STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425296	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- North Augusta	1200 Talisman Drive North Augusta, SC 29841

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview, record review, and review of facility policy, the facility failed to protect Resident (R)5 from physical abuse/mistreatment by Certified Nursing Assistant (CNA)1, for 1 of 4 residents reviewed for abuse.Findings include:Review of the facility policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property last revised on 10/27/20 revealed, It is the policy of [NAME] Health and its entities to actively preserve each patient's right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, mistreatment, and misappropriation of patient property. The Organization and its partners should assure that best efforts are made to prevent any occurrences of any form of abuse, neglect, and exploitation. This policy applies to the entire organization, and all partners, volunteers, contractors, staff of other agencies serving patients, family members, legal guardians, friends, or other individuals who come into contact with patients, including other patients. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. Abuse includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse also includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitation or enabled through the use of technology. Mistreatment is defined as the inappropriate or treatment or exploitation of a patient. Providers are to identify, correct, and intervene in situations in which abuse, neglect, mistreatment, or exploitation may occur.Review of R5's Face Sheet revealed R5 was admitted to the facility on [DATE], with diagnoses including but not limited to acute and chronic respiratory failure with hypoxia, dementia without behaviors, dysphasia following cerebral infarction, and muscle weakness.Review of R5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/25, revealed that a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that R5 was cognitively intact. Further review of the MDS revealed that R5 had no behaviors during this assessment period and is dependent on staff for most Activities of Daily Living (ADL).Review of the Facility reported Five-Day Follow-Up Report dated 10/16/25 revealed, Interventions by facility to prevent future injury/alleged abuse; residents were interviewed, staff were interviewed to see if additional witness existed. [R5] said that [CNA1] did ‘pop' him with her hand. He would like for her to continue to provide care for him, [CNA1] was terminated from employment. Staff educated on abuse as well as creating a homelike environment while maintaining professional standards. Summary report of facility investigation includes; Medical Doctor (MD), police, and Ombudsman were notified. [CNA1] was suspended pending investigation, after review of resident interview and staff statements, no other witnessed the abuse. No other residents were similarly affected. Body audit showed no injury was sustained. [R5] and his Resident Representative (RR) would like [CNA1] to continue to provide care to resident and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appreciate the rapport she has built with resident over time however, [CNA1] crossed professional boundary and was terminated from employment. Resident referred to mental health for psychosocial support, staff educated on abuse as well as creating a homelike environment while maintaining professional standards, residents to be educated on abuse in resident council meeting.Review of CNA1's Witness Statement revealed, I [CNA1] was in room (redacted) to change [R5]. [R5] and I was joking around something we always do on a daily when [R5] said a joke about my mom. I told [R5] okay stop playing and [R5] attempted to kick me. I once again stated to [R5] to stop playing so I can finish cleaning him up from his bowel movement, I asked him to turn on his side and tapped him on the side of his thigh to turn over. I was able to complete patient care and ask the resident if he needed anything else and he stated yes (the chicken out of the microwave). I told the resident I will be back to check on him before the end of my shift and continued my rounds.Review of CNA2's Witness Statement revealed, I was on the linen cart that was in-between rooms (redacted and redacted) when I witnessed [CNA1] hit [R5]. She [CNA1] told him to swing his leg into the bed and [R5] said 'no', she popped him and he popped her arm back. They started passing lick back and forth, I went and told the nurse what I saw.Review of Licensed Practical Nurse (LPN)1's Witness Statement revealed, I received report from [CNA2] that [R5] was hit by [CNA1]. I went down and checked on the resident and reported it to the Director of Nursing immediately. A body audit was completed, and resident had complaints of pain in his leg, as needed pain medication was administered.During an observation and interview on 02/12/26 at 3:16 PM, R5 revealed that he was unable to recall the incident with CNA1. R5 denied being abused while a resident at the facility and stated that he feels safe with staff.During a phone interview on 02/12/26 at 3:44 PM, CNA2 revealed that they witnessed CNA1 hit R5, they immediately reported this incident to the nurse on duty.During an attempted phone interview on 02/12/26 at 4:03 PM, with LPN1 was unsuccessful, a voicemail was left with callback information.During a phone interview on 02/12/26 at 4:12 PM, CNA1 revealed, I remember [R5], I took care of him when I worked for the facility. Some days he would be okay, and other days he would act out (say sexually inappropriate things to staff/refuse care, and become physical with staff). I was fired because of this incident from the facility because they told me I had abuse and neglect training and knew the policies. [R5] and I had a playful relationship, on that day [R5] was being resistant to care and saying inappropriate things, so I told him to roll over and lightly/playfully tapped him on his leg/thigh. Another staff member told me and said that I hit the resident in an abusive manner, but I don't understand how she saw/witnessed that because I had the door closed when I was providing care.During an interview on 02/12/26 at 5:04 PM, the Director of Nursing (DON) revealed I was informed by LPN1 that CNA2 witnessed CNA1 hit R5. I was not at the facility at this time but instructed LPN1 to protect R5 and send CNA1 [sic], we then informed [R5's] Resident Representative and other parties (state agency, Medical Doctor MD, law enforcement, etc). When we began our investigation, [CNA1] admitted to popping [R5] on his thigh in a playful manner and later reported this incident to the CNA licensing board as well. [CNA1] was terminated from the facility due to this incident.During an interview on 02/12/26 at 5:41 PM, the Administrator revealed that CNA1 was terminated due to this incident with R5 and the facility substantiated the allegation of abuse.