STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425400	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Blythewood	1075 Heather Green Drive Columbia, SC 29229

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 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. Based on observation, interview, and facility policy review, the facility failed to ensure commercially prepared hard-cooked eggs were not stored for use beyond their use-by-date. This deficient practice had the potential to affect all residents receiving meals from the dietary department. Findings included: Review of a facility policy titled, Label, Dating, and Storage, revised 11/11/2022, specified, 4. Food and beverage items will be discarded according to guidance from a government agency such as the United States Department of Agriculture (USDA) and Food and Drug Administration (FDA). During an initial tour of the facility's kitchen on 09/15/2025 at 9:17 AM, with the Dietary Manager present, the walk-in cooler was observed to contain a white, plastic food-grade bucket of commercially prepared, hard-cooked eggs. The front of the bucket included a ?Use By' date of 09/09/2025. During an interview on 09/15/2025 at 11:09 AM, the Dietary Manager stated that the kitchen staff were supposed to discard all food on their expiration or use-by-dates. During an interview on 09/19/2025 at 9:49 AM, the Director of Health Services (DHS) stated she expected food items to be removed and discarded after their use-by-dates.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure wound care orders were transcribed into the electronic medical record at the time of admission for 1 (Resident (R)134) of 3 residents reviewed for wound care. This resulted in one missed wound care treatment on 09/15/2025. Findings include: Review of the facility policy titled, admission Orders, dated 09/2002, specified 5. Once all admission orders have been verified and documented appropriately, they are to be transcribed by the admitting nurse on the appropriate documents in the record (i.e. [id est, that is] MAR [Medication Administration Record], TAR [Treatment Administration Record], etc. [et cetera, other similar things]). Review of an undated facility document titled Dressing a Wound specified Check the individual's medical record for the healthcare provider's order, including the: order for the dressing change, type of dressing, frequency of dressing change, location of wound, cleansing solution, and peri wound protectant. Review of a Resident Face Sheet indicated the facility admitted R134 on 09/11/2025 with a medical history that included diagnoses of sepsis due to methicillin-resistant staphylococcus aureus (MRSA), cellulitis of the right lower limb, and type two diabetes mellitus with a foot ulcer. R134's Care Plan included a problem statement, initiated 09/11/2025, that indicated R134 had a foot infection, a right foot diabetic wound, right lower extremity cellulitis, and MRSA bacteremia. R134's facility History and Physical, dated 09/11/2025, revealed R134 had a right foot wound and required wound care twice daily, was minimal weight bearing on the right foot, and required a follow-up with orthopedic surgery and infectious disease as an outpatient. R134's Order History revealed wound care orders were not transcribed into the resident's medical record until 09/17/2025, six days after their admission. Per the Order History, an order was started on 09/17/2025 to cleanse the residents right foot with wound cleanser/normal saline, pat dry, apply topical A and D ointment to the wound bed, cover with an absorbent abdominal pad, and wrap with stretch-conforming gauze on Mondays, Wednesdays, and Fridays and as needed if the dressing became soiled or fell off. An observation on 09/16/2025 (Tuesday) at 3:52 PM revealed R134 was seated in their wheelchair with a white dressing on their right foot that was dated 09/13/2025 (the previous Friday). No outward signs of drainage were visible to the exterior of the dressing, and the dressing appeared intact. An observation on 09/17/2025 at 9:08 AM revealed a white dressing to R134's right foot dated 09/17/2025 with an outer dressing that contained no visible signs of drainage from the wound. During an interview on 09/18/2025 at 12:16 PM and a follow-up interview on 09/18/2025 at 12:37 PM, Licensed Practical Nurse (LPN)2 reported she assessed R134's foot wound on 09/12/2025 and obtained orders for wound care. LPN2 stated she documented the wound assessment and the new orders on a paper form but failed to transcribe the orders into the electronic medical record until 09/17/2025. LPN2 stated since the orders were not transcribed and accessible to facility nursing staff following their initiation on 09/12/2025, the dressing change was not completed on 09/15/2025 as ordered. During an interview on 09/18/2025 at 4:09 PM, Registered Nurse (RN)1 stated staff were to enter new orders in the electronic medical record at the time of admission, and she was not aware orders had not been transcribed for R134's wound care until 09/17/2025. During an interview on 09/19/2025 at 10:23 AM, the Director of Health Services (DHS) stated she expected R134's wound care orders to be transcribed into the electronic medical record on the date the order was obtained. During an interview on 09/19/2025 at 11:44 AM, the Administrator stated he would have expected the wound care orders to have been transcribed when they were first obtained.