STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425306	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Pickens	163 Love & Care Road Six Mile, SC 29682

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and interviews. The facility failed to inform Resident (R) 1's family member of R1's involvement in a resident-to-resident altercation for 1of 3 Residents reviewed for abuse. Review of facility policy titled, Abuse Prevention & Reporting, with a last revision date of 06/20/25 revealed the following: The assisted living center will not tolerate abuse, neglect or exploitation of its residents by anyone. Such incidents will be reported to all appropriate authorities, agencies, and registries and a written copy as such reports maintained in a central file and resident file.Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to: Alzheimer's, vascular dementia and dysphagia. Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/25 revealed a Brief Interview of Mental Status of 99 indicating R1 was unable to complete the interview. Review of a Facility Initial Report dated 02/16/25 revealed a resident-to-resident altercation where R1 was pushed by R2 in the back because R1 was attempting to get into the food cart. No injuries noted.Review of R1's progress notes from 02/01/25 and 03/31/25 revealed no progress note indicating that the resident was involved in a resident-to-resident altercation. Subsequent review of the progress note also revealed that there was no documentation that the Resident Representative (RP) was notified of the incident in question.Review R1's Electronic Health Record revealed there was no Situation, Background, Assessment, Recommendation (SBAR) documentation in the resident's chart. Further review revealed no documentation that the facility notified R1's RP of the incident that occurred between R1 and R2. During a telephone Interview on 08/25/25 at 12:20PM, R1's RP stated he was not aware of any incident involving R2 allegedly pushing R1. He further reported that neither he nor his wife were notified of the incident in question.During an observation on 08/25/25 at 12:22PM, R1's RP requested to speak with Case Manager (CM1) to verify the legitimacy of the state agency's investigation. RP1 stated that neither he nor his wife had been contacted regarding the allegation that R2 pushed R1 in the back. CM1 apologized and acknowledged she was unaware that the RP had not been informed of this incident.During an interview on 08/25/25 at 1:25 PM, Licensed Practical Nurse (LPN)1 revealed she was unable to locate any documentation indicating R1's RP was notified of the incident involving R1's altercation with another resident. LPN1 acknowledged that in the medical field, if something is not charted, then the action has not been completed. LPN1 further stated that the staff member caring for R1 at the time of the incident should have notified the RP and documented the notification in R1's electronic health record.During an interview on 08/25/25 at 4:05PM the Director of Nursing (DON) and Administrator (LNHA) revealed that if there if staff witness a Resident to Resident interaction, it is their immediate expectation to first sperate the residents and to assess them for injuries. Once the residents are safe and assessed for injuries it is their expectation to notify the Provider, Administrator, DON, and the resident family member. During the incident in question, they were not aware that the RP was not notified of the incident in question. The nurse who was caring for the resident during the incident in question should have notified the RP and documented that the RP was notified. The nurse did not follow proper facility protocol.