STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425112	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Simpsonville Post Acute	807 South East Main Street Simpsonville, SC 29681

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 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. 47914 Based on interview, record review, document review, and facility policy review, the facility failed to ensure a certified nursing assistant (CNA) transferred a resident according to the resident's care plan for 1 (R2) of 4 sampled residents reviewed for accidents. Certified Nursing Assistant (CNA)1 used a sit to stand lift with one person instead of a mechanical sling lift with two people as specified by the resident's care plan. The failure resulted in R2 sustaining a fractured femur. Findings included: A facility policy titled, Lifting Machine, Using a Mechanical, revised 07/2017, indicated, Purpose 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. General Guidelines 1. A least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. A facility policy titled, Safe Lifting and Movement of Residents, revised 07/2017, indicated, Policy Statement In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. The policy specified, 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. An Admission Record revealed the facility admitted R2 on 10/17/2022. According to the Admission Record, the resident had a medical history that included diagnoses of late onset Alzheimer's disease, anxiety disorder, unspecified dementia with other behavioral disturbance, unspecified psychosis, and vitamin D deficiency. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2024, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for chair/bed-to-chair transfers. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER: Simpsonville Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 807 South East Main Street Simpsonville, SC 29681	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Care Plan, included a focus area initiated 10/25/2022, that indicated the resident required assistance with activities of daily living related to limited range of motion and weakness. Interventions directed staff to utilize a Mechanical/Hoyer lift with the assistance of two people to transfer the resident (initiated 08/12/2024). R2's Nurse's Note, documented by Registered Nurse (RN)2 and dated 11/18/2024 at 5:00 PM, indicated R2 was observed grimacing during patient care, swelling was noted to the resident's left femur, and an order was received to complete an x-ray. A Visit Note Report, dated 11/18/2024, revealed RN2 notified hospice that R2 complained of pain in their left leg. Per the Visit Note Report, there had been no reported falls, but the resident's leg was swollen, and RN2 thought the resident's leg might be dislocated. Per the Visit Note Report, RN6 visited the facility on 11/18/2024 at 8:47 PM and noted the resident's left ankle was turned out. The Visit Note Report indicated, the resident had pain and swelling in their left lower hip area, with pain seemingly present only when their leg was moved, and RN6 applied a soft splint. R2's Order Summary Report, contained an order dated 11/19/2024, for an x-ray of the resident's left knee and hip. The Radiology Results Report, dated 11/19/2024 at 9:20 AM, revealed R2 had an acute appearing femoral fracture. Contained within the facility's investigation was CNA1's Witness Statement, dated 11/18/2024, which indicated CNA1 acknowledged she alone transferred R2 to the bed by using a stand up lift. The Five-Day Follow-Up Report, dated 11/22/2024, revealed R2 had a fracture of the mid femoral shaft with malalignment. Per the Five-Day Follow-Up Report, a CNA transferred the resident to the bed by usage of a stand-up lift. The Five-Day Follow-Up Report, while the CNA had been trained on resident transfers, the CNA did not transfer the resident per the resident's plan of care and the CNA's employment with the facility was terminated. The Post Falls Assessment and Root Cause Investigative Report, dated 11/20/2024, revealed R2 was improperly transferred with a mechanical lift and the assistance of one staff. An Employee Counseling Form, signed by CNA1 and dated 11/28/2024, revealed the nature of the infraction was the CNA transferred a resident without assistance. Per the Employee Counseling Form, CNA1 was terminated. During an interview on 01/02/2025 at 1:31 PM, RN2 stated she was in the room with another resident on 11/18/2024 and was called to come and check R2. RN2 stated she noticed something was wrong with the resident's leg and asked the resident what happened. RN2 stated the resident said they did not know, and it was not like that earlier that morning. RN2 stated the resident required a sling type mechanical lift and she was not present with the resident to know how the resident was transferred. RN2 stated there had not been any issues with transfers prior to the incident because everyone knew with a mechanical lift, there always needed to be two people for assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/02/2025 at 1:22 PM, CNA3 stated she was working on the day of the incident, but she did not recall anything unusual. CNA3 stated R2 had not had any falls or anything of which she was aware. CNA3 stated for residents that required a mechanical lift for transfers, there should always be two people. During an interview on 01/02/2025 at 1:43 PM, CNA #4 stated she did restorative, trained the CNAs on the mechanical lift, and instructed them to make sure they always had two people with them, especially for safety reasons. During an interview on 01/02/2025 at 3:50 PM, the Administrator stated he contacted the Director of Nursing (DON), and she stated CNA1 did not give a reason for why she did not have two people present for the transfer of R2. During a follow-up interview on 01/02/2025 at 5:04 PM, the Administrator stated he expected residents to be transferred per their care plan, with the correct number of staff for assistance. On 01/02/2025 at 12:42 PM and 1:54 PM and 01/03/2025 at 8:35 AM, a telephone interview was attempted with CNA1. There was no answer and each time a voicemail message was left, and no return telephone call was received. CN

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47914 Based on interview, record review, document review, and facility policy review, the facility failed to implement their Quality Assurance and Performance Improvement (QAPI) plan following an incident of an improper transfer for 1 (Resident (R)2) of 4 sampled residents reviewed for accidents. Findings included: A facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program-Analysis and Action, revised 03/2020, specified, Quality deficiencies that are identified through feedback and data and will undergo appropriate corrective action. Corrective actions are monitored against established goals and benchmarks by the QAPI committee. An Admission Record revealed the facility admitted R2 on 10/17/2022. According to the Admission Record, the resident had a medical history that included diagnoses of late onset Alzheimer's disease, anxiety disorder, unspecified dementia with other behavioral disturbance, unspecified psychosis, and vitamin D deficiency. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2024, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for chair/bed-to-chair transfers. R2's Care Plan, included a focus area initiated 10/25/2022, that indicated the resident required assistance with activities of daily living related to limited range of motion and weakness. Interventions directed staff to utilize a Mechanical/Hoyer lift with the assistance of two people to transfer the resident (initiated 08/12/2024). Contained within the facility's investigation was Certified Nursing Assistant (CNA)1's Witness Statement, dated 11/18/2024, which indicated CNA1 acknowledged she alone transferred R2 to the bed by using a stand up lift. R2's Order Summary Report, contained an order dated 11/19/2024, for an x-ray of the resident's left knee and hip. The Radiology Results Report, dated 11/19/2024 at 9:20 AM, revealed Resident #2 had an acute appearing femoral fracture. The Five-Day Follow-Up Report, dated 11/22/2024, revealed R2 had a fracture of the mid femoral shaft with malalignment. Per the Five-Day Follow-Up Report, a CNA transferred the resident to the bed by usage of a stand-up lift. The Five-Day Follow-Up Report, while the CNA had been trained on resident transfers, the CNA did not transfer the resident per the resident's plan of care and the CNA's employment with the facility was terminated. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Post Falls Assessment and Root Cause Investigative Report, dated 11/20/2024, revealed R2 was improperly transferred with a mechanical lift and the assistance of one staff. The Quality Assurance Committee Meeting Agenda and Guide, dated 12/19/2024, indicated R2's injury was reviewed, and an action plan was implemented. The QAPI/Action Plan, dated 11/18/2024, revealed the issue was an inappropriate transfer. The action plan revealed an audit would be initiated by the Director of Nursing/nurse management weekly for four weeks and monthly for two months to ensure transfer methods were accurate and reflected on a resident's care plan and information guide used by CNA staff. During an interview on 01/03/2025 at 3:19 PM, the Administrator stated the facility had not yet started the audits for the QAPI plan related to the inappropriate transfer. The Administrator stated the QAPI team met on 12/19/2024 and the week of 12/23/2024, he was off work and the DON was off the week of 12/30/2024. The Administrator stated the audits would start the week of 01/06/2025, when the DON returned. During an interview on 01/03/2025 at 5:07 PM, the Administrator stated he expected when something was presented to QAPI, the facility would make a plan and follow through with the implementation of it.