STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425288	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Ridgeway	213 Tanglewood Court Ridgeway, SC 29130

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 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, record review, and facility policy review, the facility failed to ensure residents seated at the same table ate at the same time for two of two residents (Resident (R)124 and R103) reviewed for dignity in dining out of a total sample of 37 residents. This failure had the potential to cause R103 and R124 to feel less dignified.Findings include:Review of the facility's policy titled, Dining Program, with a review date of 10/21/25, indicated, It is the policy of [Name] to enhance the meal experience for all patient/residents who participate in the dining program.1. Review of R124's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/05/25 and located in the electronic medical record (EMR) under the RAI [Resident Assessment Instrument] tab, revealed the resident had problems with short-term memory and long-term memory. Further review revealed the resident was coded as being dependent with eating.Observation on 01/19/26 at 12:52 PM revealed R124 and R27 were seated at a table in the 400 hall dining room. At this time, a Certified Nurse Aide (CNA)2 was observed feeding R27. R124 was seated in a reclined geri-chair next to the table with her uneaten lunch meal tray positioned on the table.Continuous observation on 01/19/26 from 12:52 PM to 1:15 PM revealed CNA2 continued to feed R27 her meal, while R124 was not assisted with her lunch meal. At 1:15 PM CNA2 finished feeding R27 her meal and assisted the resident from the dining room. At 1:17 PM, CNA2 was observed to begin serving R124 her meal. At 1:34 PM CNA2 was observed to finish feeding R124 her meal.During an interview on 01/19/26 at 1:34 PM, CNA2 confirmed R124 was served her meal after her tablemate (R27) had finished eating her meal and had been assisted from the dining room.2. Review of R103's quarterly MDS, with an ARD of 11/18/25 and located in the EMR under the RAI tab, revealed the resident had problems with short-term memory and long-term memory.Observation on 01/20/26 at 12:35 PM revealed R103 and R27 were seated at a table in the 400 hall dining room. At this time, an CNA was observed feeding R27. R103 was seated in a reclined Geri (geriatric) chair (wheeled recliner) next to the dining room table and had not been served a lunch meal.Continuous observation on 01/20/26 from 12:35 PM to 12:45 PM revealed staff continued to feed R27 while R124 had not been served a meal and watched staff feed R27. At 12:45 PM staff finished feeding R27 her meal. At 12:47 PM, staff were observed to assist R27 from the dining room. At 1:07 PM, staff was observed to serve R103 her lunch meal in the dining room.During an interview on 01/20/26 at 1:40 PM, Licensed Practical Nurse (LPN)2, who was the 400-hall unit manager, confirmed R103 was served her meal later than her tablemate (R27). LPN2 stated during the 01/20/26 lunch meal some residents were served their lunch later than scheduled because the hallway's second meal delivery cart arrived much later than the hallway's first meal cart. LPN2 stated staff on the 400 hall were not informed there would be a delay in the hallway's meal service.During an interview on 01/20/26 at 3:45 PM, the Dietary Manager (DM) confirmed during the lunch meal on 01/20/26 the 400 hallway's second meal cart was transported to the hallway later than scheduled due to a mix up in the kitchen, and this (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delay was not communicated to the staff on the hall. The DM stated residents who ate meals at the same dining room table should be served their meals at the same time because it was a dignity issue.During an interview on 01/21/26 at 5:20 PM, the Director of Nursing (DON) stated she expected residents who were eating meals at the same dining room table to be served their meals at the same time to promote dignity.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, record review, and policy review, the facility failed to protect the residents' right to be free from physical abuse by a resident for seven of ten residents (Resident (R) 66, 84, 136, 120, 93, 125, and 115) reviewed for abuse out of a total sample of 37 residents. Five altercations occurred with R66 involved in three of the five: one with R84, one with R136, and one with R120. In addition, R93 struck R125 in the back several times; and R136 hit R115. This failure had the potential to cause serious physical injury or emotional distress to residents.Findings include: Review of the facility's policy titled, Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, dated 11/15/24, revealed, It is the policy of [facility] . to actively preserve each patient's right to be free from . physical . abuse, . 1. Review of an investigation summary titled, [R66] and [R84] Investigation, provided by the Administrator, revealed Incident involves two residents on the secured unit. At approximately 3:41pm on 7/13/25 a CNA [Certified Nurse Aide] walked into their room and witnessed [R66] scratching [R84's] arm on the left arm. The CNA immediately moved [R84] from the room. The Director of Nursing (DON) assessed both residents and identified a skin tear to R84's right arm. Due to cognition, neither resident was able to answer questions. Review of R66's undated Face Sheet, located in the resident's electronic medical record (EMR) under the Resident tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbances and mood disorder. Review of R66's nursing Progress Note, dated 07/13/25 at 5:41 PM and located under the Resident tab of the EMR, revealed Patient conflict with [R84] earlier in shift . patient removed from resident immediately by nurse and CNA, [R66] was placed in day room with 1 on 1 [staff member assigned to monitor] care. R66 was calm while 1 on 1 care was provided. Review of R66's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/25, located under the RAI (Resident Assessment Instrument) tab of the EMR, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was moderately cognitively impaired. The MDS also revealed the facility assessed the resident to not have engaged in any behaviors during the assessment period. Review of 84's undated Face Sheet, located in the resident's EMR under the Resident tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, muscle weakness, and chronic pain. Review of R84's quarterly MDS with an ARD of 10/21/25, located in the resident's EMR under the RAI tab, revealed the facility assessed the resident to have a BIMS Score of 0 out of 15, which indicated the resident was severely cognitively impaired. During observations from 01/19/26 to 01/21/26, R84 propelled herself in her wheelchair on the secured unit. She was cognitively unable to answer questions and had no observed injuries, indicative of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Attempts were made to interview R66, but she was not oriented and refused to speak at all or be interviewed. 2. Review of an investigation summary titled, [R66] and [R136] Investigation, provided by the Administrator, revealed Incident involves two residents on the secured unit. At approximately 4:30pm on 7/27/25 [Licensed Practical Nurse [LPN] 4] was at the nurses' station and witnessed [R66] and [R136] attempting to get through the doorway to the dining room in their wheelchairs at the same time. According to the report, R66 began flailing her arms and hit R136 with open hands. R136 then hit R66 with her fists in the face. LPN4 separated the residents. R66 and R136 were assessed and no injuries were noted. Review of R136's undated Face Sheet, located in the resident's EMR under the Resident tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included dementia with other behavioral disturbances, and mood disorder. She was discharged to another facility on 9/10/25. Review of R136's quarterly MDS with an ARD of 08/08/25 revealed the facility assessed the resident to have a BIMS score of 12 out of 15, which indicated the resident was moderately cognitively impaired. The MDS also revealed the facility assessed the resident to not have engaged in any behaviors during the assessment period. Review of R136's nursing Progress Note, dated 07/27/25 at 4:30 PM and located under the Resident tab of the EMR, revealed Patient conflict with [R66] earlier in shift . patient removed from resident immediately by nurse and [CNA2]. [R136] placed in day room with 1 on 1 care. [R136] was calm while 1 on 1 care was provided. Attempts were made to interview R66, but she was not oriented and refused to speak at all or be interviewed. 3. Review of an investigation summary titled, [R66] and [R120] Investigation, provided by the Administrator, revealed Incident involves two residents on the secured unit. At approximately 8:05 pm on 10/19/25 [CNA10] walked into their room and witnessed [R66] and [R120] grabbing each other. [R66] had scratches on her face and blood on her mouth, [R120] had scratches on her chest. The CNA immediately moved [R120] from the room. The DON assessed both residents with no serious injuries found. Neither resident was able to be interviewed due to their cognitive status. Review of R120's undated Face Sheet, located in the resident's EMR under the Resident tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included dementia with other behavioral disturbances, and mood disorder. Review of R120's nursing Progress Note, dated 10/19/25 at 8:05 PM and located under the Resident tab of the EMR, revealed Patient conflict with R66 earlier in shift . patient removed from resident [sic] immediately by nurse and CNA2. R120 placed in day room with 1 on 1 care. R120 was calm while 1 on 1 care was provided. Review of R120's quarterly MDS with an ARD of 10/25/25 revealed the facility assessed the resident to have a BIMS score of 0 out of 15, which indicated the resident was severely cognitively impaired. The MDS also revealed the facility assessed the resident to not have engaged in any behaviors during the assessment period. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Attempts were made to interview R66, but she was not oriented and refused to speak at all or be interviewed. During an interview with LPN4 on 01/21/26 at 10:00 AM, she said R66 was not combative unless someone was in her space. LPN4 said she had no issues with R66, but the resident was monitored closely due to her history of altercations. She said the staff on the unit knew the resident well and removed her from situations when other residents were in her personal space. During an interview with CNA2 on 01/21/26 at 11:00 AM, she said R66 had not had any issues with any residents since October 2025. CNA2 said R66 was not exhibiting any behavior and was doing well on the secured unit. During an interview on 01/21/26 at 5:25 AM, the Administrator stated it was his expectation that all residents would be free from abuse, including resident to resident abuse. 4. Review of the facility's investigation of a 09/04/25 incident between R93 and R125, provided by the facility, revealed the investigation specified the facility unsubstantiated resident to resident abuse. Included in the facility's investigation were witness statements from staff who were working when the incident occurred. A witness statement written by CNA11 indicated, Resident was in the dining room getting ready for dinner. Resident became very frustrated at this time and hit another resident multi [multiple] times across the back. A witness statement written by LPN4 specified, Staff alerted me that an altercation was happening in the dining room. I went in and removed the patient to her room. Review of R93's admission Record, located in the Resident section of the EMR, revealed R93 was admitted to the facility on [DATE] with a diagnosis of bipolar disorder. Review of R93's quarterly MDS assessment with an ARD of 08/16/25, located in the RAI tab of the EMR, revealed R93 scored 99 on the BIMS, which indicated she was unable to compete the interview. The MDS indicated R93 exhibited no physical, verbal, or other behavioral symptoms directed toward others. Review of R93's Care Plan, located under the RAI tab of the EMR, contained the following Problem area, which was initiated on 09/04/25, Presence of behavioral symptoms physical aggression as evidenced by: physical altercation with another resident on 09/04/25. The care plan's goal specified, Patient will not harm themselves or others secondary to their behaviors through next review. Review of R93's notes, located in the Progress Notes section of the EMR, revealed the following entry: 09/04/25 at 6:56 PM: While in dining room; before dinner; pt [patient] approached another pt that was sitting down at a table. She then struck the pt that was sitting with a closed hand at least 6 times. Staff immediately separated the residents taking the pt to her room, providing a calm environment by dimming the lights and turning the tv on low. When asked why she struck the other patient, the pt stated because she did not want a shower. Pt educated that we do not hit others no matter what or just because they're having a bad day. Pt stated she understood and that she was sorry. We are currently awaiting an incident number from police regarding incident. There were no injuries to either patient. Observation on 01/19/26 at 2:45 PM revealed R93 was in her room. R93 was exhibiting no problem (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	behaviors and was confused. R93 did not understand questions being asked to her. Review of R125's admission Record, located in the Resident section of the EMR, revealed R1125 was admitted to the facility on [DATE] with a diagnosis of senile degeneration of brain. Review of R125's quarterly MDS assessment with an ARD of 07/21/25, located in the MDS tab of the EMR, revealed R125 scored three of 15 on the BIMS, which indicated she was severely cognitively impaired and had not exhibited any physical, verbal, or other behavioral symptoms towards others. Review of R125's notes, located in the Progress Notes section of the EMR, revealed the following entry: 09/04/25 at 5:34 PM: Pt struck by another pt while sitting in the dining area before dinner. Pt was struck in the back approx.6-10's, with a closed hand. Immediately moved the aggressive pt to her room; alleviating the situation. Pt states she is ok. The pt is assessed for an injury and there is none noted at this time. Pt states she is fine because the pt that hit her hits like a flea. Observation on 01/19/26 at 2:10 PM revealed of R125 was seated on a couch in a common area with other residents near her. R125 was pleasantly confused and was exhibiting no problem behaviors toward others. During an interview on 01/21/26 at 9:30 AM, LPN4 stated she was working on 09/04/25 when the incident between R93 and R125 occurred. LPN4 stated a CNA informed her that R93 was hitting R125 on the back in the 400-hall dining room. LPN4 stated she immediately went to the dining room, and the staff had the residents separated. LPN4 explained that the residents were taken to their rooms and she examined both residents for injuries and found none. LPN4 stated following the incident R125 was calm and did not express any signs of pain or being afraid. During an interview on 01/21/26 at 3:05 PM, CNA11 stated she recalled the incident between R93 and R125 which occurred on 09/04/25. CNA11 explained on 09/04/25 at around 5:00 PM she and another CNA were in the 400-hall dining room when she heard a loud slap. CNA11 stated she turned and observed R93 forcefully hitting R125 on the back. CNA11 stated she and the other CNA immediately separated the two residents and informed the nurse of the incident. CNA11 stated when the residents were separated R125 was not visibly upset or expressing any signs of pain. CNA11stated she was not aware of R93 or R125 exhibiting any physical behaviors towards others prior to or since the 09/04/25 incident. During an interview on 01/21/26 at 5:40 PM, the Administrator stated the facility's investigation of the 09/04/25 incident when R93 was observed hitting R125 on the back should have been substantiated by the facility because the abuse happened. The Administrator stated the staff try hard to prevent resident abuse and the facility trained staff on identification of abuse and to always immediately report abuse. 5. Review of a facility investigation dated 08/29/25, and provided by the facility, noted on 08/26/25, R115 had wandered into R136's room several times prompting R136 to yell get out. Each time, staff redirected R115 out of the room. The last time R115 wandered into the room, staff seated him/her in the dining room, R136 came from behind and slapped R115 in the face. At the time of the incident, both residents resided on the secured Memory Support Unit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Face Sheet located under the Resident Dashboard tab in the EMR identified R115 was admitted on [DATE] with diagnoses that included dementia with mood disturbance. Review of R115's Care Plan, located under the RAI tab in the EMR, initiated 06/28/25, revealed R115 resided on the secured Memory Support Unit due to dementia and wandering. Review of R115's Quarterly MDS, located under the RAI tab in the EMR, with an ARD of 11/30/25 revealed a BIMS score of three out of 15 which indicated R115 was severely cognitively impaired. Review of the Face Sheet, located under the Resident Dashboard tab in the EMR identified R136 was admitted on [DATE] with diagnoses that included dementia, severe, with mood disturbance, and anxiety disorder. She was discharged to another facility on 9/10/25. Review of the Quarterly MDS, located under the RAI tab in the EMR, with an ARD of 08/08/25, revealed a BIMS score of 12 out of 15 which indicated R136 was moderately cognitively impaired. Review of the care plan, initiated 06/11/25, revealed When resident begins to become socially inappropriate and aggressive behaviors, provide comfort measures for basic needs [for example [ex.] pain, hunger, toileting]. Observation of R115, on the secured Memory Support Unit (MSU), on 01/21/26 from 2:00 to 2:45 PM, revealed R115 was in common area seated with other residents. She was calm, seated directly next to another resident and placed her head on the other resident's shoulder with both residents resting. At 2:45PM, R115 was observed up and walking about independently on the hallway. R115 was observed to wander into the room at the end of the hallway, exit, and walk back down the hall. R115 was observed walking in and out of the dining room speaking calmly with other residents. In an interview on 01/21/26 at 8:09 AM, the Administrator stated They fight back there [MSU] a lot. We usually substantiate these allegations because it happened. They have dementia. Some don't like others in their space. During an interview on 01/21/26 at 2:45 PM, CNA5 stated R115 is usually calm but can get agitated during care.

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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 observation, record review, and staff interviews, the facility failed to ensure that the environment for one of six residents (Resident (R) 32) remained free from accident hazards to prevent falls. This failure increased R32's risk of falls.Findings include:Review of R32's Face Sheet, located in R32's electronic medical record (EMR), under the Face Sheet tab, revealed the facility admitted R32 from home on [DATE]. R32's pertinent diagnoses included right above-knee amputation (AKA), right hemiplegia and hemiparesis following cerebral infarction, cognitive communication deficit, difficulty walking, and right-hand contracture.Review of the facility's Incident Report dated 06/29/25, provided by the Administrator, revealed the R32 sustained an unwitnessed fall out of bed with head involvement. Staff initiated a low bed as an intervention to help prevent further falls.Review of the Nursing Progress Note dated 06/29/2025, located in R32's EMR under the Progress Notes tab, revealed that a Certified Nursing Assistant (CNA) observed R32 on the floor next to their bed. R32 sustained a hematoma to their right forehead and right eye. Staff initiated neurological checks with no abnormal findings and notified R32's physician, who requested R32 be sent to the emergency room for further evaluation. [R32 returned from the hospital on [DATE] with no injuries noted].Review of the Morse Fall Scale assessment, dated 06/30/25, located in R32's EMR under the Observations tab, revealed R32 was at high risk for falls.Review of the facility's Initial Report dated 06/30/25, provided by the Administrator, revealed R32 sustained a fall from their bed. R32 complained of head pain, and staff sent R32 to the emergency room for further evaluation. R32 returned to the facility with no injuries noted.Review of the facility's Five-Day Follow-Up Report, dated 07/02/25, provided by the Administrator, revealed that on 06/29/25, staff observed R32 on the floor by their bed. R32 fell exiting the bed without assistance. The nurse assessed R32 and noted a raised area on R32's right forehead and right eye. Staff assisted the resident back to bed, initiated neurological checks, and notified the provider, who ordered that R32 be sent to the hospital for further evaluation. Interventions implemented to prevent further injury included placing R32's bed in the lowest position, physical therapy referral, and re-education.Review of R32's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/25, located in R32's EMR under the RAI [Resident Assessment Instrument] tab, revealed R32 was readmitted to the facility from an acute care hospital on [DATE]. R32 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 indicated severe cognitive impairment. R32 was dependent on staff for bed mobility, transfers, toileting, and personal hygiene.Review of R32's care plan, last reviewed/revised on 01/19/26, located in R32's EMR, under the Care Plan tab, revealed R32 was at risk for falls related to right AKA and fall on 06/29/25. On 07/02/2025, the facility updated the care plan directing staff to keep R32's bed in the lowest position.During an observation on 01/20/26 at 2:00 PM, R32 lay in bed watching television. R32's bed was elevated and not in its lowest position. At 2:19 PM, CNA8 entered the resident's room to provide care and exited shortly afterward without placing the bed in the lowest position. Follow?up observations at 4:31 PM and 9:00 PM revealed R32's bed remained elevated.During an observation on 01/21/26 at 9:15 AM with Registered Nurse (RN)1, R32 was observed lying in bed watching television. R32's bed remained elevated.During an interview on 01/21/26 at 9:15 AM, RN1 reviewed R32's care plan and stated that R32 was at risk for falls. RN1 acknowledged R32's bed was not in the lowest position at this time. RN1 stated the bed should be as low to the ground as the mechanical bed would allow.During an interview on 01/21/26 at 1:12 PM, CNA8 stated that she has worked at the facility since July 2025. CNA8 stated that she learned today (01/21/25) that R32 was a fall risk, stated that fall interventions were outlined in the resident's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan, and that she should have placed R32's bed in the lowest position before exiting the resident's room on 01/20/26.During a telephone interview on 01/21/26 at 1:16 PM, Licensed Practical Nurse (LPN)1 stated that prior to the fall on 06/29/25, R32 was not a fall risk. LPN1 stated that on 06/29/25, R32 sustained an unwitnessed fall out of bed. LPN1 assessed R32, notified the physician, and sent the resident to the emergency room for further evaluation. After the fall, LPN1 implemented a low bed to help prevent further falls.During an interview on 01/21/26 at 1:45 PM, LPN2 reviewed the resident's care plan and stated that the resident is at risk for falls but does not move around much in bed. LPN2 stated that R32's bed should be in the lowest position and that staff do not document whether it is in the lowest position during each shift.