Specifically, failed to ensure weekly skin assessments were routinely completed by licensed nurses on residents who were at risk of altered skin integrity and treatment orders were documented and completed as ordered. 1. Administration failed to ensure the implementation of the plan of care for weekly skin inspections for two residents (R9 and R12),and failed to develop interventions for routine weekly skin assessments for residents (R1, R3, R8 and R11) who were at risk for skin breakdown. Cross refer to F656. 2. Administration failed to ensure licensed nursing staff performed routine weekly skin assessments to identify skin breakdown timely for six residents (R1, R3, R8, R9, R11 and R12) at risk for skin breakdown, and failed to document treatment orders carried out for three residents (R3, R11 and R12). Cross Refer to F686. 3. Administration failed to ensure an effective Quality Assurance and Performance Improvement process was utilized to identify concerns related to the identification, care and management of the Wound Management System. There was no indication a Performance Improvement Plan (PIP) was developed as recommended by the Regional Nurse Consultant on 2/12/25 after he identified problems with the Skin Management Program. Cross Refer to F867 During an interview with the Administrator and the DHS on 5/6/2025 at 9:45 am, they stated from August 2024 to April 2025 they have had a total five treatment nurses. It was stated that at one time there was only one treatment nurse and it was hard for them to document on wounds. It was reported that wounds were discussed in weekly meetings.

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	115628	A. Building B. Wing	05/29/2025

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on staff interviews, record review and review of the Quality Assurance and Performance Improvement policy, the facility failed to have a Quality Assurance and Performance Improvement committee that effectively provided oversight and monitoring to ensure staff were performing weekly skin assessments to ensure timely identification and treatment of pressure ulcers. On May 20, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Nurse Consultant and the Area [NAME] President were informed of the Immediate Jeopardy on May 20, 2025, at 2:49 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on December 24, 2024. The survey team validated the implementation of the removal plan through observations, staff interviews, and review of resident records. The immediacy of IJ was removed on May 23, 2025. Findings include: Review of the facility policy titled Quality Assurance and Performance Improvement Policy (QAPI) with a revision date of 12/1/2017 documented the following: The purpose of QAPI program at (Facility Name) is to continually take a proactive approach to assure and improve the way we provide care and engage with our patients, partners, and other stakeholders so that we may fully realize our vision, mission, and commitment to caring pledge. Process: All (Facility Name) partners and contracted staff are responsible for the quality of care and services within their respective departments and are expected to participate in the (Facility Name) QAPI Program. Each center must develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care, quality of life, and resident choice. It is the expectation of the (Facility Name) QAPI program that each location will follow the established QAPI process to guide and direct the operations of that location. The executive leadership of (Facility Name) sets the expectation and provides the resources for implementation. Each SNF establishes a QAPI committee which has overall responsibility to develop and modify their respective QAPI plan, review information, and set priorities for performance improvement projects (PIP). Performance Improvement Projects: As part of its QAPI program, each (Facility Name) develops, implements, and evaluates PIP's. PIP's must include at least annually a project that focuses on high risk, high volume or problem-prone areas for improvement identified through the data collection and analysis based on: Feedback and input from stakeholders, Data/metrics reported monthly from all departments, Adverse event monitoring and investigation/analysis. The center must set priorities for PIP's based on the results of quality monitoring that consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. Review of the Quality Assessment and Assurance/QAPI Committee Meetings and the corresponding Agenda Items for 1/14/25, 3/11/25 revealed there was no indication the QAPI committee identified the staff's failure to perform weekly skin assessments to ensure timely identification and treatment of pressure ulcers. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the Regional Nurse Consultant on 5/7/25 at 10:00 am, he stated on 2/11/25 he completed an Annual Risk checklist which identified problems with wound care. He recommended the facility do a Performance Improvement Plan (PIP) and put a plan in place. Stated he did not know why the facility decided not to do a PIP. If a facility decides not to do a PIP then the DHS will do a system checklist monthly that includes audits of all residents with wounds. He stated these were not done. During a post survey interview with the Administrator on 6/24/2025 at 5:24 pm who acknowledged that the facility did not implement a Performance Improvement Plan (PIP) until April after the survey team entered the facility. She explained that she felt they were working on correcting issues through staff education, morning clinical meetings, and Patient At Risk (PAR) meetings. However, some things were missed due to the some of the ongoing changes in leadership. Cross Refer to F656, F686 and F835