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	08/20/2025

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to ensure staff implemented the care plan for 1 (Resident (R)5) of 3 sampled residents reviewed for falls. Specifically, on 07/19/2025, a staff member attempted a bed-to-chair transfer for R5 with a mechanical lift, with only one staff member present. The mechanical lift malfunctioned, and the resident fell to the floor. Findings include: Review of a facility policy titled Care Plans, Comprehensive Person-Centered, dated 03/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of an admission Record revealed the facility admitted R5 on 09/26/24. According to the admission Record, the resident had a medical history that included, but was not limited to, diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other specified disorders of bone, morbid (severe) obesity due to excess calories, transient cerebral ischemic attack, and chronic diastolic congestive heart failure. Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/25 revealed R5 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff assistance to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and for transferring to and from a bed to a chair. Review of R5's Care Plan Report included a problem statement initiated on 10/03/24 that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to lack of coordination, weakness, and a cerebrovascular accident (CVA) history. An intervention initiated on 10/03/24 directed the staff to provide two-person assistance with a mechanical lift for transfers. Review of R5's Visual/Bedside Kardex Report (a documentation system used by nursing staff that directs patient care), dated 08/20/25, indicated the resident required substantial/maximal assistance of two staff for bed mobility. The report also indicated the resident required a mechanical lift with the assistance of two staff for transfers with a large sling. Review of a Progress Note dated 07/19/25 at 3:58 PM and signed by Registered Nurse (RN)1, revealed Certified Nursing Assistant (CNA)2 notified the nurse that R5 fell from the mechanical lift during a transfer from the bed to the wheelchair. The Progress Note revealed that when RN1 entered the room, R5 was observed seated on the floor with the mechanical lift pad beneath the resident. The Progress Note revealed the sling attachment bar was lying across the resident's body. The Progress Note indicated R5 was conscious but did not verbally respond to questions and could not give any details concerning the fall. The Progress Note indicated R5 was assessed and showed no signs of pain or obvious injury. Per the progress note, CNA2 was directed to call 911 for emergency response services, emergency medical services (EMS) arrived, and the resident was transported to the hospital. Review of a document titled [Facility name] Witness Interview/Statement Form signed by CNA2 on 07/19/25 revealed that CNA2 was in the hall when CNA3 asked her to come to R5's room. Per the statement, when CNA2 entered the room, R5 was lying on the floor with part of the mechanical lift on the resident's stomach. The statement indicated CNA2 got RN1, and RN1 directed the CNA to call 911. Review of a document titled [Facility name] Witness Interview/Statement Form signed by CNA3 on 07/19/25 revealed that on 07/19/25 at approximately 10:30 AM, CNA3 was assisting R5 with a transfer using the mechanical lift. The statement indicated, During the transfer process, I noticed that the lift appeared to malfunction (the bar dislodged). As a result of the malfunction, the resident slipped to the floor while still inside the sling. During an interview on 08/19/25 at 9:11 AM, R5 stated there was only one staff member present for the transfer on 07/19/25. R5 stated the aide knew how to use the mechanical lift, and she tried to get another person to assist, but no one was available. R5 stated the resident fell straight down and tipped to the left and had no fractures from the incident. During an interview on 08/19/25 at 1:18 PM, the Director of Nursing (DON) stated she was notified of R5's fall during a transfer with a mechanical lift. She stated she came to the facility the day of the incident and saw the resident when the resident returned from the hospital. CNA3 told her she was aware R5 was a two-person assist for transferring, but everyone was busy, and she did not want to bother anyone. During an interview on 08/19/25 at 3:24 PM, RN1 stated the CNAs had access to the Kardex to determine the care needs for a resident. During a phone interview on 08/20/25 at 1:46 PM, CNA3 stated she did not look at the resident's Kardex. CNA3 stated that during Coronavirus disease (COVID) they had a lack of CNAs, and she got accustomed to doing a mechanical lift by herself, and she knew that was a no, no. CNA3 stated, I do take responsibility for that. She stated R5 wanted to get up out of bed, and she looked in the hallway and did not

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and review of the owner's manual for Model: F600B Bariatric Full Body Patient Lift, the facility failed to ensure staff safely transferred 1 (Resident (R)5) of 3 sampled residents reviewed for falls. Specifically, on 07/19/25, a staff member failed to follow the resident's care plan and ignored the noises emitted from the mechanical lift when she assisted the resident with a transfer from their bed to their wheelchair. During the transfer, the mechanical lift malfunctioned, and R5 fell to the floor. Findings include: Review of a document titled Competency Assessment Lifting Machine, Using a Mechanical, revised on 07/2017, revealed, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. The Steps in the Procedure section revealed, 8. Make sure that all necessary equipment (slings, hooks, chains, straps and supports) is on hand and in good condition.An Owner's Manual for the Model: F600B Bariatric Full Body Patient Lift, undated, under the section titled, Operating Instructions, revealed, Double check all assemblies for tightness and read operating instructions carefully prior to use. The section titled, Maintenance & Inspection, revealed, The operator of the lift shall inspect the [name brand] lift before each use. Check all bolts for tightness. Make sure the base can be easily widened, and that all lift parts are in place.Review of an admission Record revealed the facility admitted R5 on 09/26/24. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other specified disorders of bone, morbid (severe) obesity due to excess calories, transient cerebral ischemic attack, and chronic diastolic congestive heart failure.Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/10/25, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff assistance to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and for transferring to and from a bed to a chair.Review of R5's Care Plan Report, included a problem statement initiated on 10/03/24 that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to lack of coordination, weakness, and a cerebrovascular accident (CVA) history. An intervention initiated on 10/03/24 directed the staff to provide two-person assistance with a mechanical lift for transfers.Review of R5's Visual/Bedside Kardex Report (a documentation system used by nursing staff that directs patient care), dated 08/20/25, indicated the resident required substantial/maximal assistance of two staff for bed mobility. The report also indicated the resident required a mechanical lift with the assistance of two staff for transfers with a large sling.Review of an Incident Log, dated 08/18/25, indicated R5 had a fall on 07/18/25 at 11:00 AM.Review of a Progress Note, dated 07/19/25 at 3:58 PM and signed by Registered Nurse (RN)1, revealed Certified Nursing Assistant (CNA)2 notified the nurse that R5 fell from the mechanical lift during a transfer from the bed to the wheelchair. The Progress Note revealed that when RN1 entered the room, R5 was observed seated on the floor with the mechanical lift pad beneath the resident. The Progress Note revealed the sling attachment bar was lying across the resident's body. The Progress Note indicated R5 was conscious but did not verbally respond to questions and could not give any details concerning the fall. The Progress Note indicated R5 was assessed and showed no signs of pain or obvious injury. Per the progress note, CNA2 was directed to call 911 for emergency response services, emergency medical services (EMS) arrived, and the resident was transported to the hospital.Review of a hospital report, dated 07/19/25, under the section titled History of Present Illness, indicated R5 sustained a fall while being transferred by a mechanical lift. The section titled Activity Restrictions or Additional Instructions revealed the resident's trauma workup was negative for acute fracture or traumatic injury, and a lytic lesion was identified that was concerning for malignancy versus metastatic disease.Review of a typed document, dated 07/19/25 and signed by the Director of Nursing (DON), revealed they received a phone call from RN1 at 12:01 PM. The document indicated RN1 reported R5 fell from a mechanical lift, and the RN was sending the resident to the hospital. Per the document, RN1 reported the mechanical lift malfunctioned, causing the fall. The document further revealed that CNA3 reported that when she was lifting the resident up from the bed, she noticed the mechanical lift was making a funny noise but did not think anything about it because mechanical lifts make noises (which was normal). The document revealed the facility concluded the incident was attributed to poor judgement made by CNA3. The report revealed CNA3 was removed from the facility, not to return.Review of a document titled [Facility name] Witness Interview/Statement Form, signed