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	05/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and interviews, the facility failed to ensure the protection of Resident (R)36's privacy during patient care. Specifically, during a dressing change, Laundry Staff 1 entered the resident's room without requesting permission to enter. Findings include: Review of the facility policy titled Clean Dressing Change effective April 2024, states, 1. Every resident has the right to privacy. No one should enter a resident's room without first knocking on the door, waiting for a response and only entering with permission. If there is no response, then knock again, and announce your name and the reason for entering the room. Review of R36's Face Sheet revealed R36 was admitted to the facility on [DATE], with diagnoses including but not limited to: injury at T7-T10 of thoracic spinal cord, pressure ulcer of unspecified site, stage 4, paraplegia, pressure ulcer of right buttock, stage 4, and pressure ulcer of left buttock, unstageable. Review of R36's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R36 was cognitively intact. During an observation on 05/15/25 at 2:41 PM, Laundry Staff 1 knocked on R36's door and proceeded to come into the room. Registered Nurse (RN)2 and Certified Nursing Assistant (CNA)2 yelled patient care several times. Laundry Staff 1 continued to enter the room. Laundry Staff 1 left the door wide open and proceed to get the laundry out of the room. During an interview on 05/15/25, at an unspecified time, Laundry Staff 1 stated, I didn't hear the staff telling me not to enter the room. I just come in and get the linen baskets and leave the room. During an interview on 05/15/25 at 3:48 PM, the Director of Nursing (DON) stated, My expectation with the staff is if anyone knocks on the door I expect for them not to enter the room if staff says they are conducting patient care.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, video footage, and interviews, the facility failed to ensure Resident (R)45 was free from physical abuse from Certified Nursing Assistant (CNA)1. Findings include: Review of the facility policy titled, Protection from Harm Policy last revised, November 2024 revealed A significant aspect of residents' rights is the right to be free from abuse/neglect. The facilities of C. M. [NAME], Jr. Nursing Care Center have a 'zero tolerance' for any type of abuse. A. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. Willful as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. G. Mistreatment means inappropriate treatment or exploitation of a resident. I. Physical Abuse means hitting, slapping, pinching, kicking, and includes controlling resident behavior through corporal punishment. Review of R45's Face Sheet revealed R45 was admitted to the facility on [DATE], with diagnoses including, but not limited to: dementia, depression, difficulty in walking, history of falling, other lack of coordination, and unsteadiness on feet. Review of R45's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/09/25, revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severe cognitive impairment. Review of surveillance video footage provided by the facility, recorded on 05/13/25 at 3:23 PM, revealed R45 in the unit day area attempting multiple times to headbutt, punch, and kick CNA1. CNA1 then attempted to move in front of R45, who tripped her with his foot/leg. CNA1 then turned to face R45, grabbed and lifted his leg to her hip level, held it there for a few moments, then dropped it back down while saying something to R45 before walking away and the video ends. Review of CNA1's Notice of Termination dated 04/24/25, revealed, After reviewing statements and video footage for Friday, April 18, 2025, you were observed in the main hallway on your unit turning a patient around in his wheelchair. This action resulted in the resident becoming combative, and he began swinging his fist and kicking his feet at you. You grabbed the patient's legs, saying to him, I'm not the one! You then dropped the patients' legs back to the floor. During an interview with R45 on 05/13/25 at 3:29 PM, revealed he could not recall anything from the incident with CNA1. R45 stated he tried to avoid negative encounters if he can. The resident denies being fearful for his life. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Physical Therapist (PT) on 05/14/25 at 10:08 AM, revealed the incident occurred in the day area on Unit 122 (secure/all male unit). R45 was considered a new admission at that time. The PT stated she was coming down the main center hall. Once she reached the entrance to the day area, she saw R45 head-butt CNA1. The PT explained she was distracted by another resident on her left side. She turned around and walked back towards R45 because he was her patient that day for therapy. She saw R45 punching CNA1 but was unable to recall if he connected with the punches. The PT expressed uncertainty about whether he tried to kick the CNA or attempted to trip her. She observed CNA1 standing in front of the resident, locking his wheelchair and grabbing his legs at her waist level. CNA1 said something to the resident about a problem, but she couldn't recall exactly what was said at that time. The tone of her (CNA1) voice was stern. The PT reported that she walked up to intervene, expressing that she was taken aback and instructed everyone to step away to cool off. R45's nurse was nearby at the cart. The PT stated she notified the DON (Director of Nursing) about the incident. The PT mentioned that R45 has a history of behaviors; however, he had not displayed them with her. During a phone interview with Licensed Practical Nurse (LPN)1 on 05/14/25 at 10:27 AM, revealed she witnessed the event and was R45's nurse on the day of the incident. R45 was a new admission at the time and had a history of dementia with behaviors. LPN1 stated that while she was standing at the med cart, she saw CNA1 forcibly move R45's wheelchair. R45 responded by trying to headbutt CNA1 by throwing his head backward. CNA1 then walked beside R45, and he attempted to punch her. CNA1 then walked in front of R45's wheelchair, where he tried to trip her and then kicked at her. CNA1 then grabbed both of R45's legs and pulled them up into the air while telling the resident, I'm not the one, in a loud, aggravated tone, and then dropped his legs down, slightly rocking R45's wheelchair before walking off. LPN1 stated that initially, she was in shock; she assessed the resident, and he appeared to be fine at baseline with no injuries following the encounter. During a phone interview with CNA1, on 05/14/25 at 11:20 AM, revealed she had been employed at the facility for approximately a year. CNA1 confirmed that she was R45's aide and recalled the encounter with R45. CNA1 stated that she began to move R45's wheelchair from the middle of the hallway. R45 started to attempt to headbutt her in the stomach/abdomen area. CNA1 stated she turned R45 away from other residents, and he began to punch and kick her. CNA1 admitted to grabbing R45's legs and lifting them to her hip level before releasing them. She indicated that she was not going to bend over and place R45's legs on the ground. CNA1 reported that she told R45, I'm not the one that bothered you, I'm not the one and noted that other staff and residents were present during this encounter. CNA1 mentioned that she was suspended pending investigation, and a few days later terminated due to the allegation of physical abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Facility Administrator (FA) in the presence of the Director of Nursing (DON) on 05/15/25 at 1:51 PM, revealed he is responsible for the investigating and submissions of reportable's, with the assistance of the DON. The FA revealed he was notified of R45's incident related to physical abuse on 04/18/25 by the DON. The FA states he was told that R45 became aggressive with CNA1, and CNA1 lifted R45's legs and held his legs up for a few seconds, then dropped them back down. The protocol was followed, and CNA1 was suspended following the allegation and escorted from the facility. The FA stated that, per clinical staff, R45 was assessed and had no apparent injuries. R45's Representative (RP), and Medical Director (MD) were notified of the alleged event. The FA revealed he ran the video footage back and saw CNA1 lift R45's legs immediately after R45 attempted to trip her. She held his legs up at her waist height for a moment. She then dropped R45's legs to the floor and returned to assisting other residents. The FA agrees that the lifting of the resident's legs to her waist height and dropping them was not acceptable and deems these actions to have been unnecessary. CNA1 should have walked away and allowed R45 to cool down, but she did not follow the process. Three unsuccessful attempts were made to contact R45's RP via phone on 05/13/25 at 3:40 PM, 05/14/25 at 10:05 AM, and 1:07 PM.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policy, observation and interview, the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents. Findings include: Review of an undated facility policy titled Storage of Medication on Units states, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Review of the facility policy titled Medication Administration: Oral effective October 2024, states, Procedure: . Key Points/Rationale: No medications or scissors should be on Top of medication cart when nurse steps away. During an observation on 05/14/25 at 8:22 AM, Registered Nurse (RN)1 walked away from the medication cart on Hall 122 with Metoprolol (a blood pressure medication) sitting on top of the cart. RN1 then leaves and enters a residents room. During an interview on 05/15/25, RN1 stated, It is not my regular procedure of leaving medications on the cart. I thought I took it with me. During an interview on 05/15/25 at 3:48 PM, the Director of Nursing (DON) stated, [RN1] is a night nurse. She was helping filling a shift. She was nervous. She did come tell me she may have forgot to do something.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food was handled in a sanitary manner to prevent cross-contamination in the main kitchen. This deficient practice had the potential to affect all residents who request alternative and/or extra trays from the kitchen. Findings include: During a dining observation on 05/13/25 at approximately 11:25 AM, both independent and dependent residents were observed being brought into the main dining room, located outside the main kitchen, along with facility staff. The Dining Services Supervisor (DSS) and a Dietary Aide (DA) transported retherm carts into the dining room. The DA opened one of the retherm carts and removed six individual covered meal trays that had not been served. These trays were untouched and were removed directly from the hot box compartment of the cart. The DA then transported these six trays to the soiled area of the kitchen. The trays were placed one by one on a two-tiered metal cart located near the dishwasher, two soiled trash cans and a bucket containing a soiled mop and dirty mop water. The DA then returned to the dining room, performed hand hygiene, and began assisting nursing aides with passing out meal trays to residents. During an interview on 05/13/25 at 11:45 AM, the Dining Services Supervisor (DSS) acknowledged the observation and findings. The DSS stated that the trays placed on the metal cart were extras and that if nobody needed an extra tray or a substitution, they would be discarded. The DSS stated that regardless of whether a resident needs an extra tray or not, meals that could potentially be eaten do not need to be stored in that area. During an interview on 05/13/25, at 2:06 PM, the Dining Services Manager (DSM) stated that her expectation is that substitution or extra trays are to remain on the cart to prevent potential cross-contamination. She stated the trays are not to be placed in soiled work areas if there is a potential for consumption. The DSM stated that to alleviate the concern, she would discuss the issue with the dietary staff. During an interview on 05/15/25 at 11:08 AM, the Director of Nursing (DON) stated that trays are to be kept in the retherm cart until the nursing department confirms whether any residents need additional or extra trays. The DON stated that once all residents have eaten and there is no need for extra trays, then the trays can be removed from the hot box and discarded.