STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425067	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Beaufort	11 Todd Drive Beaufort, SC 29901

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, record review, interview, and facility document and policy review, the facility failed to ensure staff did not utilize a geriatric chair without assessing whether the use of the geriatric chair was considered a restraint for 1 (Resident (R)1) of 3 residents reviewed for falls. Specifically, despite a known history of climbing out of the side of their geriatric chair and a history of climbing from their bed over their geriatric chair when staff positioned it by the resident's bed, staff placed R1 in a geriatric chair in a reclined position and also utilized the geriatric chair positioned along the side of the resident's bed while the resident was in bed to prevent the resident from getting up without staff's knowledge. Findings included: A facility policy titled, Use of Restraints, revised 04/2017, indicated, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. The policy specified, 1. 'Physical Restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The policy further specified, 4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility when in bed; and c. placing a resident in a chair that prevents the resident from rising. The policy indicated, 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine need for restraints and 9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). R1's admission Record indicated the facility admitted the resident on 03/29/2024. According to the admission Record, the resident had a medical history that included diagnoses of cauda equina syndrome (a condition that occurs when the cauda equina, the bundle of nerves at the base of the spinal cord, become compressed); other mechanical complication of internal fixation device of vertebrae; history of falling; lack of coordination; muscle weakness; dementia; bipolar disorder, current episode manic severe with psychotic features; unspecified mood disorder; anxiety disorder; low back pain; spondylosis (degeneration of the vertebral column); other intravertebral disc degeneration of the lumbar region; and posterior displaced type II dens fracture (a break in the odontoid process in the cervical spine). (continued on next page)

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/04/2025, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated R1 did not use a mobility device and required supervision or touching assistance with bed mobility; chair/bed-to-chair transfers; toilet transfers; when walking 10 feet, 50 feet with two turns, and 150 feet; and when transitioning from a seated position to lying down, from lying down to a seated position, and from a seated position to standing. R1's Care Plan Report revealed the resident's care plan was last reviewed by the facility on 04/30/2025. The Care Plan Report included a focus area, initiated on 04/08/2024, that indicated the resident had an activities of daily living (ADL) self-care performance deficit. Another focus area, initiated 04/08/2024, indicated R1 was at risk for falls related to gait/balance problems, incontinence, poor communication/comprehension, psychoactive drug use, history of falls and being unaware of safety needs. An intervention initiated on 06/25/2024 directed staff to provide Supervision of 1:1 caregiver as needed, and an intervention initiated on 09/21/2024 indicated the resident may use a geriatric recliner for rest periods. The Care Plan Report did not indicate that any type of restraint should have been utilized for R1. An event report, dated 01/25/2025 at 10:01 PM, indicated R1 was heard repeatedly yelling from the hallway, My eye hurts. The event report indicated a nurse responded and saw the resident walking down the hallway while holding the handrails. The event report further indicated R1 had a bruise on their face. According to the event report, the resident could not bear their own weight, and the nurse assisted the resident to control slide to the floor for an assisted fall. The event report revealed, Resident unable to describe why or how [his/her] eye hurts. A Nursing Note, dated 01/25/2025 at 10:44 PM, indicated R1 was placed into bed approximately five to ten minutes prior to the incident due to the resident falling asleep in their geriatric chair. According to the note, the resident was heard yelling that their eye hurt and upon quick assessment, the resident's right eye was more irritated and redder than the left eye, which was not noted before the resident was placed in bed. The note also indicated, unknown how bruise was accrued but hit to gerichair [geriatric chair], which was beside the head of the bed is possible. A Nursing Note, dated 01/26/2025 at 7:10 AM, revealed R1 began having complaints of neck pain during the morning while the nurse was checking the resident's vitals. The note indicated the resident would only follow movement with their eyes, and when attempting to move their head, the resident cried out in pain. According to the note, the resident was sent to the hospital for further evaluation. An Emergency Physicians report, dated 01/26/2025, revealed R1 had a history of frequent falls and fell during the night on 01/25/2025 while trying to climb over a geriatric chair. The report indicated R1 was diagnosed with a type II fracture of the odontoid process and a contusion of the face. An observation on 05/12/2025 at 9:15 AM revealed R1 was seated in the dining room in a reclined geriatric chair. The geriatric chair was pushed up to a dining table with no other individuals at the table. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent observation and interview on 05/12/2025 beginning at 3:56 PM revealed R1 was seated in a reclined geriatric chair in the dayroom area when the resident was observed to kick their legs over the left side of the geriatric chair in an attempt to rise to a standing position. Nurse Aide (NA)16 and another aide responded to the resident. NA16 stated, R1 has a known history of attempting to stand from their geriatric chair. During an interview on 05/12/2025 at 11:32 AM, NA12 stated a geriatric chair was routinely used for R1 during the night shift when she worked. NA12 further stated the resident's geriatric chair was placed next to the resident's bed during the night shift, and the resident had a history of attempting to climb out of their geriatric chair when seated in it and also had a history of attempting to climb out of their bed and over the geriatric chair (when the geriatric chair was positioned along the side of the resident's bed). During a follow-up interview on 05/13/2025 at 8:23 AM, NA12 stated staff usually put R1 to bed between 8:00 PM and 9:00 PM and routinely placed the resident's geriatric chair in the reclined position along the length of the resident's bed, with the footrest of the geriatric chair positioned towards the bottom of the resident's bed. During an interview on 05/12/2025 at 12:53 PM, Licensed Practical Nurse (LPN)1 stated she worked night shift on R1's unit. LPN1 stated that R1 was at high risk for falls and stayed up all night most of the time. LPN1 stated that generally, during the night shift, when R1 was put to bed, the resident's geriatric chair was placed at the head of the right side of the bed facing the foot of the bed. LPN1 stated the geriatric chair was routinely placed next to the resident's bed in a reclined position in an attempt to prevent the resident from getting up without staff's knowledge. LPN1 further explained that the resident's geriatric chair made noise when the resident's legs hit it, which alerted staff that the resident was trying to get up. During an interview on 05/12/2025 at 2:53 PM, NA2 stated that she arrived at work on 01/25/2025 around 7:00 PM. She stated she put R1 to bed during her first set of rounds sometime around 8:30 PM or 9:00 PM. NA2 further stated that when she put R1 to bed during the night shift, including the night of 01/25/2025, she normally put the resident to bed, then placed their geriatric chair along the side of the resident's bed in a reclined position with the wheels locked and the footrest of the geriatric chair positioned beside the head of the resident's bed, because the resident was always trying to get out of bed. NA2 stated she knew that the resident had tried climbing over the geriatric chair from their bed many times, but staff usually heard the resident when they started to get out of bed, as long as they had the geriatric chair placed next to the bed. During an interview on 05/15/2025 at 4:15 AM, NA24 stated she worked the night shift, primarily on R1's unit but was not working the night of 01/25/2025 when the resident fell. NA24 stated that sometimes R1's geriatric chair was left in the hallway outside their room, and other times, it was left in the resident's room. She said that when the geriatric chair was left in the resident's room, it was placed against the resident's bed to prevent the resident from being able to get up from the bed easily in hopes the resident would not fall. NA24 stated she was taught that the definition of a restraint was when something prevented a resident's movement and that they were not to use restraints in the facility; however, NA24 acknowledged the geriatric chair would have been an attempt to restrain the resident from getting up from their bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/12/2025 at 5:00 PM, the Administrator stated that during the course of the facility's investigation into the injuries sustained by R1 on 01/25/2025, the facility had not elicited information from staff that they had placed the resident's geriatric chair up against the bed as a barrier to prevent the resident from getting up. During a follow-up interview on 05/16/2025 at 2:30 PM, the Administrator stated that the use of the geriatric chair for R1 was initiated for rest periods and was not intended to be used at all times. The Administrator said that although she knew the definition of a restraint was something that restricted movement, she did not feel she had the expertise to determine if utilizing the resident's geriatric chair in a reclined position would be considered a restraint. The Administrator stated that if a geriatric chair was pushed up close to a bed while a resident was in bed, then the geriatric chair would not be appropriate. During an interview on 05/15/2025 at 9:05 AM, Registered Nurse (RN)3, the Risk Management Nurse, stated restraints were not allowed to be used in the facility. She stated a restraint was anything that prevented the resident from rising based on the resident's ability to stand and walk independently. RN3 provided an example of a restraint to be something that prevented a resident from getting up, such as a chair in the locked position next to their bed; however, she indicated she did not consider it a restraint when staff placed the resident's geriatric chair next to R1's bed, because she believed the resident could push the geriatric chair out of the way to get up. RN3 then acknowledged that if the geriatric chair was positioned in that manner and the wheels were locked, it could possibly be considered a restraint. RN3 stated she also did not consider having R1 in the common area in a reclined geriatric chair a restraint unless the resident was pushed up to a table, which would prevent them from rising. RN3 said that in her opinion, R1 could still throw their legs over the side of the chair and get up if they wanted to, even if the chair was in the reclined position. She said she did not think the geriatric chair in a reclined position would prevent R1 from getting up. RN3 further stated the facility had not completed assessments for geriatric chair use for any resident in the facility and had not assessed R1's use of the geriatric chair as a potential restraint until after the survey began. She said she did not consider geriatric chair use a restraint as geriatric chairs were primarily used for positioning and comfort and not confinement. During an interview on 05/16/2025 at 5:17 PM, the Director of Nursing (DON) stated the use of the geriatric chair for R1 was initiated by the interdisciplinary team (IDT), and they had discussed the appropriateness for the resident during rest periods, because R1 was always go-go-go and needed the geriatric chair to use when the resident became fatigued. She said the facility did not evaluate residents for geriatric chair usage or the potential for a geriatric chair to be identified as a restraint. The DON stated she would not consider the geriatric chair a restraint when in use by R1 and in a reclined position or when the geriatric chair was placed in a locked, reclined position next to the resident's bed for the resident, because R1 was able to move the chair by pushing it. She was not aware the resident had a history of climbing out of or over their geriatric chair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/2025 at 9:28 AM, the Medical Director (MD) stated he was aware R1 had an incident on 01/25/2025 that resulted in a cervical neck fracture. He stated he was also aware the resident had an initial bruise noted to their eye from an unknown source. He stated he did not see how injuries such as the neck fracture and eye bruising could have occurred from the assist fall or control slide by the nurse. The MD stated he was not made aware that staff were placing the resident's geriatric chair along the side of the bed to prevent falls or that the resident had a history of climbing out of their geriatric chair or over their geriatric chair from the bed. He stated that in his opinion, using the geriatric chair in this manner was not a good thing and was at least an attempt at a restraint. The MD stated that in his professional opinion, the injuries sustained by the resident on the night of 01/25/2025 could have occurred as a result of the resident climbing out of their bed and over the geriatric chair if the resident fell while doing so or if they hit their head or neck in the process. During a follow-up interview on 05/16/2025 at 1:26 PM, the MD stated that a geriatric chair should not be initiated as an intervention until the resident was assessed for its appropriateness, and the continued use of the geriatric chair should be monitored to determine if it remained appropriate. He stated that a resident placed in a reclined geriatric chair who was normally mobile and ambulatory, safe or not, would be considered a restraint.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview, record review, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected falls and resulting injuries for 1 (Resident (R)1) of 3 sampled residents. Findings included: A facility policy titled, MDS 3.0 Completion, reviewed/revised on 09/30/2024, revealed, According to federal regulations, the facility conducts initially a periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI [Resident Assessment Instrument] specified by the State. The section of the policy titled, Care Plan Team Responsibility for Assessment Completion, 1. Interdisciplinary Responsibility for Completion of MDS Sections specified, c. Persons completing part of the assessment must attest to the accuracy of the section they completed. R1's admission Record indicated the facility admitted the resident on 03/29/2024. According to the admission Record, the resident had a medical history that included diagnoses of cauda equina syndrome (a condition that occurs when the cauda equina, the bundle of nerves at the base of the spinal cord, become compressed); other mechanical complication of internal fixation device of vertebrae; history of falling; lack of coordination; muscle weakness; dementia; bipolar disorder, current episode manic severe with psychotic features; unspecified mood disorder; anxiety disorder; low back pain; spondylosis (degeneration of the vertebral column); other intravertebral disc degeneration of the lumbar region; and posterior displaced type II dens fracture (a break in the odontoid process in the cervical spine). R1's Care Plan Report included a focus area, initiated 04/08/2024, that indicated the resident was at risk for falls. An event report, dated 01/25/2025 at 10:01 PM, revealed R1 was heard yelling from the hallway, and a nurse responded and saw the resident walking down the hallway while holding the handrails. According to the event report, the resident could not bear their own weight, and the nurse assisted the resident to control slide to the floor for an assisted fall. An Emergency Physicians report, dated 01/26/2025, revealed R1 was seen in the emergency room for a fall the night before. The report indicted the resident injured their right eye, and a computed tomography (CT) scan revealed the resident had a type II odontoid fracture with dorsal displacement. A modified significant change in status MDS, with an Assessment Reference Date (ARD) of 02/03/2025, revealed R1's most recent admission/entry or reentry to the facility was on 03/29/2024. The MDS was coded to reflect that R1 had not had any falls since admission/entry, reentry, or their prior assessment. A Fall event report, dated 04/18/2025, revealed R1 pushed a staff member and fell backwards onto [his/her] bottom. The event report indicated the fall was witnessed and no injuries were observed at the time of the incident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS, with an ARD of 05/06/2025, revealed R1's most recent admission/entry or reentry to the facility was on 03/29/2024. The MDS was coded to reflect that R1 had not had any falls since admission/entry, reentry, or their prior assessment. During an interview on 05/15/2025 at 2:15 PM, the MDS Coordinator reviewed R1's modified significant change in status MDS, with an ARD of 02/03/2025, and stated the assessment was coded to reflect that the resident had not sustained any falls since admission/entry, reentry, or their prior assessment. After reviewing R1's medical record, the MDS Coordinator stated the resident sustained a fall that resulted in a cervical neck fracture on 01/26/2025. She stated the MDS should have reflected that the resident had sustained a fall since admission/entry, reentry, or their prior assessment and also should have specified that the resident had no falls without injury, no falls with minor injury, and one fall with major injury. The MDS Coordinator also reviewed R1's quarterly MDS, with an ARD of 05/06/2024, and stated the assessment was coded to reflect that the resident had not sustained any falls since admission/entry, reentry, or their prior assessment. After reviewing R1's medical record, the MDS Coordinator stated that the resident sustained a fall without injury on 04/18/2025. She stated the MDS should have reflected that the resident had sustained a fall since admission/entry, reentry, or their prior assessment and also should have specified that the resident had one fall without injury, no falls with minor injury, and no falls with major injury. During an interview on 05/16/2025 at 5:17 PM, the Director of Nursing (DON) stated she expected MDS assessments to be complete and accurate, and the MDS Coordinator should have reviewed the medical record when completing the assessments. During an interview on 05/16/2025 at 7:19 PM, the Administrator stated she expected all MDS assessments to be completed timely and accurately.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview, record review, and facility policy review, the facility failed to ensure staff checked for incontinence and/or provided incontinence care during routine rounds for 1 (Resident (R)1) of 3 residents reviewed for falls. Specifically, on the evening 01/25/2025, after the resident experienced an assisted fall to the floor, staff placed the resident in a geriatric chair and did not check to see if the resident required incontinence care until sometime between 5:00 AM to 6:00 AM the following morning. Findings included: R1's admission Record indicated the facility admitted the resident on 03/29/2024. According to the admission Record, the resident had a medical history that included diagnoses of cauda equina syndrome (a condition that occurs when the cauda equina, the bundle of nerves at the base of the spinal cord, become compressed); other mechanical complication of internal fixation device of vertebrae; history of falling; lack of coordination; muscle weakness; dementia; bipolar disorder, current episode manic severe with psychotic features; unspecified mood disorder; anxiety disorder; low back pain; spondylosis (degeneration of the vertebral column); other intravertebral disc degeneration of the lumbar region; and posterior displaced type II dens fracture (a break in the odontoid process in the cervical spine). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/04/2025, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was always incontinent of bowel and bladder. R1's Care Plan Report included a focus area, initiated 04/08/2024, that indicated the resident had bowel and bladder incontinence. An intervention dated 04/08/2024 directed staff to check the resident for incontinence during rounds and as required. An event report, dated 01/25/2025 at 10:01 PM, revealed R1 was heard yelling from the hallway, and a nurse responded and saw the resident walking down the hallway while holding the handrails. According to the note, the resident could not bear their own weight, and the nurse assisted the resident to control slide to the floor for an assisted fall. The event report indicated the resident was transferred to a geriatric chair following the fall. A Nursing Note, dated 01/25/2025 at 10:44 PM, indicated that after the assisted fall, R1 was resting in the recreational room, so staff could keep a close eye on the resident. R1's 01/2025 Documentation Survey Report revealed no documentation of bladder activity, bowel activity, toileting transfer, or toileting hygiene provided to the resident during the evening or night shift on 01/25/2025. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 05/12/2025 at 11:32 AM, Nurse Aide (NA) #12 stated she recalled that on 01/25/2025, after R1 had an assisted fall, the resident was placed into their geriatric chair, and she and NA2 took the resident to the dayroom (common area on the unit where meals and activities were provided) to check the resident's vital signs. NA12 stated that after obtaining the resident's vital signs, she returned to her assignment on the unit, and R1 remained in the day room with NA2. NA12 further stated she did see the resident for the remainder of the night, but she knew the resident remained in their geriatric chair in the day room until the next morning. NA12 stated that R1 was incontinent of bowel and bladder and always wore a brief. NA12 confirmed she did not assist with any transfers or provide toileting or incontinence care to the resident after their fall on 01/25/2025. During a telephone interview on 05/12/2025 at 2:53 PM, NA2 stated she recalled working the night shift on 01/25/2025. She stated that around 8:30 PM - 9:00 PM on the evening of 01/25/2025, she placed R1 in bed and provided incontinence care before the resident went to sleep. She said she then left the resident and completed rounds on other residents. NA2 stated that about 45 minutes later, R1 had a fall and was placed in their geriatric chair for assessment and taken to the day room. NA2 stated she made incontinence rounds for the remainder of the residents on the hall around midnight but left R1 in their geriatric chair in the day room for the remainder of the night until approximately 5:00 AM-6:00 AM the following morning, when she took the resident to their room and placed them in bed to provide incontinence care. NA2 stated that she did not put R1 back to bed or provide incontinence care (check or change) during the remainder of the shift after the fall, because the resident was sleeping and they did not want to wake them up for incontinence care. During an interview on 05/12/2025 at 12:53 PM, Licensed Practical Nurse (LPN)1 stated that following the assisted fall on 01/25/2025, R1 went to sleep in their geriatric chair, and staff only woke the resident up when performing neurological checks, after which the resident went right back to sleep. LPN1 stated R1 was always incontinent of bowel and bladder and always wore a brief. She stated the staff did not put the resident to bed or check the resident for incontinence during the remainder of the shift after the fall, because the resident was resting peacefully. During an interview on 05/14/2025 at 5:35 PM, the Assistant Director of Nursing (ADON) stated that staff should check residents for incontinent episodes every two hours and provide incontinence care, if indicated. During an interview on 05/16/2025 at 2:30 PM, the Administrator stated she expected staff to make rounds and provide resident care, including incontinence care, every two hours.

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F 0689 Level of Harm - 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 observation, interview, record review, and facility document and policy review, the facility failed to provide one-to-one (1:1) supervision as needed in accordance with Resident (R)1's fall prevention care plan and failed to recognize and address all potential accident hazards in the resident's environment for 1 (R1) of 3 residents reviewed for falls. Specifically, on 01/25/2025, approximately five to ten minutes after the resident was assisted into bed by staff, who placed a reclined geriatric chair along the side of the resident's bed, R1 was seen coming down the hallway yelling that their eye hurt, and the resident's right eye was noted to be redder and more irritated than their left eye. While in the hallway, the resident became too weak to support their weight and was lowered to the floor by a nurse for an assisted fall. During the early morning hours of 01/26/2025, it was noted that the resident cried out in pain when trying to move their neck, and the resident was sent to the hospital for further evaluation. Hospital records reflected that the resident had a history of frequent falls and fell during the night of 01/25/2025 while trying to climb over a geriatric chair; the hospital diagnosed R1 with a type II fracture of the odontoid process and a contusion of the face. When investigating the circumstances of the resident's injuries and the assisted fall, the facility failed to consider all causal factors and did not identify that the manner in which staff were using the resident's geriatric chair posed a risk for accident or injury. The facility concluded that the resident's injuries were a result of being lowered to the floor by the nurse. Additionally, during the survey, staff left a rolling computer chair in the resident's room when it was not in use, which also posed a risk of additional accidents or injuries. Findings included: An undated facility policy titled, Fall-Clinical Protocol revealed, 1. As part of the initial assessment, individual residents with a history of falls and risk factors for subsequent falling will be identified. The section of the policy titled, Assessment specified, 2. If the cause of a fall is unclear, root cause analysis should be used to attempt to determine the cause(s) or related issues that may have precipitated the fall. The section of the policy titled, Treatment/Management specified, 1. Based on assessment, the staff in conjunction with the physician will review pertinent interventions and modify existing interventions when appropriate to try to prevent subsequent falls and to address risks of serious consequences of falling. R1's admission Record indicated the facility admitted the resident on 03/29/2024. According to the admission Record, the resident had a medical history that included diagnoses of cauda equina syndrome (a condition that occurs when the cauda equina, the bundle of nerves at the base of the spinal cord, become compressed); other mechanical complication of internal fixation device of vertebrae; history of falling; lack of coordination; muscle weakness; dementia; bipolar disorder, current episode manic severe with psychotic features; unspecified mood disorder; anxiety disorder; low back pain; spondylosis (degeneration of the vertebral column); other intravertebral disc degeneration of the lumbar region; and posterior displaced type II dens fracture (a break in the odontoid process in the cervical spine). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Beaufort	11 Todd Drive Beaufort, SC 29901

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/04/2025, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated R1 did not use a mobility device and required supervision or touching assistance with bed mobility; chair/bed-to-chair transfers; toilet transfers; when walking 10 feet, 50 feet with two turns, and 150 feet; and when transitioning from a seated position to lying down, from lying down to a seated position, and from a seated position to standing. R1's Care Plan Report revealed the resident's care plan was last reviewed by the facility on 04/30/2025. The Care Plan Report included a focus area, initiated on 04/08/2024, that indicated the resident had an activities of daily living (ADL) self-care performance deficit. Another focus area, initiated 04/08/2024, indicated R1 was at risk for falls related to gait/balance problems, incontinence, poor communication/comprehension, psychoactive drug use, history of falls and being unaware of safety needs. An intervention initiated on 06/25/2024 directed staff to provide Supervision of 1:1 caregiver as needed, and an intervention initiated on 09/21/2024 indicated the resident may use a geriatric recliner for rest periods. An event report, dated 01/25/2025 at 10:01 PM, indicated R1 was heard repeatedly yelling from the hallway, My eye hurts. The event report indicated a nurse responded and saw the resident walking down the hallway while holding the handrails. The event report further indicated R1 had a bruise on their face. According to the event report, the resident could not bear their own weight, and the nurse assisted the resident to control slide to the floor for an assisted fall. The event report revealed, Resident unable to describe why or how [his/her] eye hurts. A Nursing Note, dated 01/25/2025 at 10:44 PM, indicated R1 was placed into bed approximately five to ten minutes prior to the incident due to the resident falling asleep in their geriatric chair. According to the note, the resident was heard yelling that their eye hurt and upon quick assessment, the resident's right eye was more irritated and redder than the left eye, which was not noted before the resident was placed in bed. The note also indicated, unknown how bruise was accrued but hit to gerichair [geriatric chair], which was beside the head of the bed is possible. A Nursing Note, dated 01/26/2025 at 7:10 AM, revealed R1 began having complaints of neck pain during the morning while the nurse was checking the resident's vitals. The note indicated the resident would only follow movement with their eyes, and when attempting to move their head, the resident cried out in pain. According to the note, the resident was sent to the hospital for further evaluation. An Emergency Physicians report, dated 01/26/2025, revealed R1 had a history of frequent falls and fell during the night on 01/25/2025 while trying to climb over a geriatric chair. The report indicated R1 was diagnosed with a type II fracture of the odontoid process and a contusion of the face. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/12/2025 at 11:32 AM, Nurse Aide (NA) #12 stated she recalled working at the facility on the evening of 01/25/2025 but was not assigned to R1. NA12 recalled that she was not present when the resident fell but after returning to the unit following a short break, she saw R1 on the floor, and Licensed Practical Nurse (LPN)1 and NA2 were with the resident. NA12 stated LPN1 and NA2 transferred R1 from the floor to the resident's geriatric chair, and LPN1 asked NA12 and NA2 to check the resident's vital signs (blood pressure, pulse, temperature, and respirations). NA12 stated she and NA2 wheeled R1 to the dayroom, which was near the nurses' station, and obtained the requested vital signs before she left R1 with NA2 and continued with her assigned duties for the shift. NA12 stated a geriatric chair was routinely used for R1 during the night shift when she worked. NA12 further stated the resident's geriatric chair was placed next to the resident's bed during the night shift, and the resident had a history of attempting to climb out of their geriatric chair when seated in it and also had a history of attempting to climb out of their bed and over the geriatric chair (when the geriatric chair was positioned along the side of the resident's bed). During a follow-up interview on 05/13/2025 at 8:23 AM, NA12 stated staff usually put R1 to bed between 8:00 PM and 9:00 PM and routinely placed the resident's geriatric chair in the reclined position along the length of the resident's bed, with the footrest of the geriatric chair positioned towards the bottom of the resident's bed. During an interview on 05/12/2025 at 12:53 PM, LPN1 stated she worked night shift on R1's unit. LPN1 stated that R1 was at high risk for falls, stayed up all night most of the time, and required 1:1 supervision for periods of increased agitation; however, LPN1 stated the facility was not staffed to provide 1:1 supervision on most occasions, since only two aides were normally scheduled to work during the night shift. LPN1 stated that on the evening of 01/25/2025, NA2 put R1 to bed around 9:00 PM. LPN1 stated that generally, during the night shift, when R1 was put to bed, the resident's geriatric chair was placed at the head of the right side of the bed facing the foot of the bed. LPN1 stated the geriatric chair was routinely placed next to the resident's bed in a reclined position in an attempt to prevent the resident from getting up without staff's knowledge. LPN1 further explained that the resident's geriatric chair made noise when the resident's legs hit it, which alerted staff that the resident was trying to get up. LPN1 stated that on the evening of 01/25/2025 after the resident was put to bed, she was in a room directly behind the nurses' station and not in direct visual sight of R1's room, but she heard R1 repeatedly complaining that their eye hurt, so she exited the room behind the nurses' station and proceeded towards the resident. She stated that when she reached R1 in the hallway, she noticed the resident's eye was reddened. LPN1 stated at about that same time, R1 could no longer maintain their weight and grabbed onto LPN1. LPN1 further stated she was unable to hold R1's weight, so she yelled for NA2 to retrieve R1's geriatric chair from the resident's room to assist her. LPN1 stated she then repositioned herself behind R1 and lowered the resident to the floor by sliding the resident down her legs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/12/2025 at 2:53 PM, NA2 stated that she arrived at work on 01/25/2025 around 7:00 PM. She stated she put R1 to bed during her first set of rounds sometime around 8:30 PM or 9:00 PM. She stated that after she put the resident to bed, she provided incontinence care, and she thought the resident was asleep, so she left R1 in bed to complete her rounds. She stated that after completing her rounds and about 45 minutes after putting R1 to bed, she heard the resident scream, Owww. She stated she saw the resident at the end of the hallway holding onto the handrails, and she and the nurse both went to the resident. NA2 stated the nurse asked her to get the resident's geriatric chair, and as she was exiting the resident's room with the chair, she saw the nurse lower the resident to the floor in a seated position. NA2 stated the resident was complaining their eye hurt, so they transferred the resident into the geriatric chair, took the resident to the dayroom, and assessed their vital signs. NA2 further stated R1 remained in the day room for the remainder of the night, and she went into the day room throughout the night to keep a periodic watch over the resident. NA2 stated R1 was sent to the hospital for evaluation the following morning. NA2 further stated that when she put R1 to bed during the night shift, including the night of 01/25/2025, she normally put the resident to bed, then placed their geriatric chair along the side of the resident's bed in a reclined position with the wheels locked and the footrest of the geriatric chair positioned beside the head of the resident's bed, because the resident was always trying to get out of bed. NA2 stated she knew that the resident had tried climbing over the geriatric chair from their bed many times, but staff usually heard the resident when they started to get out of bed, as long as they had the geriatric chair placed next to the bed. During an interview on 05/12/2025 at 9:28 AM, Registered Nurse (RN) #14 stated she was familiar with R1 and routinely worked on the resident's unit. RN #14 stated R1 was normally cooperative with care until about lunchtime, at which point the resident became increasingly agitated and at times became combative with staff. During an interview on 05/12/2025 at 2:21 PM, NA #16 stated she normally worked dayshift and was familiar with R1. NA #16 stated R1 liked to ambulate a lot during the daytime but needed someone with them for balance and safety. NA #16 further stated R1 could become combative in the afternoons if staff did not allow the resident to walk around, but the resident normally calmed down quickly if staff walked with the resident or kept the resident engaged with something. NA #16 stated R1 did not typically use a geriatric chair during the daytime, but staff tried to have chairs available for the resident to sit in when the resident needed a rest break. She said she was not on duty on the night of R1's 01/25/2025 fall; however, she recalled that when she arrived to work on the morning of 01/26/2025, she was notified the resident had a fall during the night and was being transferred to the hospital for evaluation after complaining of neck pain. NA #16 did not know if night shift staff placed the resident's geriatric chair along the side of the resident's bed when the resident was in bed, but she stated she did know the resident had a history of climbing out of their geriatric chair when it was used during the day. A concurrent observation and interview on 05/12/2025 beginning at 3:56 PM revealed R1 was seated in a reclined geriatric chair in the dayroom area when the resident was observed to kick their legs over the left side of the geriatric chair in an attempt to rise to a standing position. NA #16 and another aide responded to the resident. NA #16 stated R1 had a known history of attempting to stand from their geriatric chair and indicated that when the resident wanted to get up, the resident would get up whether staff were there or not. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/12/2025 at 4:22 PM, NA21 stated she only worked at the facility occasionally, but she knew R1 often tried to get up from their geriatric chair without staff assistance. NA21 did not know where staff placed the resident's geriatric chair when the resident was put to bed. During an interview on 05/12/2025 at 4:25 PM, NA20 stated she was familiar with R1. She stated the resident had a long history of falls, attempted to get up from their geriatric chair without assistance from staff, and at times attempted to climb out of their geriatric chair. NA20 stated that during the day shift, staff tried to keep the resident up and walking when possible and allowed the resident to rest in standard chairs when needed. She stated she was not working on 01/25/2025 when R1 fell. During an interview on 05/14/2025 at 11:46 AM, NA #19 stated she primarily worked on R1's unit and was familiar with the resident. She recalled that she worked with R1 on 01/25/2025 during the day shift, and the resident was on 1:1 supervision during the day. She stated she and another aide provided 1:1 to the resident by rotating out during breaks. During a follow-up interview on 05/16/2025 at 10:10 AM, NA #19 stated staff knew they were assigned 1:1 responsibilities because it was listed on their assignment sheets. NA #19 said that R1 had various behaviors, including combativeness and getting up without assistance, and was sometimes difficult to redirect. NA #19 stated there had been times when a staff member called out that they did not have the staff available to provide 1:1 but in those situations, they usually took R1 to the hallway or a common area so everyone could keep a watch on the resident. During an interview on 05/15/2025 at 3:45 AM, LPN #23 stated she worked night shift but had not routinely worked on R1's unit until after the fall on 01/25/2025. LPN #23 stated she was unsure if R1 required 1:1 prior to the fall on 01/25/2025 but indicated that staff knew whether 1:1 was needed by reviewing the schedule, which indicated when a staff member was assigned 1:1 responsibilities. During an interview on 05/15/2025 at 4:15 AM, NA24 stated she worked the night shift, primarily on R1's unit but was not working the night of 01/25/2025 when the resident fell. NA24 stated that sometimes R1's geriatric chair was left in the hallway outside their room, and other times, it was left in the resident's room. She said that when the geriatric chair was left in the resident's room, it was placed against the resident's bed to prevent the resident from being able to get up from the bed easily in hopes the resident would not fall. NA24 reported that staff knew if a resident required 1:1 because it was listed on the schedule. During an interview on 05/13/2025 at 10:50 AM, RN #3, the Risk Management Nurse, stated that upon reviewing R1's electronic medical record (EMR), she determined the resident had sustained 16 falls since their admission to the facility in 03/2024. RN #3 stated the facility implemented 1:1 supervision as needed following a fall on 06/24/2024; however, she stated there was no documentation available for when 1:1 was provided. She further stated the resident had another fall in 09/2024 while in their room, and the facility added an intervention to use a geriatric chair for rest periods. RN #3 verified that the facility did not have any documentation for 1:1 supervision and stated she was unable to validate when 1:1 was provided for R1 or its effectiveness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/13/2025 at 2:27 PM, the Director of Nursing (DON) stated that on 01/25/2025, a nurse slid R1 to the floor for an assisted fall. She stated the resident sustained a bruise (to the eye/face), but the facility was unable to determine if another fall may have occurred prior to the nurse lowering the resident to the floor or what may have happened to cause the fracture that was later identified in the emergency room. She stated she did not recall knowing that the resident's geriatric chair was used in a reclined position up against the resident's bed. She further stated that it was not determined during the facility's investigation that R1 had a history of climbing out of their geriatric chair or over the geriatric chair from their bed. During an interview on 05/14/2025 at 2:45 PM with RN #3, the DON, the Assistant Director of Nursing (ADON), the Administrator, and the MDS Coordinator present, the DON stated that the nurse management team determined when 1:1 was needed for R1. She further stated they put 1:1 in place periodically when the resident was more agitated and then discontinued it once any behaviors had calmed down for 24 hours or so. RN #3 stated the resident used to work night shift and had their days and nights mixed up. The DON stated that when 1:1 was needed for the resident, they added an additional person to the schedule. During an interview on 05/14/2025 at 6:11 PM, the Administrator stated she first learned of the incident involving R1 when she arrived to work early on Monday, 01/27/2025, and noticed that R1 was at the nurses' station sitting in a standard wheelchair. The Administrator stated it was not R1's normal routine to use a standard wheelchair, so she asked staff what was going on with the resident. She stated she was informed that the resident had an assist fall and had started complaining of neck pain and was transferred to the ER for evaluation. The Administrator stated that the facility determined that they thought R1's injuries occurred as a result of the assisted fall. During an interview on 05/16/2025 at 8:45 AM, the facility's Former Scheduler stated she currently worked as a nurse aide but was the facility's scheduler from 04/2024 until 04/2025. The Former Scheduler stated that R1's unit usually only required two nurse aides during the night shift, but a third nurse aide was added if 1:1 was needed. The Former Scheduler stated she was unsure how it was determined when 1:1 was needed. She stated that for the night of 01/25/2025, if no one informed her 1:1 was needed, then she did not schedule anyone to provide 1:1 during the night shift. She further stated she only assigned someone the responsibility of 1:1 when instructed to do so by the DON. She stated she documented a 1:1 with a circle around it beside the staff member's name on the schedule to indicate they were responsible for providing the 1:1. R1's 01/2025 Documentation Survey Report revealed staff were monitoring for the presence of the following behaviors every shift: physical behavioral symptoms directed toward others, verbal behavioral symptoms directed towards others, other behavioral symptoms not directed toward others, wandering, and rejection of care. According to the Documentation Survey Report, staff documented the presence of the following behaviors in the days leading up to 01/25/2025: -01/19/2025 evening shift: verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others -01/20/2025 day shift: physical behaviors directed towards others, verbal behaviors directed towards others, other behaviors not directed towards others, rejection of care, and wandering (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-01/21/2025 day shift: physical behaviors directed towards others, verbal behaviors directed towards others, other behaviors not directed towards others, rejection of care, and wandering -01/22/2025 night shift: other behavioral symptoms not directed towards others -01/23/2025 evening shift: wandering -01/24/2025 evening shift: other behavioral symptoms not directed towards others -01/25/2025 day shift: wandering R1's 01/2025 Medication Administration Record (MAR) revealed the transcription of an order dated 01/13/2025 for lorazepam 1 milligram (mg) every eight hours as needed for anxiety and agitation. According to the MAR, the resident's as-needed lorazepam was administered due to increased anxiety and agitation twice on 01/20/2025; twice on 01/21/2025; and once on 01/22/2025, 01/23/2025, and 01/24/2025. The facility's Daily Schedule Breakdown revealed that 1:1 was noted on R1's unit during the dayshift on 01/25/2025; however, there was no indication 1:1 was in place during the evening or night shifts on 01/25/2025. During an interview on 05/16/2025 at 7:19 PM, the DON and Administrator were referred to the prior interview in which the DON stated 1:1 was initiated for R1 periodically when agitation was increased then was discontinued after the resident's behaviors had calmed down for 24 hours or so. They were then provided copies of the Daily Schedule Breakdown for 01/25/2025 that reflected 1:1 was initiated during the dayshift but not evening or night shifts. After reviewing the Daily Schedule Breakdown, the DON and Administrator both stated they would not have done 1:1 on just day shift, but they requested time to look at documentation they referred to as a breakdown sheet and come back and answer the question further. On 05/16/2025 at 9:10 PM, the DON, RN #3, and the Administrator returned to the conference room, and the DON stated they were unable to find the documentation they were looking for. RN #3 stated that during the time of R1's fall on 01/25/2025, they were only doing 1:1 during the 7:00 AM-7:00 PM shift because the resident was sleeping better at night. The surveyor then referred the DON, RN #3, and the Administrator to the resident's medical record, including the 01/2025 MAR that reflected the resident's as-needed lorazepam was administered multiple days leading up to 01/25/2025 and the 01/2025 Survey Documentation Report that indicated the resident had been experiencing behaviors leading up to 01/25/2025. After reviewing the information in the resident's record, the DON stated there had been no period of time where R1's behaviors and agitation resolved completely, but they had lessened during the timeframe of the resident's fall on 01/25/2025. The DON stated the administration of as-needed lorazepam for agitation was not considered when evaluating whether 1:1 was needed. The DON further stated the facility did not have any documentation of when 1:1 was provided for the resident, no documentation of how the facility evaluated for the effectiveness of 1:1 supervision, no documentation of what information nurse management considered when making the determination as to whether 1:1 was needed for the resident, and no documentation regarding how or when the decision was made 1:1 was no longer needed. The DON and Administrator both stated that having a resident on 1:1 for one shift but not the next was not the facility's normal practice. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/14/2025 at 9:28 AM, the Medical Director (MD) stated he was aware R1 had an incident on 01/25/2025 that resulted in a cervical neck fracture. He stated he was also aware the resident had an initial bruise noted to their eye from an unknown source. He stated he did not see how injuries such as the neck fracture and eye bruising could have occurred from the assist fall or control slide by the nurse. The MD stated he was not made aware that staff were placing the resident's geriatric chair along the side of the bed to prevent falls or that the resident had a history of climbing out of their geriatric chair or over their geriatric chair from the bed. The MD stated that in his professional opinion, the injuries sustained by the resident on the night of 01/25/2025 could have occurred as a result of the resident climbing out of their bed and over the geriatric chair if the resident fell while doing so or if they hit their head or neck in the process. During a follow-up interview on 05/16/2025 at 1:26 PM, the MD stated R1 should have required 1:1 supervision at the time of the incident on 01/25/2025. He further stated 1:1 should have been provided until the resident's behaviors were fully managed and controlled effectively. The MD stated it was the facility's responsibility to keep the residents safe at all times. He stated when investigating the circumstances of R1's injuries, the facility should have assessed environmental factors and conducted extensive interviews with staff, other residents if applicable, and anyone else that could have witnessed something in an attempt to determine root cause so that they could implement appropriate and effective interventions. An observation on 05/13/2025 beginning at 9:39 AM revealed R1 was lying in bed with their eyes closed without staff present in the room. A rolling computer chair was observed positioned against the bed on the resident's right side. While the surveyor remained in the room with R1, NA #16 entered the room. NA #16 stated the rolling computer chair was in R1's room for use by staff while providing 1:1 care, although the resident was not currently assigned to 1:1 care at the time of the observation. During an interview on 05/14/2025 at 2:45 PM with RN #3, the DON, the ADON, the Administrator, and the MDS Coordinator present, RN #3 and the DON stated the rolling computer chair was for staff to sit in when providing 1:1 to R1. The DON stated she hoped staff were removing the rolling computer chair from the resident's room when it was not in use. During an interview on 05/14/2025 at 6:11 PM, the Administrator stated she had made rounds on multiple days and saw the rolling computer chair in R1's room but had not thought about the chair being a hazard. During an interview on 05/16/2025 at 5:17 PM, the DON stated that having a rolling computer chair in R1's room when not in use by staff would be an accident hazard. She stated the rolling computer chair should not be in the resident's room if staff were not using it.