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	11/24/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, resident and staff interviews, record review, review of the facility provided recipe titled Chicken and [NAME] Casserole and Broccoli and review of the facility's policies titled Puree Policy and Diet Order System, the facility failed to ensure that the puree menu was followed. The deficient practice had the potential to affect the nutritional status for 18 of 18 residents' receiving a puree diet. In addition, the facility failed to follow the diet ordered for one of 51 residents (R) (R10) related to large portions and serving food not on a renal diet placing R10 at nutritional risk. Findings include: Review of the facility's undated policy titled Puree Policy under the section titled Preparation Steps documented, 1. Depending on the resident's dietary restrictions, follow the proper recipe to prepare the regular consistency food item. 2. Portion out the prepared food according to the number of pureed portions needed, remembering to include a little extra to make up for the loss of volume when pureeing. Review of the facility's policy titled, Diet Order System last revised 9/29/2022 revealed, All partners involved in meal service will check each tray against the diet card prior to delivery to the patient/resident. 1. Observation of the preparation of the puree meal and interview on 9/24/2025 at 11:45 am with Dietary [NAME] (DC) PP who was preparing the lunch meal revealed that 18 residents received a pureed diet. The Regional Registered Dietician (RRD) provided a copy of the menu and the recipe for Chicken and [NAME] Casserole and Broccoli. DC PP added a large pan of Chicken and [NAME] Casserole into the food processor, pureed the contents and checked for consistency. Interview with DC PP revealed that she added 18 spoonsful or more of the casserole to the recipe. She states density was checked with additions of chicken broth, alternating with processing until the desired consistency was reached. An interview on 9/24/2025 at 11:45 am with the RRD revealed that the menu recipe produced for the surveyor was generic and was configured for a serving size of 210. She stated that they reduced the number of servings to match the number of residents on puree consistency, which was a serving size to equal 18 residents plus a few extra portions. 2. Review of the electronic clinical record Face Sheet diagnoses for R10 included but were not limited to, hydronephrosis bilaterally, end stage renal disease, dependence on renal dialysis, anemia in chronic kidney disease, obstructive and reflux uropathy, malignant neoplasm of colon, secondary malignant neoplasm of lung, and anxiety disorder. Review of active physician orders revealed, a NAS (no added salt) diet with Special Instructions: No (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potatoes or bananas which was dated 8/15/2025. Review of the most recent Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed, Section C (Cognitive function) Brief Interview for Mental Status (BIMS) score of 15, which indicated little to no cognitive impairment. Section O (Special treatments) was coded for dialysis. Review of the care plan last dated 9/21/2025 revealed: focus, goal and interventions included but not limited to 1. Potential for complications related to hemodialysis for Renal failure with intervention to consult with dietician for nutritional support. 2. Nutrition risk related to dialysis dependence and other diagnoses with intervention to provide diet as ordered, therapeutic diet liberalized renal diet as ordered/tolerated Interview on 9/23/2025 at 11:02 am with R10 revealed that he was not supposed to eat potatoes, bananas, or tomatoes because he is on a liberalized renal diet. He states he constantly gets potatoes. He states he was supposed to get large portions and thinks the staff does not read the meal slip/tickets. R10 provided photographs of multiple meal tickets representing food he states he received, which included potatoes, bananas and tomatoes. He states he does not receive large portions. Observation of breakfast tray on 9/24/25 revealed, one-half banana served on the meal tray to R10. Interview on 9/25/2025 at 3:00 pm with the RRD provided and verified the facility policy titled, Diet Order System last reviewed 9/29/2022 revealed, All partners involved in meal service will check each tray against the diet card prior to delivery to the patient/resident. The RRD revealed that dietary staff received education/training on checking meal slip tickets to ensure meals are plated correctly according to the diet ordered. She revealed it was the responsibility of all staff to make sure that food served is what was ordered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property the facility failed to report an injury of unknown origin for one of four residents (R) (R5) reviewed for accidents. Findings include:Review of the facility's policy titled Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, reviewed 11/15/2024, revealed, Procedures 1. Any allegation, suspicion, or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of an unknown source, should be immediately reported to the Administrator of the provider entity. 2. In accordance with applicable laws and regulations, the Administrator or his or her designee should notify the appropriate state agency (or agencies), the patient's attending physician, and the patient's designated representative of any allegation or incident described above and of the pending investigation. The state survey agency and the state law through established procedures of any allegations of abuse, neglect, exploitation or mistreatment, including injuries of an unknown person source and misappropriation of patient property, within 2 hours after the allegation is based involve abuse or result in serious bodily injury, and not later than 24 hours if the events upon which the allegation is based do not involve abuse and do not result in serious bodily injury.Review of R5's Quarterly Minimum Data Set (MDS), dated [DATE], for Section C (Cognitive Patterns) revealed, a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment.Review of clinical records for R5 revealed, diagnoses that included, but were not limited to, aphasia following cerebral infarction, chronic systolic heart failure, type 2 diabetes mellitus without complications, vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression.Review of R5's progress note dated 8/6/2025 revealed, the resident sustained an injury on 8/5/2025 from an unwitnessed fall. Interview on 9/24/2025 at 3:25 pm with Licensed Practical Nurse (LPN) CC revealed that she was working when a staff member was walking the hall and observed the resident in his room lying on a fall mat. LPN CC revealed, she was called to the room where she observed discoloration to the resident's eye. She assessed him, notified the provider and family. Neuro checks were completed as well as a post fall assessment. She stated the fall was documented in the medical record and was discussed the next morning at the clinical meeting that they have every day. She stated all department heads were in attendance including the Director of Nursing (DON), she was unsure if the Administrator was in attendance but stated she normally was.Interview on 9/24/2025 at 3:34 pm with the DON revealed that all falls with injuries are discussed during morning clinical meetings. She confirmed she was aware of R5's injury he sustained from an unwitnessed fall on 8/5/2025. The DON revealed that he was assessed and the next day it was determined the resident should go to the emergency room due to swelling of the eye. The DON further revealed that R5 was admitted due to being on an anti-coagulant and for a high level of lactic acid.Interview on 9/24/2025 at 3:35 pm with the Administrator revealed she did not remember the resident falling and obtaining an injury. She confirmed that all unwitnessed falls with an injury should be reported to the state and that the resident's injury from 8/5/2025 was not reported to the state.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled Care Plans, the facility failed to develop and implement care plans for six of 51 residents (R) (R111, R109, R18, R5, R135, and R155). Specifically, the facility failed to implement the care plans for R111, R5, R135, and R155 related to fall mats, for R18 related to oxygen and for R5 related to diet. In addition, the facility failed to develop a care plan for R18 related to oxygen use. This failure had the potential for the residents not to receive treatment and/or care according to their needs.Findings include: A review of the facility's undated policy titled Care Plan, reviewed 9/18/2025 revealed 3. The comprehensive person-centered care plan is developed to include measurable goals and timeframes 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. 1. Review of the electronic health records (EHR) for R111 revealed that diagnoses that included but were not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, unsteadiness on feet, and wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing. Review of the Quarterly Minimum Data Set (MDS) for R111 dated 9/16/2025 for Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) of eight which indicated the resident's cognition was moderately impaired. Review of R111's care plan dated 12/27/2023 revealed a focus area for fall with an intervention that included fall mats at beside bed. Observations on 9/23/2025 at 1:33 pm and 4:05 pm revealed R111 lying in bed without fall mats placement on the right and left side of the bed. Further observation revealed that the two fall mats were folded and leaning against the wall instead of being positioned on each side of the resident bed. Observation on 9/24/2025 at 8 :12 am and 2:03 pm revealed, R111 lying in bed without fall mats placement on the right and left side of the bed. Further observation revealed that the two falls mats folded and leaning against the wall instead of being positioned on each side of the resident bed. During an observation and interview on 9/24/2025 at 10:29 am with the Director of Nursing (DON), the DON confirmed that R111 was a lying in bed without fall mats placement on right and left side of the bed. 2. Review of R109's EHR revealed diagnoses that included but not limited to chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, dependence on supplemental oxygen, and shortness of breath. Review of the admission MDS dated [DATE] for Section C (Cognitive Patterns) revealed a BIMS score of five which indicated severe cognitive impairment and Section O (Special Treatments, Procedures, and Programs) revealed, oxygen therapy was received. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R109's physician order form (POF) revealed an order for oxygen at 2 LPM (two liter per milliliter) via nasal cannula. Review of R109's care plan listed a Focus Area Oxygen Use 2L/NC secondary to cough, COPD, Chronic Respiratory Failure /Terminal Illness with an intervention that included oxygen saturation as ordered. During an observation of R109's room on 9/23/2025 at 10:19 am and 1:01 pm, R109 was observed receiving oxygen at a flow rate of four liters per minute (LPM) via (by way of) nasal cannula (NC) from the oxygen concentrator. Observation on 9/23/2025 at 4:30 pm was conducted with the Administrator, the Administrator confirmed that R109 was receiving oxygen at a flow rate of four liter instead of two liters without a humidifier water bottle attached. Interview on 9/25/2025 at 2:30 pm with the MDS revealed that her expectation were for the licensed nursing staff to follow the order and care plan for oxygen therapy. She revealed she was unaware that resident was receiving oxygen at four liters instead of two liters . Cross Reference F695 3. Review of R18's cute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (Primary, Admission), acute respiratory disease, acute respiratory failure with hypercapnia, cerebral infarction, unspecified, chronic obstructive pulmonary disease. Review of R18's Quarterly MDS dated [DATE] for Section C (Cognitive Patterns) revealed a BIMS score of eight, which indicated moderate cognitive impairment, Section J (Health Conditions) revealed shortness of breath Review of R18's care plan with last reviewed/revised date of 9/11/2025 revealed that R18 was not care planned for the use of oxygen. Observation on 9/23/2025 at 11:15 am revealed, R18 was observed eating lunch and receiving oxygen was set on 4 LPM via NC. Observation on 9/24/2025 at 9:15 am revealed, R18 was observed lying in bed and receiving oxygen at 4 LPM via NC. Observation on 9/24/2025 at 4:55 pm revealed, R18 was observed in bed eating dinner and receiving oxygen at 4 LPM via NC. Interview on 9/25/2025 at 12:03 pm with Assistant Director of Nursing (ADON) LL confirmed that if a resident was on oxygen that they should have an order and be care planned for oxygen. ADON LL confirmed that R18 did not have a care plan for oxygen. 4. Review of the EHR for R5 revealed diagnoses that included but were not limited to, aphasia following cerebral infarction, chronic systolic heart failure, type 2 diabetes mellitus without complications, vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R5's Quarterly MDS dated [DATE] for Section C (Cognitive Patterns) revealed a BIMS score of 0 indicating severe cognitive impairment. Review of R5's physician order dated 9/26/2024 listed a dietary order for a regular diet, puree consistency. Review of a progress note dated 4/5/2025 revealed that R5 had a choking incident. The progress note revealed that R5 was given a snack of the wrong consistency compared to the physician's order. Review of R5's care plan dated 6/24/2022 revealed that R5 was at risk for falls related to limited mobility and weakness. Interventions included a fall mat to both sides of the bed with a start date of 7/1/2023. Further review of the care plan with start date of 6/24/2022 and revised date 8/27/2025 revealed that R5 is at nutrition and hydration risk related to multiple chronic conditions; history of cerebral infarction resulting in dysphagia and need for both pureed diet and enteral feedings to meet nutritional needs. An observation on 9/23/2025 at 10:21 am revealed one fall mat on the left side of R5's bed and not one on the right side. An observation on 9/23/2025 at 3:00 pm revealed one fall mat to the left side of R5's bed and not one on the right side. Observation on 9/24/2025 at 8:59 am revealed the fall mat on the left side of the bed was rolled up on the floor and no fall mat on the right side. Interview on 9/24/2025 at 2:00 pm with Certified Nurse Assistant (CNA) LL revealed that on 4/5/2025, it was her first time passing out snacks to residents. She stated there was a variety of choices and she asked the resident if he wanted a snack. She confirmed R5 received a peanut butter sandwich without knowing he was on a special puree diet. Interview and rounding on 9/24/2025 9:28 am with the Director of Nursing (DON) confirmed that R5 should have a fall mat on each side of the bed. She confirmed there was no mat on the right side of the bed and that the mat on the left side was rolled up. The DON revealed that it was her expectation that fall mats be placed for residents that required them. She reviewed the pictures the surveyor had taken the day prior that captured there was no fall mat on the right side of the bed. Although the DON was not employed at the facility during the time the resident choked she revealed, her expectations was that staff follow the care plan and it's interventions. 5. Review of EHR for R135 revealed diagnoses that included but were not limited to, unspecified sequelae of cerebral infarction, major depressive disorder, single episode, unspecified, muscle weakness, anxiety disorder, unspecified, vascular dementia, unspecified severity, with mood disturbance, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of the Quarterly MDS assessment for R135 dated 8/21/2025 for Section C (Cognitive Patterns) revealed a BIMS score of 0 indicating severe cognitive impairment. A review of the care plan revealed that R135 was at risk for falls related to impaired mobility, incontinence, and medication regimen. Interventions included but not limited to a fall mat on both (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sides of the bed with a start date of 1/14/2022 Observation on 9/23/2025 at 10:13 am revealed the resident asleep in bed and his fall mats rolled up by the sink that was across from the resident's bed. Observation on 9/23/2025 at 2:40 pm revealed the resident in bed with the fall mats still rolled up next to the sink and not on side of the resident's bed. Observation on 9/24/2025 at 8:58 am revealed a fall mat by the right bed side of the resident's bed however there was no fall mat on the left side of the bed. Observation and rounding on 9/24/2025 at 9:28 am with the DON confirmed R135 had a fall mat to the right side of his bed but not one on his left side. Surveyor showed the DON a picture taken on 9/23/2025 that displayed the mats rolled up next to the resident's sink. She confirmed they should be on the floor when the resident was in bed. 6. Review of EHR for R155 revealed diagnoses that included but were not limited to amyotrophic lateral sclerosis, schizophrenia, unspecified, epilepsy, unspecified, not intractable, without status epilepticus, and type 2 diabetes mellitus without complications. Review of the Quarterly MDS assessment for R155 dated 7/21/2025 for Section C (Cognitive Patterns) revealed a BIMS score of three which indicated severe cognitive impairment. Review of the care plan dated 9/25/2019 revealed R155 was at risk for falls related to impaired mobility, fall history, and epilepsy. Interventions included but not limited to, fall mat to bed side. Observation on 9/23/2025 at 10:42 am revealed there was no fall mat next to R155's bed, however his roommate had a floor mat next to bed, but it was more centered between both beds. Observation on 9/23/2025 at 2:41 pm revealed there was no fall mat next to R155's bed, however his roommate had a floor mat next to his bed, but it was more centered between both beds. Observation on 9/24/2025 at 8:58 am revealed there was no fall mat next to R155's bed, however his roommate had a floor mat next to his bed, but it was more centered between both beds. Interview and rounding on 9/24/2025 at 9:28 am with the DON confirmed that the resident should have a fall mat next to his bed. She said staff were responsible for ensuring mats are placed correctly during rounds. Interview on 9/25/2025 at 2:35 pm with the MDS Coordinator revealed that care plans were developed and implemented to give the residents the best care. She stated that interventions for residents that were at risk for falls or have a history of falls included but were not limited to fall mats by the bedside. She confirmed the resident required fall mats by his bedside and was unaware they were not being utilized. The MDS Coordinator revealed it was her expectation that staff follow the care plan for the residents' safety.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to ensure assistance devices were placed at bedside to prevent accidents for four of five residents (R), (R111, R5, R135, R155) reviewed for accidents. Specifically, the facility failed to ensure fall mats were placed at bedside for the residents who had a history of falls.Findings include: 1. Review of the electronic health records (EHR) for R111 revealed that diagnoses that included but were not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, unsteadiness on feet, and wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing. Review of the Quarterly Minimum Data Set (MDS) for R111 dated 9/16/2025 for Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) of eight which indicated the resident's cognition was moderately impaired. Review of R111's care plan dated 12/27/2023 revealed a focus area for fall with an intervention that included fall mats at beside bed. Further review of R111's care plan with last reviewed/revised date of 9/12/2025 revealed, Patient/Resident at risk for fall related to general weakness-12/27/2023: 1/10/2024 observed sitting on floor (fall without injury), 1/10/2024 sitting on floor-no injury, 1/25/2024 witnessed sliding to floor with no injury-4/15/2024: unwitnessed fall with minor injury (pain to right hand), 5/27/2024 unwitnessed fall with minor injury. Observations on 9/23/2025 at 1:33 pm and 4:05 pm revealed R111 lying in bed without fall mats placement on right and left side of the bed. Further observation revealed that two fall mats were folded and leaning against the wall instead of positioned on each side of the resident bed. During an observation and interview on 9/24/2025 at 10:29 am with the Director of Nursing (DON), the DON confirmed that R111 was a lying in bed without fall mats placement on right and left side of the bed. Interview on 9/24/2025 at 10:34 am, the DON reported that her expectation were for staff to monitor for fall mats placement while in the residents' room. 2. Review of the EHR for R5 revealed diagnoses that included but were not limited to, aphasia following cerebral infarction, chronic systolic heart failure, type 2 diabetes mellitus without complications, vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression. Review of R5's Quarterly MDS dated [DATE] for Section C (Cognitive Patterns) revealed a BIMS score of 0 indicating severe cognitive impairment. Review of R5's care plan dated 6/24/2022 revealed that R5 was at risk for falls related to limited mobility and weakness. Interventions included but not limited to, a fall mat to both sides of the bed with a start date of 7/1/2023. Further review of the care plan revealed, an unwitnessed fall without (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury on 7/1/2023, an unwitnessed fall with laceration to left eyebrow on 8/5/2025, and an unwitnessed fall with hematoma to left eye brow (sent to ER for evaluation with admit on 8/6/2025). An observation on 9/23/2025 at 10:21 am revealed one fall mat on the left side of R5's bed and not one on the right side. An observation on 9/23/2025 at 3:00 pm revealed one fall mat to the left side of R5's bed and not one on the right side. Observation on 9/24/2025 at 8:59 am revealed the fall mat on the left side of the bed was rolled up on the floor and no fall mat on the right side. Interview and rounding on 9/24/2025 9:28 am with the DON confirmed that R5 should have a fall mat on each side of the bed. She confirmed there was no mat on the right side of the bed and that the mat on the left side was rolled up. The DON revealed it was her expectation that the fall mats be placed for residents that required them as it was a safety device that reduces the risk of injury in case of a fall. During this time, she reviewed the pictures the surveyor had taken the day prior that captured there was no fall mat on the right side of the bed. 3. Review of the EHR for R135 revealed diagnoses that included, but were not limited to, unspecified sequelae of cerebral infarction, major depressive disorder, single episode, unspecified, muscle weakness, anxiety disorder, unspecified, vascular dementia, unspecified severity, with mood disturbance, Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of R135's Quarterly MDS dated [DATE] for Section C (Cognitive Patterns) revealed, a BIMS score of 0 which indicated severe cognitive impairment. A review of R135's care plan dated 6/26/2019 revealed that R135 was at risk for falls related to impaired mobility, incontinence, and medication regimen. Interventions included a fall mat to both sides of the bed with a start date of 1/14/2022. Further review of R135's care plan revealed, Resident is observed on the floor by the bed 6/3. Fall without injury 9/24/2021. Fall without injury 1/14/2022 and 5/14/2025: Unwitnessed fall without injury. Observation on 9/23/2025 at 10:13 am revealed R135 was asleep in bed with the fall mats rolled up next to the sink and not placed on both sides of the bed. Observation on 9/23/2025 at 2:40 pm revealed R135 lying in bed with the fall mats still rolled up next to the sink and not placed on both sides of the bed. Observation on 9/24/2025 at 8:58 am revealed a fall mat by the right bed side of the resident's bed but not on the left side. Observation and rounding on 9/24/2025 at 9:28 am with the DON confirmed that R135 had a fall mat to the right side of his bed but not on the left side. During this time the surveyor showed the DON a picture taken on 9/23/2025 that displayed the mats rolled up next to the resident's sink. The DON revealed it was her expectation that fall mats be placed for residents that required them as it was a safety device that reduces the risk of injury in case of a fall (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	11/24/2025

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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the EHR for R155 revealed, diagnoses that included but were not limited to amyotrophic lateral sclerosis, schizophrenia, unspecified, Epilepsy, unspecified, not intractable, without status epilepticus, and type 2 diabetes mellitus without complications. A review of R155's quarterly MDS assessment dated [DATE] for Section C (Cognitive Patterns) revealed a BIMS score of three which indicated severe cognitive impairment. A review of R155's care plan dated 9/25/2019 revealed R155 was at risk for falls related to impaired mobility, fall history, and epilepsy. Interventions included fall mat to bed side. Further review of R155's care plans dated 9/25/2019 revealed that the resident had a fall w/o (without) injury on 8/27/2020; a fall without injury on 5/1/2021; a fall without injury on 5/3/2021; an unwitnessed fall with injury to right side of forehead on 10/10/2023, a fall without injury on 5/1/2024, an unwitnessed fall without injury on 8/4/2024 and a controlled fall, without injury on 9/2/2025. Observation on 9/23/2025 at 10:42 am revealed there was no fall mat next to R155's bed, however his roommate had a floor mat next to bed, but it was more centered between both beds. Observation on 9/23/2025 at 2:41 pm revealed, there was no fall mat next to R155's bed, however his roommate had a floor mat next to his bed, but it was more centered between both beds. Observation on 9/24/2025 8:58 am revealed, there was no fall mat next to R155's bed, however his roommate had a floor mat next to his bed, but it was more centered between both beds. Interview and rounding on 9/24/2025 at 9:28 am with the DON confirmed that R155 should have a fall mat next to his bed. The DON revealed that staff were responsible for ensuring mats were placed correctly during rounds. The DON revealed that It was her expectation that fall mats be placed for residents that required them as it was a safety device that reduces the risk of injury in case of a fall.

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	11/24/2025

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Pruitthealth - Palmyra	1904 Palmyra Road Albany, GA 31702

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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, Oxygen Administration, the facility failed to ensure that one of 16 sampled residents (R) (R109) was administered oxygen (O2) therapy in accordance with the physician orders. This failure had the potential to place R109 at risk for medical complications, unmet needs, and a diminished quality of life.Findings include:Review of the facility's policy titled Oxygen Administration dated 8/2/2023 revealed, It is the policy of the facility to provide oxygen safely and accurately to appropriate patients/residents. Oxygen .Oxygen will be administered by licensed personnel only when ordered by the physician , PA (Physician Assistant) or NP (Nurse Practitioner). The physician order may be written PRN (as needed) for comfort/dyspnea or may specify the number of liters, method of administration and length of the time the oxygen is to be administered. (1). O2 humidifier bottles should be used on all patient/resident s receiving higher than 2 liters/minute of oxygen flow. Review of R109 's electronic health records (EHR) revealed the following diagnoses but not limited to chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, dependence on supplement oxygen, and shortness of breath.Review of R109's admission Minimum Data Set (MDS) dated [DATE] for Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of five which indicated the resident's cognition was severely impaired, Section O (Special Treatments, Procedures, and Programs) revealed the resident received oxygen therapy. Review of R109's physician order form (POF) revealed an order for oxygen at 2 LPM (two liter per milliliter) via nasal cannula.Observation on 9/23/2025 at 10:19 am and 1:01 pm revealed R109 lying in bed receiving oxygen by oxygen concentrator and nasal cannula at a flow rate of four liters with no humidifier bottle attached.An observation was conducted with the Administrator on 9/23/2025 at 4:30 pm in R109's room, the Administrator confirmed that the resident was receiving oxygen at a flow rate of four liters instead of two liters without a humidifier bottle. She reported that her expectations for her licensed nursing staff were to monitor and ensure that the resident's oxygen flow rates were set per the physician orders. Cross Reference F656

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	115628	A. Building B. Wing	11/24/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a snack provided to a resident was in accordance with that resident's prescribed diet for one of 18 residents (R) (R5) that resulted in choking. Findings include:Review of the medical records Face Sheet revealed R5 had diagnoses that included but not limited to dysphasia and aphasia following cerebral infarction, chronic systolic heart failure, type 2 diabetes mellitus without complications, vascular dementia, and depression.Review of the Minimum Data Set (MDS) Annual assessment dated [DATE] revealed, Section C (Cognitive Patterns) documented a code 0 that Brief Interview for Mental Status (BIMS) should not be conducted as resident is rarely/never understood.Review of R5's physician order dated 9/26/2024 revealed, a dietary order for a regular diet, puree consistency. Review of the care plan with start date 6/24/2022 and revised date 8/27/2025 revealed, R5 is at nutrition and hydration risk related to multiple chronic conditions; history of cerebral infarction resulting in dysphagia and need for both pureed diet and enteral feedings to meet nutritional needs.Review of a progress note dated 4/5/2025 revealed that R5 had a choking incident. The note documented that R5 was given a snack of the wrong consistency compared to the physician's order. Interview on 9/24/2025 at 11:25 am with Corporate Dietician Consultant revealed that nurses and CNA's pass out snacks. She stated there are puree consistency snacks available such as pudding, apple sauce, and ice cream. She stated staff have a diet list on each floor that lists physician ordered diets. She confirmed that she was going to start posting that list on the snack carts. She stated this will make diet orders accessible to staff which will prevent staff from giving out the wrong type of snack and eliminate choking.Interview on 9/24/2025 at 2:00 pm with Certified Nurse Assistant (CNA) LL revealed that she was employed at the facility beginning March 2025. She stated she received education during orientation on resident diets. She confirmed 4/5/2025 was her first time passing out snacks to residents. She stated there was a variety of choices and asked the resident if he wanted a snack. She stated he received a peanut butter sandwich without knowing he was on a special puree diet. She stated he was choking, so she turned him on his side, and he was able to cough up the food. She stated she was educated after the incident by the night shift nurse on giving the correct snacks, but no other education was provided.