STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425104	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Bamberg	439 North Street Bamberg, SC 29003

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record reviews, and interviews, the facility failed to properly account for and reconcile controlled medications to prevent potential loss, diversion, or accidental exposure. This deficiency is evidenced by the missing controlled drug record sheet for Resident (R)4, 1 of 3 residents reviewed. Review of a facility policy titled, Controlled Substances for Healthcare Centers, last reviewed 04/01/25 revealed, It is the policy of PruittHealth Pharmacy that medications listed as controlled substances (Schedules I-V) under federal or state regulations will be properly stored with maintained accountability. Reconciliation of controlled substances will be performed at the end of each shift by licensed professional nurses. This policy applies to all nursing staff in a healthcare center serviced by PruittHealth Pharmacy. Records . 5. Current Controlled Drug Record forms are maintained in the narcotic book. When completed, the sheets are submitted to the Director of Health Services and kept on file for two (2) years at the healthcare center. Accounting: A physical inventory of all controlled substances is conducted at each shift change by the oncoming and outgoing licensed professional nurses. The inventory is documented on the Controlled Drug Shift Audit Sheet.Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE] with diagnoses including, but not limited to, paraplegia, pressure ulcer of sacral region, stage 4, neuromuscular dysfunction of bladder and psoriasis.Review of R4's admission Minimum Data Set (MDS) with an Assessment Reference Date of 07/25/25 revealed R4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R4 is cognitively intact.Review of R4's Physician Orders dated July 28- August 22, 2025, revealed Oxycodone - Schedule II tablet, 15 milligram (mg) tablet, take 1 tablet orally every 4 hours per home regimen.R4's Controlled Substance (Narcotic) Sheet for 08/13/25 - 08/15/25 could not be found.During an interview on 08/25/25 at 10:26 AM, R4 stated, They are managing my pain. She didn't have any concerns.During an interview on 08/25/25, at 10:29 AM, the Director of Health Service (DHS) stated, Our policy states we contact the pharmacy to notify if anything is going on with the medications and or if there are any missing doses. We have a sheet where you count the cards and match them to the narcotic sheet. We count the narcotic sheets individually and make sure they match. The Medical Director (MD) was not notified because we did not have any doses missing for R4, just the narcotic sheets. The pharmacy knew that the narcotic sheets were missing, but the MD did not. I found out on Sunday morning when Licensed Practical Nurse (LPN)2 called me.During an interview on 08/25/25 at 10:37 AM, LPN1 stated, I am new. I only worked there for about a month. That day, we had 4 nurses working. One nurse took all her cards off my cart, and she had the medication cart keys. I told her to let me know when she was finished so I could make sure my narcotic count was right. After we counted the next day, I found out the narcotic cards were missing. Another nurse was working on the other hall. We both had a set of the narcotic keys. She had to get the narcotics medications off my cart. She took her resident's cards off my cart and took them to her cart. She placed all the medications and narcotics back in the medication cart at the end of the shift. I don't know the normal practice of removing medications from the medication cart. That was my first day back from being sick. We counted the narcotic sheets. We record the residents' medications by marking them off when we give any narcotics. If we take a narcotic card off or a sheet we highlight the whole sheet for completion. The next day, when I came in to work. I was asked what happened. I was told to write a statement and then I was suspended until further investigation. I am still on suspension.During an interview on 08/25/25 at 10:58 AM, LPN2 stated, I was on the medication cart afterwards. The count was accurate. All the narcotic sheets were accounted for. The narcotic card procedure is we count and make sure the narcotic count validates the count on the narcotic sheet card. Cards are counted every shift. Everything must match on the cards. The day shift forgot to add the new narcotic medications to the narcotic card. We add the cards as they come in at night. The unit manager checks behind us as they are added to the inventory sheet. One nurse counts, and the other nurse counts behind us. The unit manager zeros the other sheet out.During an interview on 08/25/25 at 11:51 AM, LPN3 stated, I don't know much. I was called to write a statement. I heard my signature was used, but I didn't work that day, and I didn't sign for anything because I wasn't there. They implemented the log to count the narcotic cards. We sign a narcotic log sheet where we have to enter the count at each shift.During an interview on 08/25/25 at 02:38 PM, the Administrator stated, The staff have to make sure they are signing narcotics on the paper and the MAR. The nurses check the inventory sheets every shift. The DHS checks the paperwork as well as the unit manager. The DHS is responsible for checking off the narcotic sheets. She