STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425009	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faith Healthcare Center	617 West Marion Street Florence, SC 29501

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure residents and/or their responsible party (RP) were provided with a written notice of transfer and/or a written bed hold for one of three residents reviewed for hospitalizations Resident (R)105.This failure had the potential to affect the resident and their Responsible Party (RP) by not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. Findings include:Review of the facility's policy titled, Discharge/Transfer dated 10/23/19, stated, .facility will include the patient/resident and family in developing a safe discharge plan to address the patient's/resident's individual needs by obtaining a discharge/transfer order from the physician, to notify the patient/resident, his/her legal representative, if any, or an interested family member and document the discharge.Review of R105's Resident Face Sheet located in the resident's archived medical record revealed that the resident was admitted to the facility on [DATE] with diagnoses that included dementia, severe psychotic disturbance, hallucinations, paranoia, major depressive disorder, and anxiety disorder. Review of R105's admission Minimum Data Set (MDS) with an assessment refence date (ARD) of 12/19/25 revealed a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated the resident was severely cognitively impaired. Review of R105's Progress Note, dated 01/28/26, located in the resident's archived paper medical record and completed by the Nurse Practitioner (NP) revealed, .the resident is seen today for follow-up evaluation to assess the need for transfer to a higher level of care due to ongoing severe behavioral disturbances and psychosis related to schizophrenia.Discussed with administrator and Hospital social services regarding the transfer above and they are aware and agreeable to assist with this issue. R105 was transferred to the hospital on this date.Further review of R105's archived paper medical record revealed there was no evidence that the resident and/or their RP was issued a written notice of transfer or a bed hold upon or soon after the resident's transfer to the hospital. During an interview on 03/10/26 at 4:39 PM, the Administrator stated, .there was no bed-hold policy or written notice of transfer provided to the RP [of R105] .

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to ensure respiratory equipment was properly stored for one of one resident reviewed for respiratory care, Resident (R)9, of 23 residents sampled. This failure had the potential to increase the risk of infection and improper respiratory equipment maintenance.Findings include: A review of the facility's policy titled, Handheld Nebulizer, revised 02/12/24, included in the procedure process: .23. Disassemble device and rinse the mouthpiece and nebulizer cup with water and dry. Place the entire unit in a bag to be maintained in the patient's/resident's room. Dispose of equipment every 24-48 hours. Review of R9's Face Sheet, in the resident's paper medical revealed the resident was admitted to the facility on [DATE] with diagnoses which included pneumonia. Review of R9's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/12/26, located under the Assessments section of the MDS, indicated R9 had a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated the resident was moderately cognitively impaired. During an interview and observation of R9 on 03/09/26 at 10:34AM, a nebulizer machine, mask, and tubing were observed on the resident's nightstand uncovered. The mask and tubing were not labeled or dated to indicate when they were last replaced. R9 confirmed that the nebulizer belonged to him and stated that he believed he had recently received a nebulizer treatment because he had been feeling congested. Review of R9's Physician's order, located in the resident paper medical record under the Physician's Orders section revealed an order dated 01/05/26 of Ipratropium/Albuterol; 1 vial (3ML [milliliter]) nebulizer every six hours as needed for pneumonia. change nebulizer tubing one time a day every week on Sunday. A review of R9's Medication Administration Records (MARs) and Treatment Administration Records (TARs) dated January 2026, February 2026, and March 2026 and located under the MAR/TAR section of the resident's paper medical record, indicated that R9 had not received a nebulizer treatment since admission. During a follow-up observation on 03/10/26 at 10:37AM, the nebulizer, mask, and tubing remained on the R9's nightstand and continued to be stored uncovered. During an interview on 03/10/26 at 2:24 PM, Licensed Practical Nurse (LPN) 2 confirmed that R9 had not received a nebulizer treatment per the MAR, as it would have been documented on the MAR. LPN2 further stated that the nebulizer equipment was normally stored in a bag in the resident's drawer, but that the resident had removed it. During an interview on 03/11/26 at 10:18AM, the Director of Nursing (DON) stated that nebulizers, masks, and tubing are expected to be cleaned and stored properly. She further stated that when mask and tubing are replaced, they should be labeled with the replacement date or documented in a log.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, the facility failed to assess residents for the use of bed rails, obtain physician's orders and informed consent prior to the installation of side rails on residents' beds for two of seven residents reviewed for accidents out of 26 sampled residents (Resident (R) 11 and R14). These failures placed the residents at risk for injury and restraint. Findings include:Review of the facility's policy titled, Bed Rails and Side Rails, Installation and Use Policy, revised 05/05/23 indicated, The facility will attempt to use appropriate alternatives prior to installing a side or bed rail.Qualified staff will assess the patient/resident for continued use of bedrails/side rails at least quarterly, annually and with a significant change.The risks and benefits of bed rails/side rails will be reviewed with the resident and/or responsible party. Consent and physician order will be obtained prior to the installation of bed rails/side rails.1. Review of R11's undated Resident Face Sheet found in the resident's paper medical record located at the nurse's station, revealed the resident was admitted to the facility on [DATE]. Observation on 03/09/16 at 12:31 PM revealed R11 was lying in her bed with her eyes closed. One side of the resident's bed was against the wall, and the other side of her bed had 1/3 side rails in the raised position in the middle of the bed. Observation on 03/10/26 at 9:02 AM revealed R11 was lying in her bed with her eyes closed and the 1/3 side rail was in the raised position on her bed. Observation on 03/10/26 at 3:12 PM revealed R11 was lying in her bed with her eyes closed. The resident's bed had a 1/3 side rail in the raised position on one side of the bed. Review of R11's annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 12/02/25 and found in the MDS Binder located at the nurse's station, revealed a Brief Interview for Mental Status (BIMS) assessment was not able to be completed due to the resident's poor cognition and disorganized thinking. The MDS indicated the resident required partial to moderate assistance from staff to roll from side to side in her bed and was dependent upon staff to transfer in and out of her bed. The MDS also indicated the resident did not have side rails in place on her bed during the assessment period.Review of R11's Physician's Order Report, dated 03/01/26 through 03/31/26 and found in the resident's paper medical record located at the nurse's station revealed the resident was ordered to have bilateral half side rails in the raised position on her bed.Review of R11's comprehensive Care Plan, most recently dated 01/13/26 and found in the Care Plan Binder located at the nurse's station revealed the resident had side rails on her bed to promote independence with bed mobility. Review of R11's complete paper medical record revealed no documented evidence the resident had been assessed for the use of side rails or that other alternatives had been attempted prior to the resident's use of side rails. Additionally, there was no documented evidence to indicate informed consent had been obtained for the use of side rails on R11's bed.2. Review of R14's undated Resident Face Sheet found in the resident's paper medical record located at the nurse's station revealed the resident was admitted to the facility on [DATE] with diagnoses which included kidney cancer, liver cancer, and frontotemporal neurocognitive disorder.Observation on 03/09/26 at 12:49 PM revealed R14 was lying in his bed with his eyes closed. The resident had 1/3 bilateral side rails in the raised position in the middle of the bed.Observation on 03/10/26 at 9:01 AM revealed R14 was lying in bed with his eyes closed with bilateral side rails in the raised position on her bed.Observation on 03/10/26 at 10:34 AM revealed the resident was lying in bed with his eyes closed with bilateral side rails in the raised position. Observation on 03/10/26 at 3:14 PM revealed R14 was lying in bed with his eyes closed. The resident's bed had bilaterial side rails in the raised position. Review of R14's significant change in status MDS, with an ARD of 02/19/26 and found in the MDS Binder located at the facility's nurse's station revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated the resident was (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moderately cognitively impaired. The MDS indicated the resident required assistance from staff to roll from side to side in his bed and required substantial to maximal assistance from staff to transfer in and out of his bed. The MDS indicated the resident did not have side rails in place on her bed during the assessment period.Review of R14's Physician's Order Report, dated 03/01/26 through 03/31/26 and found in the resident's paper medical record located at the nurse's station revealed no physician order for the resident to have side rails on his bed. Review of R14's comprehensive Care Plan, most recently dated 05/21/25 and found in the Care Plan Binder located at the nurse's station revealed the resident was not care planned for the use of side rails on his bed. Review of R14's Evaluation For Use of Bed Rails, dated 05/01/25 and found in the resident's paper medical record located at the nurse's station revealed no documented evidence it was recommended for the resident to have side rails on his bed. Review of R14's complete paper medical record revealed no documented evidence of any other evaluations for the use of side rails. During an interview on 03/10/26 at 2:03 PM, Unit Manager/Licensed Practical Nurse (UM/LPN1) confirmed the side rails were raised on R11's and R14's beds. UM/LPN1 stated residents were to have physician's orders for use of the side rails. UM/LPN1 also stated she thought side rail evaluations for continued use of the side rails were to be done annually. During an interview on 03/10/26 at 2:54 PM, the Director of Nursing (DON) confirmed side rail use was to be assessed quarterly. The DON stated physician orders and a care plan were to be in place for the use of side rails. The DON confirmed she could not locate anything to show that R11 had ever been assessed, or that informed consent was obtained for her use of side rails. The DON also confirmed that R14 had most recently been evaluated for his use of side rails on 05/01/25 (10 months prior to the survey). The DON stated there was not a physician's order for R14 to have side rails and that a care plan had not been developed for the resident's use of side rails. She stated her expectation was these things should have been done.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and facility policy review, the facility failed to ensure bed rails were inspected and maintained per the facility policy for two of seven residents (Resident (R) 11 and R14) reviewed for accidents out of 26 sampled residents. There was no evidence that the residents' beds were appropriately inspected and maintained to ensure the installed side rails were safe for residents' use. This failure placed the residents at risk for risk of entrapment. Findings include:Review of the facility's Bed Rails and Side Rails, Installation and Use Policy, revised 05/05/23 indicated, The resident will be evaluated for the risk of entrapment prior to installation (of bed rails), and Facility will ensure the patient/resident's bed dimensions are appropriate based on the patient/resident size (height and weight) prior to installation, to minimize the potential for entrapment.1. Review of R11's undated Resident Face Sheet found in the resident's paper medical record at the nurse's station, revealed the resident was admitted to the facility on [DATE] with diagnoses which included history of stroke and dementia with psychotic disturbance.Observation on 03/09/16 at 12:31 PM revealed R11 was lying in her bed with her eyes closed. One side of the resident's bed was against the wall, and the other side of her bed had 1/3 side rails in the raised position in the middle of the bed. Review of R11's complete paper medical record located at the nurse's station nothing to indicate the maintenance department had assessed that R11's bed was equipped with side rails that were safe and functioned properly.Review of the facility's untitled bed maintenance documentation provided by the facility revealed no documented evidence indicate the maintenance department had assessed R11's bed was equipped with side rails that were safe and functioned properly. 2. Review of R14's undated Resident Face Sheet found in the resident's paper medical record at the facility nurse's station, revealed the resident was admitted to the facility on [DATE] with diagnoses which included frontotemporal neurocognitive disorder. Observation on 03/09/26 at 12:49 PM revealed R14 was lying in his bed with his eyes closed. The resident had 1/3 bilateral side rails in the raised position in the middle of the bed. Review of the resident's complete paper medical record located at the nurse's station revealed nothing to indicate the maintenance department had assessed that R11's bed was equipped with side rails that were safe and functioned properly.Review of the facility's untitled bed maintenance documentation provided by the facility revealed no documented evidence indicate the maintenance department had assessed R11's bed was equipped with side rails that were safe and functioned properly.During an interview on 03/10/26 at 2:03 PM, Unit Manager/Licensed Practical Nurse (UM/LPN1) stated it was the responsibility of the Maintenance Department to conduct physical assessments of any resident bed for which side rails were to be applied. During an interview on 03/10/26 at 2:27 PM, the Maintenance Director (MD) stated general physical checks on resident beds were conducted by the facility maintenance team periodically; however, beds were not specifically checked by maintenance for each resident when rails were applied to the bed to ensure physical safety. He stated, We assume the nurses have done that. The MD further stated that neither R11's nor R14's bed and the attached side rails had been inspected or checked for safety. During an interview on 03/10/26 at 2:54 PM, the Director of Nursing (DON) stated that resident beds that were equipped with side rails or that would be equipped with side rails, it was her expectation that the side rails to be physically safe to keep residents becoming entrapped within the bed mattress and side rail.