STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425107	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sumter East Health & Rehabilitation Center	880 Carolina Avenue Sumter, SC 29150

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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 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, interview, and facility policy review, the facility failed to ensure food was stored off the floor, failed to label, date, and cover stored food, and failed to discard food with expired use by or best by dates in two of two facility kitchens. These failures had the potential to create an environment for food-borne illnesses which could affect 165 residents who consumed food prepared from the facility's two kitchens.Findings include:Review of the facility's undated policy titled, Date Marking for Food Safety, indicated, Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. Policy Explanation and Compliance Guidelines for Staffing: 1. Refrigerated, ready-to-eat, time/temperature control for safety food (i.e. perishable food) shall be held at temperatures of 41 [degrees] F [Fahrenheit]. for a maximum of 7 days. 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded . 4. The marking system shall consist of a food label, the day/date of opening, and the day/date the item must be consumed or discarded. 5. The discard day or date may not exceed the manufacturer's use-by date, or three days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Thursday.) . Review of the facility's undated policy titled, Food Safety Requirements, indicated, Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by the federal, state, and local authorities. Food will also be stored, prepared, distributed, and served in accordance with professional standards for food service safety . Policy Explanation and Compliance Guidelines: . 3b. Dry food storage - keep foods/beverages in a clean, dry area off the floor . c. Refrigerated storage - . iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; and v. Keeping foods covered or in tight containers .1. Observation on 03/08/26 from 6:50 AM to 7:20 AM, during the initial inspection of the facility's [NAME] kitchen revealed the following food storage concerns:a. In the kitchen's dry storage room a crate which housed 24 four-ounce containers of thickened cranberry juices was stored directly on the floor.b. The kitchen's walk-in refrigerator contained an opened and undated package of American cheese slices, two opened and undated packages of Swiss cheese, an opened and undated one gallon container of mayonnaise, two large opened and cut fully cooked hams which were labeled with an opened date of 02/17/26, but were not labeled with a use-by or discard date, and four five pound containers of cottage cheese with expired manufacturer's use by dates of 03/07/26. c. The kitchen's walk-in freezer contained three large plastic bags of dumplings and one large box of garlic bread that were stored open to air and not protected from possible contamination.On 03/08/26 at 7:25 AM DD1 was shown each of the above food storage concerns that were identified in the facility's [NAME] kitchen and he observed and confirmed each concern.During an interview on 03/08/26 at 7:35 AM, DD1 stated when staff placed food into storage, the food should be completely covered, dated, labeled, and stored off the floor. DD1 also stated food with expired use by, or expiration dates should be discarded.During an interview with on 03/10/26 at 12:05 PM, DD1 stated the two large fully cooked hams that were observed on 03/08/26 stored in the [NAME] kitchen's walk-in refrigerator that were labeled as opened on (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	02/17/26 should have been discarded by staff seven days after their open date.2. Observation on 03/08/2026 from 9:50 AM to 10:10 AM, during the initial inspection of the facility's East kitchen, with DD2 present, revealed the following food storage concerns:a. The kitchen's walk-in refrigerator contained one opened and undated package of shredded Swiss cheese, three large plastic packages of cut lettuce, which had slight browning on some of the lettuce, that had expired manufacturer's best by dates of 03/03/26 on each bag, one five-pound container of cottage cheese with an expired manufacturer's use by date of 03/07/26, and one box of egg patties that were stored opened to air and not protected from possible contamination.During an interview on 03/08/26 at 10:00 AM, DD2 stated staff should check stored food and discard any food found with an expired expiration date. DD2 also stated staff should date food when opened and completely close food when stored.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interviews, record review, and facility policy review, the facility failed to complete an assessment of the building to determine where Legionella and other opportunistic waterborne pathogens can grow and spread. Additionally, there was no diagram of the water maintenance as it flows through the facility. This had the potential to affect 168 of 168 residents who resided at the facility. These failures had the potential to allow for the growth of waterborne pathogens to be unnoticed and placed residents at risk for the spread of infections. Findings include:Review of the facility's Infection Prevention and Control Program under number 17, indicated, Water Management, provided by the facilities, infection preventionist, revealed an assessment of the building was not completed where Legionella could grow and spread. a. A water management program has been established as part of the overall infection prevention and control program. b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The Maintenance Director serves as the leader of the water management program.During an interview on 03/09/26 at 3:42 PM, the Maintenance Director (MD) provided a drawing that showed where water entered both buildings of the facility and indicated where the shut-off valves were for the water supply. The drawing did not indicate the water flow throughout the facility or areas of potential stagnation where the growth of waterborne pathogens, including Legionella could occur. The MD confirmed he had not completed a building assessment and was unaware one was needed for the water management programDuring an interview on 03/09/26 at 4:10 PM, the MD provided blueprints of the two buildings that made up the facility. Review of the blueprints revealed the blueprints were original and had not been updated to show the current water flow in the buildings.During an interview on 03/10/26 at 12:29 PM, the Administrator confirmed the drawings provided by the MD only showed the shut-off locations for the water supply. The Administrator confirmed there was not a building assessment completed to show areas where waterborne pathogens could grow.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one of 20 supplemental residents was assessed for self-administration of medications Resident (R) 177. R177 had seizure medications at her bedside; however, she had not been assessed for or ordered by her physician to be able to self-administer her medications. This failure placed the resident at an increased risk of seizure activity if the medications were not administered as ordered by the physician. Findings include:Review of the facility's policy titled, Resident Self-Administration of Medication, dated 2025, revealed, A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely . When determining if self-administration is clinically appropriate . the results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record . Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication.Review of R177's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with a diagnosis of altered mental status.Review of R177's Brief Interview for Mental Status (BIMS) assessment dated [DATE], located under the Assessments tab of the EMR revealed the facility assessed the resident to have a BIMS score of eight of 15 which indicated she was moderately cognitively impaired. During an observation on 03/08/26 at 10:37 AM of R177's room revealed on the resident's bedside table was a small souffle cup that contained two large blue and white medication capsules. R177 was not in her room and was observed walking down the hallway. At 10:42 AM, R177 entered the room and stated she had forgotten about her medications on the table and was supposed to take them earlier.During an observation and interview on 03/08/26 at 10:43 AM in R177's room, Licensed Practical Nurse (LPN) 1 confirmed the souffle cup with blue and white medication capsules was present on R177's bedside table. LPN1 stated the medication should not have been left in the resident's room unattended. LPN1 encouraged R177 to take her medications, and R177 swallowed the pills. LPN1 stated the pills were Depakote [anti-seizure medication] and were given to R177 around 9:30 AM. LPN1 stated she thought R177 had taken the pills and did not realize they were left in her room unattended. LPN1 stated R177 was unable to self-administer medications. Review of R177's physician Order, dated 03/05/26 and located in the resident's EMR under the Orders tab revealed an order for 125 milligrams of Depakote capsules to be administered twice daily for seizures The order specified the morning dose should be given at 9:00 AM.Review of R177's EMR under the Assessments tab revealed no assessment of the resident's ability to self-administer medications or safety with keeping medications at her bedside.During an interview on 03/10/26 at 5:00 PM, the Director of Nursing (DON) stated it was her expectation the nursing staff watch residents swallow their medication. The DON also stated she expected nurses never to leave medications at the bedside unattended unless a resident had been assessed to be able to self-administer medications.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure one of five residents Resident (R)18 reviewed for unnecessary medications out of a total sample of 35 had adequate indication for the use of an antipsychotic medication. R18 was ordered Seroquel (Quetiapine), an antipsychotic medication for schizophrenia, without documented evidence of the diagnosis. This failure placed the resident at risk of receiving unnecessary medications. Findings include:Review of the facility undated policy titled, Restraint Free Environment revealed, . If a medication was initially administered for a medical symptom and continues to be administered in the absence of such symptom, the facility should re-evaluate the need for such medication to ensure that it does not sedate the resident or make it easier for the staff to care for the resident . Review of R18's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted on [DATE] with diagnoses that include senile degeneration of brain, dementia with behavioral disturbance, and psychosis not due to substance or known physiological condition.Review of R18's Preadmission Screening and Resident Review (PASARR) with a screening date of 06/25/25 and located under the Miscellaneous tab of the electronic medical record (EMR) revealed no documented evidence of a mental illness.Review of R18's Order Summary Report, located under the Orders tab of the EMR, revealed a physician's order for Quetiapine Fumarate Oral Tablet 100 milligrams (mg) one tablet by mouth two times a day for schizophrenia. Review of R18's Care Plan, dated 07/16/25 and located under the Care Plan tab of the EMR, revealed the resident was not care planned for schizophrenia. It was documented that R18 was receiving antipsychotic medications related to psychosis/ behavior management. Review of the Consultant Pharmacist Recommendations to Physician, dated 12/07/25 and provided by the facility, revealed R18 had been taking quetiapine 100mg twice a day since 07/09/25 without a Gradual Dose Reduction (GDR). Pharmacist recommendation was to attempt a dose reduction at this time to quetiapine 50 mg once in the morning and 100mg once at night to verify the resident was on the lowest possible dose. It was recorded the physician agreed with recommendation to have the resident's dose reduced to 75mg twice daily. Review of R18's Order Summary, located in the EMR revealed no documented evidence the gradual dose reduction was initiated. Review of R18's of Progress Notes, dated 02/08/26 through 03/07/26 and located under the Progress Notes tab of the EMR, revealed no documentation of R18 experiencing behaviors.Review of R18's Medication Administration Record (MAR), dated 03/01/26 through 03/09/26 and located under the Orders tab of EMR, indicated R18 had behaviors. R18 was observed not having any behaviors during the survey process.During an interview on 03/10/26 at 10:48 AM, the Director of Nursing (DON) confirmed the resident did not have a proper schizophrenia diagnosis and that a GDR should have been started. The DON also confirmed the GDR recommended for R18 was not followed. The DON revealed she would look for PASARR results when a resident is prescribed an antipsychotic but missed R18. During an interview on 03/10/26 at 3:18 PM, the Registered Pharmacist Consultant (RPHC) confirmed she was not familiar with R18 and that R18's Seroquel order noted the resident had schizophrenia. The Pharmacist confirmed she did not question the use of Seroquel in the monthly reviews because the order was signed by the provider for schizophrenia.An attempt was made to contact the Medical Director during the survey, but he was unreachable.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, interviews and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected a facility fall for one of three residents reviewed for falls Resident (R)150 out of a total sample of 35. This failure had the potential to lead to lack of care plan interventions to prevent falls. Findings include:Review of the facility's undated policy titled, MDS 3.0 Completion revealed, . Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections.Review of R150's admission Record, located under the Profile tab of the electronic medical record (EMR), indicated R150 was admitted on to the facility on [DATE] with diagnoses of acquired absence of right leg below knee (BKA), lack of coordination and abnormalities of gate and mobility.Review of R150's Progress Note, dated 01/17/26 at 1:39 PM and located under the Progress Notes tab of the EMR, revealed, Staff was alerted that resident was on the floor. Upon entering staff observed resident lying on his left side parallel to his bed. The resident's head was resting against the nightstand beside his bed . Review of R150's admission MDS, with an Assessment Reference Date (ARD) of 01/19/26 and located under the MDS tab of the electronic medical record (EMR), revealed the assessment did not indicate the resident had a fall while in the facility. During an interview on 03/10/26 at 10:48 AM, the Director of Nursing (DON) confirmed R150 had a fall in the facility on 01/17/26 and the admission MDS dated [DATE] was inaccurate and should have reflected R150's fall in the facility.During an interview on 03/10/26 at 2:53 PM, the MDS Coordinator (MDSC) 2 confirmed R150 had a fall in the facility on 01/17/26 and the MDS with an ARD date of 01/19/26 was inaccurate and should have reflected R150's fall in the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to ensure the comprehensive care plan was developed to accurately reflect the indication of the resident's use of an antipsychotic medication for one of five sampled residents Resident (R)18 reviewed for unnecessary medications out of a total sample of 35. This failure placed the resident at risk of staff not meeting the resident's care needs. Findings include:Review of the facility's undated policy titled, Comprehensive Care Plan, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . The care planning process will include an assessment of the resident's strengths and needs . The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .Review of R18's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R18 was admitted on [DATE] with diagnoses that included major depressive disorder.Review of R18's Care Plan, dated 05/01/25 and located under the Care Plan tab of the EMR, revealed R18 received an antipsychotic medication related to insomnia. Review of R18's Order Summary Report, located under the Orders tab of the EMR, revealed and order dated 12/09/25 for Risperdal (an antipsychotic medication) one milligram (mg) one tablet orally at bedtime for depression. Review of R18's Order Note, dated 12/09/25 and located under the Progress Notes tab of the EMR, revealed the resident was ordered Risperdal one mg tablet to be given at bedtime for depression. Review of R18's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/15/26 and located under the MDS tab of the EMR, revealed R18 had a Staff Interview for Mental Status (SAMS) score of three, which indicated the resident was severely cognitively impaired. It was recorded the resident received antipsychotic medications during the lookback period.During an interview on 03/10/26 at 2:50 PM, the MDS Coordinator (MDSC) 2 confirmed that R18 was ordered Risperdal for depression and care planned for Risperdal with insomnia. MDSC2 confirmed the care plan should match the physician's order and be specific to the diagnosis.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure one of 35 sampled residents Resident (R)6 care plan was revised to reflect the resident's end of life wishes. R6's wishes was to be a Do Not Resuscitate (DNR); however the resident's care plan documented the resident wanted to receive life saving measures of cardio-pulmonary resuscitation (CPR) in the event her heart stopped or she stopped breathing. This failure placed R6 at risk to receive CPR against her wishes for a natural death, potentially causing serious injury from compressions or psychosocial harm related to her preference not being honored. Findings include:Review of the policy titled, Comprehensive Care Plans, dated 2025, revealed, The comprehensive care plan will describe, at a minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicablephysical, mental, and psychosocial well-being'b. Any services that would otherwise be furnished, but are not provided due to the resident'sexercise of his or her right to refuse treatmentc. The resident's goals for admission, desired outcomes, and preferences for future discharge.d. Discharge plans. as appropriate.e. Resident specific interventions that reflect the resident's needs and preferences and align withthe resident's cultural identity, as indicated.Review of R6's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including stroke, diabetes, heart failure, and encephalopathy.Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located under the MDS tab of the EMR, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS), score of three out of 15 which indicated the resident was severely cognitively impaired. Review of R6's EMR home page revealed her code status was DNR [Do Not Resuscitate]. Review of R6's National POLST [Portable Orders for Life-Sustaining Treatment] Form, located under the Miscellaneous tab of the EMR dated [DATE], revealed R6's representative with legal decision-making authority elected DNR status.Review of R6's EMR under the Orders tab revealed a physician's order, dated [DATE], for Do Not Resuscitate - DNR.Review of R6's Care Plan initiated [DATE], revised [DATE], and located under the Care Plan tab of the EMR revealed, I . choose to have CPR [cardio-pulmonary resuscitation]. The goal was, I will have all of my wishes and advanced directives honored until I request otherwise, or until the next review period. The approaches included, Please provide CPR.During an interview on [DATE] at 10:14 AM, Licensed Practical Nurse (LPN) 4 stated R6's code status was DNR. She stated the first place to look was the report sheet or code status book, which showed R6 had a DNR status. LPN1 stated she could also look in the EMR under the resident's home page, which also indicated DNR status.During an interview on [DATE] at 11:36 AM, the MDS Coordinator (MDSC) stated R6's Care Plan was done on [DATE] and her DNR order was dated [DATE], so the Care Plan should have been updated at that time to reflect a DNR status. The MDSC stated typically, the Social Services Director (SSD) would update the DNR paperwork and the Care Plan.During an interview on [DATE] at 11:53 AM, the SSD stated she was responsible for ensuring all the DNR paperwork was completed, then she presented the code status change to the interdisciplinary team. The SSD stated the nursing staff would obtain the order for the code status and the MDSC would update the Care Plan accordingly. The SSD stated the Care Plan should have been updated to reflect the DNR with the code status change.During an interview on [DATE] at 5:20 PM, the Director of Nursing (DON) stated the MDSC was responsible for updating the Care Plan with any code status changes; however, the MDSC was not working the day R6's code status was changed. The DON stated the Care Plan should have been updated to DNR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to implement care to prevent pressure ulcer development for one of four residents reviewed for pressure ulcers Resident (R)6 out of 35 sampled residents. R6's interventions for the prevention of pressure ulcers were not being implemented. This failure placed R6 at risk for development of pressure ulcers.Findings include:Review of R6's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including stroke, diabetes, heart failure, and encephalopathy.Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/26 and located under the MDS tab of the EMR revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS), score of three out of 15 which indicated there resident was severely cognitively impaired. The MDS also revealed the resident did not exhibit any behavioral symptoms, was dependent on staff for putting on footwear, and she was at risk of developing pressure ulcers but had no current pressure ulcers.Review of R6's EMR under the Orders tab revealed a physician's order, dated 11/25/25, to Apply offloading boot 1 time each shift as tolerated by resident. Okay to float bilateral legs on pillows if better tolerated by resident for wound care/protect skin integrity. Review of R6's Care Plan dated 12/11/25 and located under the Care Plan tab of the EMR revealed, I . have potential for pressure ulcer development . r/t [related to] diabetes, CVA [stroke] w/ [with] hemiparesis, incontinence, multiple comorbidities, and recently healed Right great toe area. The approaches included, Apply offloading boot 1 time each shift as tolerated by resident. Okay to float bilateral legs on pillows if better tolerated by resident. Per MD [physician] orders. Review of R6's Medication Administration Record (MAR) dated March 2026 and located under the Orders tab of the EMR, revealed the order for an offloading boot or pillows to float heels was signed off as completed twice daily from 03/01/26 through 03/09/26.During every 15 minutes observation on 03/08/26 from 7:25 AM to 10:00 AM in R6's room, R6 was observed asleep in bed with no boots on or pillows under her legs.During an observation on 03/08/26 at 11:44 AM in R6's room, R6 was lying in bed with no boots or pillows under her legs/feet.During an observation on 03/09/26 from 9:21 AM to 10:00 AM in R6's room, R6 was lying in bed with bare feet. Her feet were in direct contact with the mattress and there were no boots or pillows in place.During an observation on 03/09/26 from 2:31 PM to 4:00 PM in R6's room, R6 was lying in bed with bare feet. Her feet were in direct contact with the mattress and there were no boots or pillows in place.During an observation on 03/10/26 at 9:52 AM in R6's room, R6 was lying in bed with bare feet. Her feet were in direct contact with the mattress and there were no boots or pillows in place.During an interview and observation on 03/10/26 at 4:31 PM in R6's room, Licensed Practical Nurse (LPN) 4 stated she had ensured R6 had her boots on earlier that morning, but R6 must have removed them since then. LPN4 confirmed there were no boots or pillows in place, and she stated she was unaware R6's feet were not being floated. LPN4 stated the boots sometimes agitated R6, as she liked to move her feet and rub them together.During an interview on 03/10/26 at 4:35 PM, LPN1 stated R6 sometimes would not cooperate with wearing boots but a pillow should be in place to float her heels. LPN1 stated she or the wound nurse would put boots on R6's feet about three times a week but it was not done every day. LPN1 stated she did not know why the MAR was signed for this every day but thought maybe the nurses assumed the boots were on because she or the wound nurse would typically put them on.During an interview on 03/10/26 at 5:00 PM, the Director of Nursing (DON) stated R6 was at risk for pressure ulcers and the staff should have been floating her heels with boots or pillows at all times.Review of the policy titled, Pressure Injury Prevention and Management, dated 2025, revealed, Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but are not limited to: . Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425107	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sumter East Health & Rehabilitation Center	880 Carolina Avenue Sumter, SC 29150

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record reviews, interviews, and policy review, the facility failed to honor known food preferences for one resident Resident (R)155 of four residents reviewed for food out of 35 sampled residents. This failure had the potential to cause R155's nutritional needs to go unmet. Findings included:Review of R155's undated admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an original admission date of 03/10/25 and diagnoses which included, type 2 diabetes mellitus with hyperglycemia, and chronic kidney disease.Review of R155's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/19/26 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated R155 was cognitively intact.Review of R155's current Care Plan, provided by the facility and most recently revised on 03/02/26, contained a Focus, which indicated, I [Resident #155's name] have an actual nutritional problem or potential nutritional problem r/t [related to] Diabetes, S/P [status post] Left BKA [below the knee amputation], PVD [peripheral vascular disease], Hypertension, CAD [coronary artery disease], Renal Insufficiency . Care plan Interventions/Tasks included, Provide, serve diet as ordered . Honor my diet preferences.Review of R155's current Physician Orders, located in the EMR under the Orders tab, revealed an order for a CCHO [controlled carbohydrate] (Diabetic) diet, Mechanical Soft consistency, Regular texture. Directions for this diet order included no oatmeal, no eggs, double portions, and no meat. The diet order had a revision date of 02/26/26.Observation on 03/08/26 at 1:31 PM revealed R155 was in his room eating lunch. Observation of R155's meal revealed he was served carrots, potatoes, a roll, a fruit dessert, iced tea, and water. Review of the tray slip that was served with R155's meal revealed he was a vegetarian, and no meat was to be served. The tray slip specified the featured menu included pot roast and the second choice was chicken breast for this meal.During the observation, interview with R155 revealed he was a vegetarian and had informed facility staff of this when he was admitted to the facility about a year ago. R155 voiced a concern that he was not always served a protein source in place of the meat that he did not eat the meals. R155 stated he did not eat pot roast or chicken and again was not served an alternative for these foods with his lunch meal. R155 specified he would eat cheese, cottage cheese, pimento cheese, salmon, and other types of fish.Observation on 03/10/26 at 8:44 AM revealed staff served R155's breakfast meal in his room. Observations of R155's meal revealed he was served grits on a plate, a four-ounce carton of apple juice, a eight-ounce carton of milk and a cup of coffee. R155 placed a can of sardines that he had in the room on the grits that were served with the breakfast meal. Review of the resident's tray slip served with this meal specified no oatmeal, no eggs, no meat, vegetarian. The tray slip also specified the Featured menu included two-ounce scrambled eggs and two ounces of sausage and contained the following: Instructions: No toast, grits, fruits breakfast only. During an interview on 03/10/26 at 8:44 AM, R155 stated he did not eat eggs and sausage and was not served alternatives with his breakfast meal for these foods that he did not eat. R155 stated his family had provided cans of sardines that he kept in the room and he ate them with grits at breakfast each morning. The resident stated he would eat cheese on his grits if it was served with the breakfast meal. R155 also stated he had requested fruit to be served with his breakfast each morning but was not served any fruit with the breakfast today. R155 specified that he enjoyed eating any type of fruit but was only served fruit at breakfast a couple times a week.On 03/10/26 at 8:55 AM Licensed Practical Nurse (LPN) 3 came to R155's room and observed the resident's breakfast meal. LPN3 confirmed R155 was not served a protein source in place of the scrambled eggs and sausage that was planned on the featured menu and was not served any fruit with the breakfast meal. LPN3 stated she would inform Dietary Director (DD) 2 of these omissions and provide R155 with fruit to eat with his breakfast meal.During an interview on 03/10/26 at 12:10 PM, DD2 stated she was aware R155 was a vegetarian and the resident should be served a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425107	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meat alternative at meals for foods he would not eat. DD2 stated R155 should have been served an alternative during the 03/08/26 lunch meal in place of the pot roast and chicken that was being served at this meal. DD2 also stated during the breakfast meal on 03/10/26, R155 should have received a substitute for the scrambled eggs and sausage that were served at this meal and should have received fruit with his/her breakfast meal that the resident had previously requested.During an interview on 03/10/26 at 2:22 PM, the facility's Registered Dietitian (RD) stated R155 was a vegetarian and his food preferences should be honored. The RD stated he was unable to find R155's original admission food preference documentation that would have been completed during the resident's 03/10/25 admission. The RD stated he did find a 04/21/25 reentry RD Nutritional Assessment for R155 which specified the resident was a vegetarian and a 08/05/25 diet requisition form which specified that R155 was vegetarian and was not to be served meat or eggs.Review of the facility's undated policy titled, Policy and Procedure, provided by the facility, indicated, Procedure . Personal Food Preferences, allergies, idiosyncrasies, and intolerances are addressed on an individual basis and assessment.