STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425085	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Orangeburg	755 Whitman Street SE Orangeburg, SC 29115

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review and interview, the facility failed to ensure that a discharge Minimum Data Set (MDS) assessment was completed timely for one of 26 sample residents (Resident (R) 37) reviewed for MDS assessments. The failure to submit the discharge MDS did not allow for the closure of the residents' MDS cycle. Findings include: Review of R37's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE]. Further review revealed R37 was discharged to the hospital on 03/30/25. Review of R37's quarterly MDS under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 03/05/25 revealed a Brief Interview for Mental Status (BIMS) assessment could not be completed. Further review revealed there was no discharge MDS assessment completed for R37. During an interview on 05/08/25 at 12:48 PM, the MDS Coordinator stated she reviewed the daily census activity report for any discharges, and they were discussed in morning meeting. She said the discharge assessment was simply missed. She said she did not complete the discharge MDS, but she should have. During an interview on 05/08/25 at 3:24 PM, the Director of Nursing (DON) stated she expected the necessary MDS assessment to have been completed.

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, record review, interview, and facility policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails, and assessments were completed for the risk of entrapment for one of two residents (Resident (R) 235) reviewed for side rails of 26 sample residents. The lack of alternate side rail measures and proper assessment/consent could lead to potential restraint or side rail entrapment. Findings include: Review of the facility's policy titled, Bed Rails, revised 08/08/24, revealed that when it has been determined by the admitting nurse and/or interdisciplinary team (IDT) that bed rails are medically necessary for a patient's care (or are requested by a patient or the patient's representative), the following procedures should be followed prior to their use. The nursing and maintenance staff should regularly inspect the mattress and bed rails for areas of possible entrapment. Review of R235's undated Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE]. Diagnoses included unsteadiness on feet, lack of coordination, and muscle weakness. Review of R235's Care Plan, initiated 05/06/24, located under the Care Plan tab of the EMR, revealed resident was at risk for Falls and intervention in place was 1/4 side rails for enabling increased movement. Review of R235's Order Summary Report located under the Orders tab of the EMR, revealed an order, dated 04/16/25, for 1/4 side rails for turning and repositioning. Review of R235's EMR revealed no documented evidence of any alternative measures prior to installation, and no documented evidence of assessing risk for entrapment. During an interview on 05/08/25 at 9:17 AM, Licensed Practical Nurse (LPN)1 stated all residents had a bedrail observation form completed on admission. She stated 99% of the time, residents got bedrails. She stated staff did not explore alternatives prior to using bedrails because residents got them the day they were admitted . She stated she had never been aware of alternatives being explored prior to bedrail use. During an interview on 05/08/25 at 12:58 PM, the Maintenance Director (MD) stated he completed a monthly audit of bedrails. He stated he checked the functionality of them to ensure they stayed up and locked, ensured the mattress was the correct size, and that the call light worked. He stated he did a visual assessment to ensure it did not appear to have a gap greater than two inches, but he did not assess the risk for entrapment. He stated he did not have a device to check for the risk for entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/25 at 3:24 PM, the Director of Nursing (DON) stated she expected staff to complete bedrail assessments. She stated that alternatives were explored on a patient-by-patient basis, and it would depend on them. She stated she was unaware that any alternatives had to be explored for any residents prior to bedrail use and that staff should assess and monitor that risk of entrapment.