STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425145	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Aiken	830 Laurens Street North Aiken, SC 29801

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure staff provided Cardio-Pulmonary Resuscitation (CPR) to one of one resident (Resident (R) 160) who did not have a valid Do Not Resuscitate (DNR) order in place. As a result, R160 expired.The facility's Administrator, Nurse Consultant, and [NAME] President were informed on [DATE] at 11:30 AM that Immediate Jeopardy (IJ) existed at F678 at a Scope and Severity (S/S) of J related to the staff's failure to initiate CPR on R160 without a valid DNR order in place. The Immediate Jeopardy began on [DATE], when staff failed to initiate CPR on R160 without a valid DNR order in place. On [DATE] at 6:16 PM, the facility provided a Removal Plan that was accepted at 6:30 PM. The survey team validated the implementation of the removal plan through observations, staff interviews, and record reviews on [DATE] at 7:10 PM, and the scope and severity was lowered to D.Findings include:Review of the Face Sheet, located in R160's electronic medical record (EMR), under the Facility Face Sheet tab, indicated that staff admitted resident R160 to the facility from an acute care hospital on [DATE] and re-admitted the resident from an acute care hospital on [DATE]. Her code status was documented as DNR, Palliative Care under the Header and Advance Directives areas. Pertinent diagnoses included urinary tract infection (UTI), type 2 diabetes mellitus, chronic kidney disease (stage 3), acute on chronic systolic congestive heart failure, and hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness) following cerebral infarction (stroke) affecting the left non-dominant side.Review of the Physician's Orders, dated [DATE] (admission) and [DATE] (readmission), located in R160's EMR under the Orders tab, revealed R160's code status was Full Code (initiate CPR in the event the resident's heart or respirations cease).Review of R160's admission Packet dated [DATE], located in the EMR, under the Resident's Documents tab, revealed a document titled, Social Services SC [South Carolina] Advance Directive for Health Care Form, signed by R160 on [DATE], which indicated, I [R160] have not executed an advance directive but would like to obtain additional information and resources to complete an advance directive. Instructions and forms for completing advance directives were provided to me. The section titled DNR noted, I [R160] do not have a DNR Order in place but would like to obtain additional information and resources on how to have one executed on my behalf. Information regarding South Carolina DNR Orders was provided to me.Review of R160's Care Plan, initiated on [DATE] and last reviewed/revised on [DATE], located in the EMR, under the Care Planning tab, revealed R160's code status was Full Code The goal of the care plan noted that, If the patient/resident's heart stops, or if the patient/resident stops breathing, CPR will be initiated in honor of the FULL CODE wishes through the next review period. Review of the Minimum Data Set (MDS) assessments, located in R160's EMR under the MDS tab, revealed the facility did not complete an admission MDS assessment. R160 was not in the facility for more than 14 consecutive days during her stays.Review of R160's EMR, under the Advanced Directives tab, revealed R160 did not have an advance directive in place at any time during her admissions to the facility. Further review revealed that the resident did not have a South Carolina (SC) Emergency Medical Services (EMS) Do Not Resuscitate (DNR) Order form or a Physician Orders for (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Life-Sustaining Treatment (POLST) portable medical order on file at any time during R160's stay. Review of R160's hospital Discharge summary, dated [DATE], located in R160's EMR, under the Resident Documents tab, indicated, the Patient states that she has signed DNR paperwork however when I clarified this would mean no chest compressions she states you can do them. I stated this would be a full code and she said fine put a full code. She then stated that she wanted me to call [son's name] and have him make the decision for her. She states what ever [sic] he puts full code versus DNR/DNI [do not intubate] she will be in agreement with. She identifies her son [son's name] as her surrogate decision-maker and I [physician] called [son's name] for collateral information. Patient's son states that she has been continuing to decline for the last few years. He [patient's son] states ever since her stroke she has been acting childlike with fluctuating emotions. He also states that the patient was living with his brother who plans to move to Florida within the next week. [Son's name] states that he has signed documents that his mother requested to be a DNR and would like her to be DNR at this time given that it is her previously expressed wish in the documentation that they have. Will plan to engage case management, they are open to considerations of hospice as he is very aware his mother's medical conditions are not reversible.Review of R160's Physician Progress Note, dated [DATE], one day after readmission, located in R160's EMR, under the Resident Progress Notes tab, revealed, [R160] was re-admitted to the hospital for altered mental status. She was diagnosed with a UTI and treated. Imaging also showed evolving effects from her stroke. She had some mild acute renal failure treated with IV [intravenous] fluids. Given her condition and chronic medical conditions, it was decided to make her a DNR. There is a plan to initiate palliative care with a transition to hospice when she is ready. See the discharge summary for further details.Review of R160's Nursing Progress Note, dated [DATE] at 4:10 AM and documented by Registered Nurse (RN) 5, revealed Writer's rounds on the floor. Resident is at her baseline-with intermittent hollering and calling out. Between 4:10 AM-5:05 AM: Writer and Certified Nurse Aid [CNA] can still hear resident hollering [sound can be heard in the nurse's station]. 5:05 AM: Writer started morning medication pass . 5:15 AM: CNA called writer to go to resident's room. Once in the room, found resident flat on bed, warm, soft to touch, no pallor. Eyes closed, not breathing. Checked pulse while calling out resident's name, no pulse, no response, tried sternal rub. Still no response, breathless, and pulseless. CNA also called another RN [name] to confirm. Double checked by both writer and colleague, resident has passed. Resident DNR on file, no resuscitation done, called time of death at 5:20 AM . A review of the Certificate of Death, dated [DATE] and provided by the facility, indicated that the certificate, obtained from the coroner's office on [DATE], listed R160's cause of death was related to a stroke.Review of the facility's Investigation, dated [DATE], provided by the facility, revealed that the facility conducted a self-initiated investigation regarding R160's code status. The investigation concluded that the responding RN acted appropriately and ethically in deciding not to initiate resuscitation, along with validation from a second RN at the time of the event. However, the facility identified a failure to transcribe current physician orders onto the active orders page; these orders were documented only in the progress notes. Additionally, a second physician documented in the hospital discharge summary that the resident's code status was DNR. The facility obtained a copy of the SC EMS DNR Transfer Form, dated [DATE], signed by the resident, which was reimplemented upon return from the hospital and aligned with the discharge summary. Corrective actions included educating all licensed nurses on the facility's policy regarding Advance Directives and conducting a 100% audit of all residents' Advance Directives to ensure the medical record clearly reflected the resident's wishes and corresponding physician orders on the active orders page. Review of the Validation Audits, dated 05/2025 through 12/2025, provided by the facility, revealed that staff conducted an initial audit of all facility residents' code status to ensure accuracy on [DATE] and continued audits periodically thereafter.Review of the Quality Assurance and Performance Improvement (QAPI) Meeting Minutes, dated 06/2025 through 11/2025, provided by the Administrator, revealed that the facility reviewed the occurrence related to R160's DNR (code status). The facility (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	noted that staff found R160 unresponsive. According to the Banner in MxC [MatrixCare- the EMR], resident DNR. MD [medical doctor] note from the facility shows the resident to be a DNR and the Nurse utilized that for determination. Nurse's determination to respect the resident's wishes and honors. Clinical Leadership stated education to be on-going related to ADs [advance directives]. Will audit accordingly to ensure validation and up-to-date. The facility continued to review code status at each monthly meeting.Review of the facility's Inservice Education Program Summary Record Forms, dated [DATE] through [DATE], revealed that the facility provided training on DNR and Full Code procedures. The training included instruction on the location and use of the DNR binder and crash cart, the facility's admission policy for Full Code/DNR status, procedures for contacting appropriate personnel during a code, and documentation of code events in Matrix. The facility provided additional in-service education sessions addressing code status on [DATE], [DATE], and [DATE]. However, the facility's documentation did not include evidence that it followed up to verify staff comprehension of the information presented during these trainings.During an interview on [DATE] at 3:49 PM, Licensed Practical Nurse (LPN) 3 stated that on [DATE], while working as a floor nurse, RN5 informed her that R160 passed away but expressed uncertainty because the Banner in the EMR indicated R160 was a DNR while the physician orders reflected Full Code. LPN3 stated that she reviewed R160's EMR and confirmed that the physician's orders documented R160 code status as Full Code. LPN3 stated that when she asked RN5 what time R160 expired, RN5 stated approximately 45 minutes ago. LPN3 contacted the Director of Health Services (DOHS) to report the situation and reported the DOHS told her that if R160 was already gone, there is nothing we can do about it now. During an interview on [DATE] at 6:00 PM, RN2 stated that if she found a resident unresponsive, she would look in Matrix (the EMR) to verify the code status. RN2 stated if there were discrepancies in the resident's code status, she would follow the code status noted in the resident's medical record; that was where she looked first.During an interview on [DATE] at 6:01 PM, CNA7 stated that if she found a resident unresponsive, she would alert the nurse. Upon inquiry, CNA7 stated that she would find the resident's code status in the resident's care plan.During an interview on [DATE] at 6:04 PM, LPN4 stated that if she found a resident unresponsive, she would call for help and look for the resident's code status. If the resident's code status were full code, she would activate a code blue and start CPR. She stated that she would follow the code status listed on the computer, as the binder may not be updated. If the clinical record contained conflicting information, she would call the responsible party first; if they did not answer, she would call the DOHS. LPN4 added that if the computer said the resident was a DNR and the binder said the resident was a full code, she would look at the notes in the clinical record, continue to research, but keep doing CPR. She would rather take the chance of keeping the resident alive.During an interview on [DATE] at 6:10 PM, LPN5 stated that if she found a resident unresponsive, she would look on the computer or the DNR binder to determine code status. If there were conflicts with the resident's code status, she would look for the signed DNR form. If one was not available, she would continue to code blue (CPR).During an interview on [DATE] at 6:10 PM, LPN1 stated that if she found a resident unresponsive, she would check the physician's order to determine the resident's code status. LPN1 stated all residents' codes statuses were noted in the resident's medical record and in a blue binder located at the nurses' station and crash cart. LPN1 stated that she followed the physician's order and that a discussion must be done with the resident or representative and paperwork completed for the resident's code status.During an interview on [DATE] at 6:10 PM, LPN7 stated that if she found a resident not breathing, she would call for help, look for the resident's code status in the DNR binder on the crash cart, in the computer, and the Banner in the EMR.During an interview on [DATE] at 6:20 PM, RN4 stated that if she found a resident unresponsive, she would look up the resident's code status on the iPad and notify the unit manager and DOHS via text. RN4 stated that there was also a blue binder at the nurses' station that listed the code status for all facility residents. RN4 stated that if there were any confusion or discrepancies in the documentation of code status, the resident would be considered a full (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	code.During an interview on [DATE] at 6:23 PM, LPN9 stated that if she found a resident unresponsive, she would check the resident and immediately start CPR, if the resident was a Full Code. The resident's code status was listed in the computer on the Banner, the face sheet, and the DNR binder. LPN9 stated that if there were discrepancies between the code status in the computer or binder, she would opt for saving the life of the resident and start CPR.During an interview on [DATE] at 6:25 PM, LPN8 stated that the facility only accepted DNR requests that included the SC Department of Health and Environmental Control (DHEC) logo. The SC EMS DNR Order was not accepted. LPN9 stated that two providers must sign the document. If the resident had a BIMS score greater than 11, the resident could sign the form, or the proxy may sign it if a properly executed medical power of attorney were on record with the facility. LPN9 stated that if verbal consent from the proxy was used, a provider must be physically present and hear the conversation with the proxy, and two nurses at the facility must witness the conversation.During an interview on [DATE] at 6:30 PM, the DOHS confirmed that the resident's physician's order listed the resident as full code. The DOHS confirmed that R160 did not have the SC DHEC form in the clinical record and stated that they were in the process of getting it. The DOHS provided copies of R160's physician progress note dated [DATE], which stated, Given her [R160's] condition and chronic medical conditions, it was decided to make her a DNR. [Name of Hospitalist] at [local hospital], Code Status: During Arrest: Do Not Resuscitate. The DOHS stated that she completed a 100% validation audit at the time of the occurrence. Each unit had its own DNR binder that included a list of residents' code status, which was updated weekly on Tuesdays.During an interview on [DATE] at 6:51 PM, RN5 stated that when R160 coded, he was in the middle of a medication pass. While he was in another room, the resident's CNA came and told him that the resident was unresponsive. He went to R160's room with his iPad. RN5 stated that during report, the nurse advised him that R160's code status was a DNR. When the resident coded, he checked the Banner in the EMR, which listed R160 as a DNR. RN5 stated that, in that situation, the first thing he checked to determine the resident's code status was the Banner in the clinical record. RN5 stated that he did not look at the physician's order to verify the resident's code status stating, I do not have time to do that in that situation. RN5 stated that he asked RN3, who was working on another unit, to confirm that R160 expired. RN5 stated that he notified Unit Manager (UM) 1 that R160 expired (unable to state the time). At that time, they identified a discrepancy between R160's physician's order (Full Code) and the physician's progress note (DNR, Palliative Care) dated [DATE].During an interview on [DATE] at 7:15 PM with the Administrator, when asked what the facility did upon finding a discrepancy between R160's physician's order (full code) and the clinical record, he stated that he felt they had done everything they needed to do to ensure it would not happen again. On [DATE], seven months after the resident expired, and after the survey team advised the facility of the serious concern identified on [DATE], the facility obtained and uploaded a copy of R160's SC EMS DNR Order form dated [DATE], which the facility obtained from the local hospital.During an interview on [DATE] at 7:53 AM, RN3 stated that on [DATE] around 5:20 AM, RN5 came down the hall with his iPad and stated that he thought R160 had passed away and wanted her to verify the resident expired. RN5 showed her the Banner in the clinical record, which showed the resident was a DNR. So, she went to the resident's room, could tell she was not alive, checked her vitals and respirations, and there were none. RN3 stated that if a resident was found unresponsive, the first person on scene stayed with the resident, called for help, checked the resident's code status in documents located in the clinical record or in the DNR binder kept at the nurses' station, and verified if they were a full code or DNR. If staff were unsure of code status, a resident was treated as a full code. RN3 stated that the resident's code status in the Banner was not linked to the physician's orders. Instead, the code status was linked to the resident's face sheet. RN3 stated that she does not rely on the Banner in the clinical record, and that the DNR binder was updated once a week or more frequently.During an interview conducted on [DATE] at 9:16 PM (post-survey exit), the resident's physician returned a phone call initiated during the survey and stated that he no longer worked for the (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility. He reported that he remembered the resident but no longer had access to the clinical record and had no recollection of the event in question. The physician indicated he could not provide additional information because the incident occurred approximately seven months prior.Review of the facility's policy titled, Cardiopulmonary Resuscitation, last reviewed on [DATE], indicated, Cardiopulmonary resuscitation [CPR] must be initiated on any patient/resident that has experienced cardiac arrest and does not have a Do Not Resuscitation [DNR] order. The nurse will not initiate CPR, even in the absence of a DNR, if a patient/resident is obviously clinically and irretrievably dead and the death was not witnessed. Examples of signs that a patient/resident is clinically irretrievably dead include: No measurable vital signs, cool to the touch, and pupils that are fixed and dilated. If there was no DNR order, and there was any question about whether or not the patient/resident was clinically and irretrievably dead, the nurse shall always initiate CPR. If the death is witnessed and there is no DNR order, CPR will be initiated, even if the patient/resident is clinically and irretrievably dead. The policy did not include a process for obtaining physician orders for code status.According to South Carolina Title 44, Chapterˆ78, the Emergency Medical Services [EMS] DNR Order applies only to pre-hospital personnel and does not fulfill nursing facility obligations to maintain a valid advance directive or physician orders for life-sustaining treatment [POST] order. Furthermore, EMS policy indicates that living wills or advance directives are not honored without a physician-signed POST order.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to provide a safe, clean, and homelike environment for residents who used Spa 100 (the shower room). This failure had the potential to adversely affect all 40 residents currently residing on Hall 100 by preventing effective cleaning of the Spa 100 shower area. Findings include:During the Resident Council Meeting on 12/17/25 at 2:00 PM, some of the residents, who requested to remain anonymous, complained that the shower room on 100 Hall was in disrepair and had mildew on the walls. Observations on 12/18/25 at 12:15 PM of the 100 Hall Spa, with the 100 Hall Nurse Manager, Licensed Practical Nurse (LPN) 6, revealed: A wall area of approximately two feet by two feet in shower one had numerous missing wall tiles. On the opposite wall, in shower one, several wall tiles were missing, and the handrail was loose, held in place by one screw. Plywood was exposed on both walls where the tiles should have been located. In shower two there were several cracked shower tiles on the walls, and there was a black substance on the grout area of the tiles located in the right back corner. In addition, the shower room was missing several ceramic tiles on the floor, where water collected and left the area difficult to clean. During an interview on 12/18/25 at 12:18 PM, LPN6 stated she did not know why repairs had not been completed and said to ask housekeeping about the black substance on the tiles and grout lines. During an interview on 12/18/25 at 12:30 PM, the Housekeeping Manager (HM) stated the shower room was on an every-other-day cleaning schedule. The HM stated she did not know if the buildup of the black substance on the wall looked like it had been there longer than two days. The HM stated there were so many resident showers being completed daily that the shower room remained in a damp condition. During an observation and interview on 12/18/25 at 1:00 PM, the Administrator and Maintenance Director (MD) confirmed Spa 100's missing tiles in shower one, missing tiles on the shower room floor, and the black substance on the wall and cracked tiles in shower two. The MD stated he tried to repair the missing tiles on the floor, but the repaired tiles would not stay down. The Administrator stated that shower one used to be blocked off so no one could use it but agreed it was currently accessible for use. The Administrator explained the building was older, and this was one of the shower rooms that had not been remodeled. The Administrator stated he did not have a housekeeping policy or written process regarding cleaning of the shower tiles.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, the facility failed to provide Resident (R)9 and R10, their right to a dignified existence. Specifically, the facility staff failed to provide R9 with appropriate clothing since his admission to the facility on [DATE]. Additionally, facility staff failed to provide R10 with dignity, when staff was observed completing in-service training in the resident's room. For 2 of 2 residents reviewed for dignity. Findings include:Review of the facility policy titled Resident's [NAME] of Rights revealed, As a resident of this facility, you have and your legal guardian has the right to personal treatment including, be treated with respect and dignity, and the right to personal privacy.Review of R9's Face Sheet revealed R9 was admitted to the facility on [DATE], with diagnoses including but not limited to cerebral infraction, other speech and language deficits following cerebral infraction, adult failure to thrive, and anxiety disorder due to known physiological condition. Review of R9's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/15/26, revealed R9 had a Brief Interview for Mental Status (BIMS) of 5 out 15, which indicated that R9 had severe cognitive impairment. Further review of the Quarterly MDS revealed that R9 requires substantial/maximal assistance with upper body dressing and is dependent on staff for lower body dressing.Review of R9's Care Plan with a problem last revised on 01/20/26, revealed, [R9] has attention seeking behavioral symptoms: yells when no on is near resident and curses when staff approach, crawls/rolls on floor in room and yells. Resident frequently states that he is hungry after receiving meals, fixated on getting food items. Interventions directed staff to behavior management program as needed, assess whether behavior endangers resident, keep bed low and pathways clear in room to decrease risk of injury when resident crawls on the floor. During an observation on 02/05/26 at 4:27 PM, R9 was observed in a reclining position wheelchair ([NAME]) in a green hospital gown and undressing himself in an area near the nurse's station, around other residents and staff. During this observation no staff made attempts to redirect the resident or cover him with appropriate clothing/blankets. During observation of R9 undressing himself in a public area Registered Nurse (RN)1 was at the nurse's station and also made no attempts to redirect the resident until asked by the surveyor. RN1 then went to place a blanket over R9 to protect his dignity while around other residents/visitors. During an interview on 02/05/26 at 4:38 PM, the Director of Nursing (DON) revealed that R9 is care planned for behaviors, but he does not have a specific care plan intervention related to his behavior of undressing himself in public. The DON further stated that [R9] has no clothes at the facility, and his Certified Nursing Assistant (CNA) had just given him Activities of Daily Living (ADL) care prior to placing him near the nurses station. We can't keep him in his room because we can't seclude the resident and he is a fall risk.During an observation on 02/05/26 at 4:46 PM, of R9's room and closet revealed that R9 had no clothing or shoes in his possession. R9 at this time was in a unit dining room/day area with a staff member supervising him, R9 was observed in a hospital type gown sitting in his [NAME] chair. During an interview on 02/05/26 at 5:22 PM, the Administrator and DON stated, [R9] has little to no family involvement and that they have not provided him with any clothing or personal items since he admitted to the facility. When residents don't have appropriate clothing nursing staff are expected to reach out to the Laundry staff to see if there any left-over clothing items from residents that have passed away or discharged from the facility. The DON stated that she was unsure why no staff made attempts to provide R9 with appropriate clothing or shoes. Review of R10's Face Sheet revealed R10 was admitted to the facility on [DATE], with diagnoses including but not limited to Alzheimer's Disease, muscle weakness, unsteadiness on feet, and restlessness and agitation. Review of R10's Quarterly MDS with an ARD of 12/01/25, revealed that R10 had a BIMS score of 3 out of 15, which indicated she had severe cognitive impairment. During an observation and interview on 02/05/26 at 4:26 PM, of R10's room (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Certified Nursing Assistant (CNA)1 sitting in a chair with the resident's bedside table in front of her completing an in-service for the facility on a facility provided tablet. CNA1 denied being on one-to-one supervision with the resident and stated that the resident was near the nurse's station outside of room. CNA1 further stated that she should have completed the in-service in a break area or at the nurse's station and should not be in a resident's room without their permission to respect the privacy of their room/home. During an interview on 02/06/26 at 5:25 PM, the Administrator and DON revealed that staff should show respect/dignity in resident's rooms. Both later admitted that the CNA's behavior did not meet their expectations related to dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425145	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Aiken	830 Laurens Street North Aiken, SC 29801

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to refer residents diagnosed with a serious mental illness for a Preadmission Screening and Resident Review (PASARR) level two evaluation for two of two residents (Resident (R) 4 and R34) reviewed for PASARR out of a total sample of 35 residents. This created a potential failure to identify what specialized services the residents needed and whether placement in the facility was appropriate.Findings include:1. Review of R4's Face Sheet located under the Resident tab in the electronic medical record (EMR) indicated R4 was admitted to the facility on [DATE] with diagnoses including major depression, bipolar disorder, and mood disorder.Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25 located in R4's EMR under the RAI tab, revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating R4 was moderately cognitively impaired. Review of R4's EMR under the Resident Documents tab revealed a Level I PASARR completed on 10/16/19, which indicated a mental illness diagnosis of bipolar disorder with the recommendation of no further evaluation. Further review of R4's EMR revealed no Level II PASARR. The facility was unable to provide a Level II PASARR for R4 completed prior to the survey.2. Review of R34's Face Sheet located under the Resident tab in the EMR indicated R34 was admitted to the facility on [DATE] with diagnoses including personality disorders, dementia, adjustment disorder with depressed mood, and depression.Review of R34's quarterly MDS with an ARD of 11/19/25 located in R34's EMR under the RAI tab, revealed a BIMS score of 14 out of 15 indicating R34 was cognitively intact.Review of R34's EMR under the Resident Documents tab revealed a Level I PASARR completed on 12/01/22 indicating a mental illness diagnosis of depression with the recommendation of no further evaluation.Review of R34's EMR under the Resident Documents tab indicated a psychotherapy note dated 10/07/25 where R34 was provided the diagnosis of bipolar II disorder.The facility was unable to provide evidence of a request for a Level II PASSAR evaluation done prior to the survey and following R34's diagnosis of bipolar disorder.During an interview on 12/18/25 at 10:30 AM, Social Worker (SW) 2, stated she was not aware, until recently, of R34's additional diagnosis of bipolar disorder. When asked if there was a process in place for her to be notified of a resident's significant mental health changes so a referral for a Level II PASARR could be completed, SW2 stated, No. During an interview on 12/18/25 at 10:35 AM, the three MDS Case Manager (MDSC) nurses, MDSC1, MDSC2, and MDSC3, stated the mental health provider should notify the facility when a new, significant mental health diagnosis was added. A psychiatrist's note did not immediately pull over into the EMR for review.During an interview on 12/18/25 at 2:45 AM, the Administrator acknowledged they completed R4's Level II PASARR during survey when unable to locate the original one that was completed several years ago. When asked if there was a policy or procedure in place to prevent this from happening in the future, the Administrator stated, No.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425145	A. Building B. Wing	12/19/2025

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Pruitthealth- Aiken	830 Laurens Street North Aiken, SC 29801

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, document review, and interviews, the facility failed to provide public access to the most recent survey results and any plan of correction. The failure had the potential to affect all residents, families, and visitors at the facility by reducing transparency. The facility reported a census of 149 residents.Findings include:Observation in the main hallway of the facility, on 12/17/25 at 2:57 PM, revealed a small, brown cabinet with a sign indicating Annual Survey Results Inside. In the cabinet was a blue binder labeled Survey Results. The binder contained survey results of complaint surveys dated 06/18/25, 03/24/25, 02/22/25, 01/23/25, 12/31/24, 11/21/24, 07/26/24, 05/02/24, 11/02/23 and 08/02/23. The facility's previous recertification survey was conducted on 09/12/24. An interview with the Administrator on 12/17/25 at 3:00 PM confirmed the facility binder titled Survey Results lacked the results of the previous recertification survey conducted on 09/12/24. An additional interview with the Administrator on 12/18/25 at 9:00 AM confirmed the facility lacked a policy addressing the survey results postings.