STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115120	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savannah Post Acute LLC	815 East 63 Street Savannah, GA 31405

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 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. Based on observations, interviews, record review, and review of the facility's policy titled Minimum Data Set (MDS)/Care Plans, the facility failed to implement a care plan to monitor for adverse effects from anticoagulant medication for one of three sampled residents (R) (R8). This deficient practice had the potential to place R8 at increased risk of medical complications. Findings include:Review of the facility's policy titled Minimum Data Set (MDS)/Care Plans, dated 2/1/2024, revealed that the Procedure section included 3. Each discipline will be responsible for the initiation and ongoing follow-up for care plans as related to their area of expertise.Review of the Quarterly MDS for R8, dated 9/28/2025, revealed Section I (Active Diagnoses) documented diagnoses including but not limited to, bilateral pulmonary embolism (a blood clot in the lung), deep vein thrombosis (a blood clot in the leg), stroke, and hypertension. Review of the care plan for R8 revealed a Focus area, initiated 9/23/2025, of diagnoses of bilateral pulmonary embolism and deep vein thrombosis. Interventions included administering medications as ordered and documenting side effects and effectiveness. Review of the Medication Administration Record (MAR) for R8, dated 10/1/2025 to 10/31/2025, revealed an order for Eliquis (a blood-thinning medication used to prevent and treat blood clots) 5 milligrams (mg) two tablets twice a day for 7 days, then 5 mg one tablet twice a day for 100 days. Further review of the MAR for R8 revealed no documented monitoring for side effects from Eliquis. Review of the clinical record revealed no documented monitoring for side effects from Eliquis. An interview with the Nurse Practitioner (NP) on 10/22/2025 at 1:33 pm revealed that when a resident received an anticoagulant, the resident would need to be monitored for medication side effects. An interview with the Director of Nursing (DON) on 10/23/2025 at 9:53 am stated that nurses were expected to follow the care plan. She confirmed there was no documentation of monitoring for side effects from the anticoagulant for R8.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, staff interviews, record review, and review of the facility's policy titled Medication Administration, the facility failed to ensure that phenytoin (a medication used to prevent and control seizures) was not administered at the same time as a high-protein supplement for one of five residents (R) (R9) observed during medication pass observation. This deficient practice had the potential to place R9 at risk of medical complications related to potential reduced medication absorption. Findings include: A review of the facility policy titled Medication Administration revealed that medications are administered as prescribed by the provider. Under procedures, medications are reviewed for any special precautions, and the needed evaluations are performed prior to administering medication to the resident. A review of the Minimum Data Set (MDS) for R9, dated 9/13/2025, revealed that Section GG (Functional Abilities and Goals) revealed that R9 required substantial assistance for activities of daily living (ADLs). Review of the care plan for R9, dated 8/20/2025, revealed that R9 was at risk for seizure activity. The goal was for R9 not to experience seizure activity through the next review date.Review of laboratory results for R9, dated 10/14/2025, revealed phenytoin levels were 9.5 micrograms per milliliter (ug/ml). The normal range was 10 to 20 ug/ml. Review of the Medication Administration Record (MAR) for R9 revealed the following medication schedules:Dilantin Infatabs oral tablet chewable 50 milligram (mg) (phenytoin) (a medication used to prevent and control seizures), three tablets by mouth three times a day, scheduled for 9:00 am, 2:00 pm, and 9:00 pm. The medication was documented as administered as ordered from 10/1/2025 through 10/22/2025. House supplement 120 milliliters (ml) two times a day, scheduled for 10:00 am and 2:00 pm. The supplement was documented as administered as ordered from 10/1/2025 through 10/22/2025, with 50 to 100 percent consumption documented. An observation and concurrent interview with Licensed Practical Nurse (LPN) AA on 10/22/2025 at 2:17 pm revealed that she administered Dilantin and the house supplement to R9 at the same time. An interview with the Pharmacy Consultant on 10/22/2025 at 3:08 pm revealed that the pharmacy label should provide instructions if the medication had food or drug interactions. She stated that the house supplement had high protein levels, and Dilantin should be administered one hour before or two hours after receiving the high-protein supplement. She confirmed that the current medication schedule for R9 was for Dilantin to be administered at 9:00 am, 2:00 pm, and 9:00 pm, and the house supplement to be administered at 10:00 am and 2:00 pm. An interview with the Director of Nursing (DON) on 10/23/2025 at 9:53 am revealed that the pharmacy made recommendations for medication schedules. She stated there were no safety alerts in place for contraindications. An interview with the Administrator on 10/23/2025 at 3:46 pm revealed that medication schedules were entered by the nurse or nurse practitioner, and the pharmacy made recommendations for medications.