STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425074	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C M Tucker Jr Nursing Care Center Fewell and Stone	2200 Harden Street Columbia, SC 29203

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, record review, and interview, the facility failed to protect Resident (R)1 from physical abuse. Specifically, Certified Nursing Assistant (CNA)1 pinched the nose of R1, resulting in R1 suffering injuries to the face.On 12/17/25 at 7:28 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 09/19/25. The IJ was related to 42 CFR 483.25 - Freedom from Abuse, Neglect, and Exploitation.On 12/18/25 the facility provided an acceptable IJ Removal Plan. On 12/18/25 the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. The SA is considering the IJ at Past Non-Compliance as of 09/19/25.An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F600, constituting substandard quality of care.Findings include:Review of the facility policy titled Freedom From Abuse, Neglect and Exploitation with a last revision date of 01/2017 revealed, To keep residents free from abuse, neglect, and corporal punishment of any kind by any person. For the purpose of this policy, abuse will be identified as willful infliction of injury, unreasonable confinement intimidation, or punishment with resulting physical harm, pain, or mental anguish. 1. Staff will be trained in the types of abuse and neglect. 2. Staff will be trained and knowledgeable in how to react and respond to resident behavior. 3. When the facility has identified abuse, the facility should take appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. Review of the facility Timeline of Events dated 09/15/25 between 8:00 AM and 8:30 AM revealed: [Certified Nursing Assistant (CNA)1] was assisting [R1] with ADL care. [Licensed Practical Nurse (LPN)1] was outside of [R1's] room preparing his medication. [LPN1] heard [R1] yelling but she could not understand what was being said. [CNA1] exited resident's room and stated [R1 called her a n****r b***h [LPN1] stated that there was nothing she could do about it. [LPN1] told [CNA1] that she could switch assignments if she wanted to. [CNA1] stated No, I have something for that. [LPN1] finished prepping the resident's medication. [LPN1] entered the resident's room. [CNA1] informed [LPN1] in a joking tone that she had pinched the resident's nose for calling her those ugly words. [LPN1] responded that she was not doing any incident reports today. [CNA1] stated, I did not do that. Approximately 04:00 PM [LPN1] went in to [R1's] room to do his wound treatment. [CNA1] immediately entered [R1's] room behind [LPN1]. [R1's] nose, mid forehead and above right eyebrow was discolored and purple. [LPN1] informed [CNA1] that she was writing this incident up. [CNA1] went and got a cream off of the treatment cart and stated, put this on it, this will clear it up. [LPN1] stated that she was not putting that cream on the resident. [LPN1] reported the incident to the supervisor. [CNA1] was removed from the unit by [Registered Nurse (RN)1] and taken to the supervisor's office. [CNA1] admitted to pinching the resident's nose. [CNA1] stated that she was triggered by the resident calling her a n****r b***h. [CNA1] remained in the supervisor's office while [RN1] notified the Director of Nursing and Administrator. Director of Nursing and Administrator took over the investigation. [CNA1] was suspended and escorted from the facility. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, oropharyngeal phase, restlessness and agitation and vascular dementia. Review of R1's 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/09/25 revealed R1 had a Brief Interview for Mental Status (BIMS) score of 99 due to the resident being rarely or never understood. Further review of the MDS revealed R1 had not exhibited any physical or verbal behaviors during the look back period.Review of R1's Progress Notes revealed no progress notes in R1's medical record related to this incident.Review of R1's Care Plan revealed R1 had potential for escalating behaviors when receiving care from staff at times, related to mood disorder, evidenced by using racial profanity and attempting to strike out with a start date of 09/19/25 after the incident. Approaches included ensure resident safety, discontinue care, and report behaviors to the nurse. Review of CNA1's Witness Statement dated 09/15/25 at 5:15 PM revealed, I was working with [R1] this morning doing patient care about to get him wash up he call me out my name the N word and a b***h. [R1] was saying that most of the time I was in their. I told him don't talk to me like that talk to me like you want me to talk to you and he still calling me out my name. I playful pinch his nose I did not do it to hurt him and then I turn him, he hit his head and nose on the bedrell [sic]. I walk out room I told [LPN1] that him was calling me out my name (and before I play pintch [sic] him, his nose was already red.) She ask me do I want to change with someone. I think I told [LPN1] no but I don't