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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, the facility failed to keep the kitchen's slicer, walk-in refrigerator's floor and shelves, and two stove top spill pans clean. These failures had the potential to create an environment for food-borne illnesses which could affect 128 residents who consumed food prepared from the facility's kitchen.Findings include:Review of the facility's policy titled, Cleaning Procedures: Kitchen Area, with a review date of 10/23/25, indicated, It is the policy of [Name] to maintain a clean and sanitary environment to prepare patient/resident meals . All soiled, dirty, dusty, surfaces and/or areas within the kitchen should be cleaned and/or sanitized [as needed] immediately upon identification.1. Observation during the initial kitchen inspection on 01/19/26 from 9:50 AM to 10:25 AM, with the Dietary Manager (DM) present, revealed the following concerns with the cleanliness of food storage and food preparation areas:a. Observation of the kitchen's walk-in refrigerator revealed the floor was unclean with loose debris and dried spills. The floor's edges and corners, which were under shelving units, had a very heavy buildup of black colored substances which could be wiped away with a paper towel. Additionally, two metal shelves in the refrigerator had plastic covers on them which were unclean with a black moldlike substance. Boxes of food were observed stored directly on these plastic shelf covers.b. Observation of the kitchen's electric slicer revealed it was covered and ready for use. Observations of the slicer's blade revealed it was unclean with a dried food substance.c. Observation of the kitchen's stove top spill pans revealed two of the pans were unclean with a heavy accumulation of dried food and dried food spills.During an interview on 01/19/26 at 10:25 AM, the DM confirmed the kitchen's walk-in refrigerator's floor and shelves, slicer, and stove top spill pans were not clean. The DM stated the walk-in refrigerator's floor and shelves should be cleaned daily, the slicer should be cleaned after each use, and the stove top spill pans should be cleaned weekly or as needed.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and failed to provide adequate supervision to prevent resident to resident altercations for seven of ten residents (R) 66, 84, 136, 120, 93, 125, and 115) reviewed. These failures placed residents at risk for physical harm. Findings include: 1.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, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. 2. 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Attempts were made to interview R66, but she was not oriented and refused to speak at all or be interviewed. 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. 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure completion of a required PASRR (Pre-admission Screening and Resident Review) when a resident's diagnosis changed. Specifically, for Residents R6 and R9, the facility did not initiate or complete a new or updated PASRR after a change in the resident's diagnosis, which had the potential to affect the residents' need for specialized services. This failure placed residents at risk of not receiving appropriate evaluations, services, and support in accordance with federal requirements.Findings include: Review of the Social Services director for the facility job description provided by the facility indicated under key responsibilities .Responds to resident behavioral and psychiatric issues by completing behavioral and psychosocial assessments, providing treatment recommendations and making referrals to appropriate mental and behavioral health providers.completes psychosocial assessments of residents. According to the South Carolina Department of Health and Human Services, Federal PASARR regulations require nursing facilities to complete a PASARR Resident Review whenever a resident shows a significant change in condition, including the development of a new mentalˆhealth diagnosis such as major depression, schizophrenia, bipolar disorder, or other serious mental illnesses. When a new diagnosis or psychiatric symptoms emerge after admission, this may indicate a PASARR significant change, requiring the facility to submit an updated Level I PASARR within 14 days and, if indicated, to trigger a Level II evaluation to determine continued eligibility and service needs. Guidance further explains that new behavioral or psychiatric symptoms suggesting mental illness—especially when not previously identified—must be referred to the appropriate PASARR authority for review. 1. Review of R9s Face Sheet from the facility electronic medical record (EMR) under the Resident tab showed an admission date of 05/02/18 with the most recent date of 10/31/24 with the following medical diagnoses that included schizoaffective disorder, bipolar type, Muscle weakness (generalized), Unsteadiness on feet, and Type 2 diabetes mellitus. Review of R9's South Carolina Department of Health and Services PASARR Level 1 screening Form provided by the facility, dated 05/02/18, indicated R9 had no diagnosis of mental illness at the time of admission. Review of R9's Orders sheet located in the EMR under the Residents tab revealed an order for Seroquel (quetiapine) tablet; 25 milligrams (mg); amount (amt): 1 tablet; oral at bedtime for the diagnosis of schizoaffective disorder, bipolar type with a created date of 12/05/24. Review of R9's Care Plan retrieved from the facility EMR under the RAI tab revealed R9 is hallucinating and seeing animals/diagnosis of schizoaffective disorder, bipolar type with a start date of 06/21/21 During an interview on 01/20/26 at 2:42 PM with the facility Social Services Director (SSD), the SSD stated R9 did not have a PASARR. When asked to clarify if that was PASARR level I or level II, the SSD responded, There is no PASARR. The SSD confirmed R9 had a new diagnosis and another Level 1 PASARR was not initiated. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/20/26 at 2:57 PM, the Administrator also confirmed R9 did not have a PASARR she further shared her expectation is all residents need a [PASARR] screening before admission or if there is a change in diagnosis indicating a mental illness (MI) or Intellectual Disability (ID). 2. Review of R6's Face Sheet, located in R6's EMR under the Face Sheet tab, revealed the facility admitted R6 on 03/12/25 from an acute care hospital. Review of the PASARR Level 1, dated 11/06/24, that was completed by the hospital prior to R6's admission to the facility, located in R6's EMR under the Resident Documents tab, revealed R6 did not have a mental illness diagnosis and indicated no further evaluation was recommended. Resident 6's pertinent diagnosis included Non-Alzheimer's dementia. Review of R6's admission MDS with an ARD of 03/12/25 revealed R6 had moderate cognitive impairment as evidenced by a BIMS score of 11 out of 15. R6's neurological diagnosis included Non-Alzheimer's dementia. R6's did not have any psychiatric or mood disorder diagnoses (i.e., bipolar disorder). R6 received antipsychotic medication during the review period. Review of the Psychiatry Initial Visit report, dated 04/15/25, located in R6's EMR, under the Resident Documents tab, revealed, Patient was admitted to the facility on [DATE]. Since admission, TID [three times daily] PRN [as needed] trazodone (antidepressant) was reduced to lower dose. She remains on chronic Seroquel for mood stabilization and history of verbal aggression. Psychiatry has been consulted for residual symptoms of mixed mood, including irritable dysphoria, disinhibition with verbal [NAME] control, hurling profanities and racial slurs at others, aggressive behaviors causing discomfort to others. Findings: Symptoms consistent with chronic bipolar disorder. Current mixed episode. She is tolerated [sic] antipsychotics in the past and was admitted on Seroquel and trazodone. Major Neurocognitive Disorder, Alcohol abuse disorder, and current remission. Progressive impairments to the nervous system secondary to chronic alcohol contributing to dementia. Symptoms consistent with likely late onset [sic] Alzheimer's disease. Orders/Plan: Start Depakote ER [extended release] 250 mg PO [by mouth] for mood stabilization, hypomania with insomnia, and reduction of impulsive disinhibited behaviors which pose risk to the safety of herself and others. In five days, increase Depakote ER to 500 mg [milligrams] PO HS (hour of sleep). During an interview on 01/20/26 at 2:38 PM, the SSD stated that she recently started working at the facility. The SSD reviewed R6's clinical record and could only find the PASSAR Level 1 dated 11/06/24. The SSD was unable to state if the facility submitted a new PASSAR Level 1 Screening as a resident review referral due to R6's new bipolar diagnosis. During an interview on 01/20/26 at 2:43 PM, the Social Worker stated that she reviewed R6's clinical record and located R6's PASSAR Level 1, which the hospital provided upon admission. The Social Worker was unable to state if the facility completed a new PASSAR Level 1 to see if a PASSAR Level 2 was needed due to the new bipolar diagnosis. During an interview on 01/20/26 at 3:00 PM, the Administrator stated that the facility relied on diagnoses provided by the hospital and information included in the PASSAR sent with the resident upon admission to the facility. They identify residents with newly evident or possible mental disorders or related conditions after admission based on observed behaviors, consults, laboratory reviews, but not the resident's diagnosis, unless they are started on a psychotropic medication. The Administrator stated that the social workers were responsible for making the referral to the appropriate state-designated authority. The Administrator was unable to state if the facility submitted (continued on next page)

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.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a new PASSAR Level 1 Screening as a resident review referral due to R6's new bipolar diagnosis. During an interview on 01/20/26 at 4:21 PM, the Director of Nursing (DON) stated that the facility did not have a policy and procedure regarding PASSARs. The DON stated that if the resident's diagnoses changed to include a major mental illness, they would verify the diagnosis and send the information to the PASARR entity to see if a PASSAR level 2. The DON was unable to state if the facility submitted a new PASSAR Level 1 Screening as a resident review referral due to R6's new bipolar diagnosis.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review, interviews, testing and tasting of food served on a requested test tray and policy review, the facility failed to ensure food was palatable and served hot to four of eight residents (Resident (R) 3, R28, R68, and R75). The failure had the potential to negatively affect 124 residents who consumed food prepared from the facility's kitchen by experiencing dissatisfaction with the meals, not eating the meals, and/or experiencing nutritional concerns.Findings include: Review of the facility's policy titled, Food Temperatures, revised 10/21/25, indicated, Policy: Statement: It is the policy of (facility name) that the Dietary Manager or designee be responsible for ensuring that all food has reached and continues to maintain proper temperature prior to tray assembly . Food will be served at palatable temperatures . In a Resident Group Interview on 01/20/26 at 1:30 PM, with eight residents, the facility identified to be reliable historians and cognitively intact, four residents voiced complaints that the food was not served hot to their rooms. 1.Review of R3's Quarterly Minimum Data Set (MDS) located under the RAI [Resident Assessment Instrument] tab in the Electronic Medical Record (EMR), with an Assessment Reference Date (ARD) of 12/13/25, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R3 was cognitively intact. 2.Review of R28's Quarterly MDS, located under the RAI tab in the EMR, with an ARD of 11/25/25, revealed a BIMS score of 15 out of 15 which indicated R28 was cognitively intact. 3.Review of R68's Quarterly MDS, located under the RAI tab in the EMR, with an ARD of 11/28/25, revealed a BIMS score of 15 out of 15 which indicated R68 was cognitively intact. 4.Review of R75's admission MDS, located under the RAI tab in the EMR, with an ARD of 10/20/25, revealed a BIMS score of 15 out of 15 which indicated R75 was cognitively intact. During the interview, R28 said her food often was cold when it arrived to her room and staff tell me they can't heat it up. During the interview, R68 said they had to eat in their rooms recently because of a flu outbreak and that they food is not hot when it comes to my room. Observation on 01/21/26 at 7:49 AM revealed a requested test tray was placed in an enclosed unheated meal delivery cart for the 300 hallway. Food temperatures on the kitchen tray line were monitored and were at acceptable levels of 135 degrees Fahrenheit (F) and above for the hot foods. The food was placed on heated plates and covered with an insulated dome lid prior to being placed in the enclosed meal delivery cart. The meal delivery cart arrived at the 300 hallway at 7:51 AM and nursing staff began serving resident meals. As nursing staff were serving meals from the meal cart it was observed that many of the insulated dome lids were not completely covering resident meal plates which was confirmed by the Dietary Manager (DM). At 8:01 AM, the last resident meal was delivered on the 300 hallway. After the last resident meal was delivered, the test tray was removed from the enclosed delivery cart by the DM. When the DM removed the test tray from the cart the insulated dome lid was only partially covering the meal plate. The DM used a calibrated facility thermometer, obtained the temperatures of the food on the test tray, and tasted each of the food items with the (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor. The scrambled eggs on the test tray registered at 88 degrees F. This surveyor tasted the scrambled eggs and they tasted cold. The DM also tasted the scrambled eggs and agreed they were cold. The grits on the test tray registered 98 degrees F. This surveyor tasted the grits, and they tasted warm and needed to be hotter. The DM tasted the grits and agreed they were warm and could be hotter. During an interview on 01/21/26 at 8:08 AM, the DM stated the insulated dome lids covering resident meal plates on the meal cart had probably slid off the plates during transport to the 300 hallway when the cart ran over a slightly elevated area of flooring located at the beginning of the 300 hallway. The DM showed the surveyor where this elevated area of flooring was located on the 300 hallway. The DM stated staff would need to transport meal delivery cart slower over this area to prevent the insulated lids from sliding off resident meal plates.