

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Pruitthealth- Estill		STREET ADDRESS, CITY, STATE, ZIP CODE 252 Liberty Street South Estill, SC 29918	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and policy review, the facility failed to ensure residents and/or their resident representative (RR) received written information regarding the right to accept or refuse medical and surgical treatments for one of two residents (Resident (R) 8) out of 23 sampled residents. This failure had the potential for the residents' wishes not to be followed if they were unable to speak for themselves. Findings include: Review of the facility policy titled, Advance Directives: South Carolina, dated 04/09/24 did not indicate the facility should provide the resident and/or the RR with written information regarding the right to accept or refuse medical and surgical treatments. Review of R8's Face Sheet, located under the Resident tab in the electronic medical record (EMR), revealed R8 was admitted on [DATE] with diagnoses including unspecified dementia with behavioral disturbance, unspecified mood disorder, post-traumatic stress disorder, and bipolar disorder. Review of R8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/26/26 and located under the Resident Assessment Instrument (RAI) tab of the EMR, revealed R8 had a Brief Interview for Mental Status (BIMS) score of five out of 15, indicating severe cognitive impairment. Review of R8's undated Social Services form titled, SC [South Carolina] Advance Directive for Healthcare, located under the Resident tab in the EMR under the Documents section, revealed it did not include information regarding the resident and/or the resident representative receiving written information regarding the right to accept or refuse medical and surgical treatments. During an interview and record review on 06/23/26 at 4:38 PM, the Social Service Director (SSD) verified the SC Advance Directive form did not indicate that R8 or her RR received written information regarding the right to accept or refuse medical and surgical treatments. During an interview and record review on 06/24/26 at 11:00 AM, the Administrator confirmed the R8's SC Advanced Directive form did not include information regarding the right to accept and or refuse medical and surgical treatments.		

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: 425315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Pruitthealth- Estill		STREET ADDRESS, CITY, STATE, ZIP CODE 252 Liberty Street South Estill, SC 29918	
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 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. Based on observations, record reviews, and interviews, the facility failed to prevent a potential accident hazard by failing to maintain hot water temperatures below 120 degrees Fahrenheit (F) to prevent potential scalding for one of three sampled residents, (Resident (R) 87). Findings include: Record review of R87's Face Sheet located under the Face Sheet tab of the Electronic Medical Record (EMR) revealed an admission date of 06/04/26 with a diagnosis of dementia. Record review of R87's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/10/26 revealed a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. R87 was independent with walking 10 feet. R87 had a diagnosis of non-Alzheimer's dementia. Observation of R87 on 06/23/26 at 4:03 PM revealed he was ambulating independently in the facility on the unit he resided on. Observation on 06/23/26 at 4:04 PM revealed the hot water in the sink of R87's bathroom felt hot to the touch with an inability to keep a bare hand in the hot water for more than two seconds without discomfort. A temperature check of the hot water with a digital thermometer revealed the temperature was 124.5 degrees Fahrenheit (F). Observation on 06/24/26 at 9:54 AM with the Administrator and the Maintenance Director (MD) revealed the hot water temperature was 121.5 degrees F with the laser thermometer used by the MD. The Administrator placed his hand in the running hot water and he confirmed that the hot water was too hot for safe use by the facility residents. Interview with the Administrator on 06/24/26 at 10:25 AM revealed the facility did not have a policy or procedure in place for maintaining the facility hot water temperatures at a safe level. Interview with the MD on 06/24/26 at 10:35 AM revealed the facility had four boilers; one for each resident unit (two), one for the laundry, and one for the kitchen. The MD revealed the boiler that provided the hot water to the unit R87 resided on was set at 135 degrees F. The MD confirmed the hot water setting on the boiler had to be lowered to 118 degrees F to be at the safe temperature. Interview with Certified Nursing Assistant (CNA)1 on 06/24/26 at 10:57 AM revealed R87 used the bathroom for toileting and handwashing.		