

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 08/28/2024
NAME OF PROVIDER OR SUPPLIER Simpsonville Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42424</p> <p>Based on observation, interview, and facility policy, the facility failed to provide dignity to Resident (R)68 by failing to knock prior to entering the resident's room. The facility further failed to provide dignity to R68 with his urinal, 1 of 5 residents reviewed for dignity.</p> <p>Findings include:</p> <p>Record review of facility policy titled Dignity last revised 02/28/21, revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy interpretation and implementation include residents are treated with dignity and respect at all times; when assisting with care, residents are supported in exercising their rights for example residents are provided with a dignified dining experience. Staff are expected to knock and request permission before entering resident's rooms. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents by promptly responding to resident's request for toileting assistance.</p> <p>R68 was admitted to the facility on [DATE] with the diagnosis including but not limited to type 2 diabetes, hypertension, and acquired absence of left and right legs above knee. Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed R68 has a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicates that he is cognitively intact. Further review of the Quarterly MDS revealed that R68 is dependent on staff for toileting hygiene and personal hygiene.</p> <p>An observation and interview on 08/26/24 at 9:06 AM with R68 revealed the resident in bed and he had just finished breakfast. Further observation revealed a urinal lying on it's side, almost full with urine. R68 stated that staff had just left out of the room to take up the his plate/utensils, but did not offer to empty his urinal. R68 further stated that staff do not offer to provide him assistance with Activities of Daily (ADL) care, unless he asks.</p> <p>An observation on 08/26/24 at 9:14 AM with R68 revealed that he pressed his call light for assistance for staff to empty his urinal.</p> <p>An observation on 08/26/24 at 9:14 AM revealed Certified Nursing Assistant (CNA)1 entered the room without knocking or permission to enter the room, to empty R68 urinal.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 08/26/24 at 9:15 AM revealed CNA1 exiting R68's room and entered another resident room across the hall without knocking or waiting for permission to enter the room.</p> <p>An interview on 08/26/24 at 9:18 AM with CNA1 revealed that they did not knock on R68 and door because it was open then CNA1 stated staff are expected to knock prior to entering rooms regardless of the door was open. CNA1 further admitted that she did not knock on the door across the hallway as well. CNA1 finally stated that she is assigned to R68 for the day, but was not the staff member who picked up his breakfast tray and was unsure of who that staff member was.</p> <p>An interview on 08/28/24 at 5:30 PM with the Director of Nursing (DON) revealed that staff are expected to knock and wait for permission prior to entering residents rooms and that staff are expected to offer resident's assistance with their urinals when they observe that they need to be emptied.</p> <p>Record review of R68 Care Plan last revised 08/26/24 revealed I am at risk for chronic Urinary Tract Infection (UTI). Prefers urinal on bedside table at all times, I will not have a UTI through next review. Interventions include: administer medications and treatments as ordered, observe and document responses; encourage fluid intake; I will need post incontinent care every two hours and as needed; monitor and obtain labs as ordered and as needed; notify the Medical Director/ Nurse Practitioner as needed; monitor for signs and symptoms of UTI.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42424</p> <p>Based on observation, interview, and facility policy the facility failed to ensure that Resident (R)102 had the right to exercise autonomy/self-determination related to her preferred sleeping schedule. 1 of 1 reviewed for self-determination.</p> <p>Findings include:</p> <p>Record review of facility policy titled Resident Self-Determination and Participation last revised 08/31/22 revealed Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Policy interpretation and implementation include each resident is allowed to choose activities, and schedule health care and healthcare providers that are consistent with his or her interests, values, assessments, and plans of care, including: daily routine, such as sleeping and waking, eating, exercise and bathing schedules. In order to facilitate resident choice, the administration and staff: inform the residents and family members of the resident's right to self-determination and participate in preferred activities.</p> <p>R102 was admitted to the facility on [DATE] with the diagnosis including but not limited to dementia with severe agitation, hypertension, major depressive disorder, and psychotic disorder with hallucinations due to a known physiological condition. According to the Quarterly Minimum Data Set (MDS) dated [DATE] revealed R102 has a Brief Interview of Mental Status (BIMS) score of 3 out of 15, which indicates she is not cognitively intact.</p> <p>An observation on 08/27/24 at 8:30 AM revealed a Certified Nursing Assistant (CNA) attempting to wake R102 and encouraging her to eat her breakfast.</p> <p>A phone interview on 08/28/24 at 1:56 PM with R102 Resident Representative (RR) revealed that the resident often sundown's and does not go to bed at times until after midnight. During the interview the RR had concerns with the facility not allowing to the resident self-determination due to them attempting to provide ADL care to R102 at 6:30 AM this morning (08/28/24). RR further stated that at times the resident does not want to be awoken before 9:00 AM and has had this pattern prior to admission to the facility.</p> <p>An interview on 08/28/24 at 2:18 PM with CNA2 revealed that the resident was very agitated this morning and refused to get up, when the resident is agitated CNA2 stated that she leaves the resident alone and gives her time to calm down and notifies the nurse of the behavior so they can chart it in the Electronic Medical Record (EMR). CNA2 stated that she attempted to provide the resident ADL care around 9:00 AM this morning and resident began to curse at her. CNA2 finally stated that R102 has never hit them when she gets agitated, she curses at staff and will ball up her fists but has not witnessed R102 be physically aggressive with staff.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview on 08/28/24 at 3:37 PM with the Psychiatric Nurse Practitioner (NP) revealed that they were informed by a 3rd shift CNA that the resident was attempting to fight staff this morning during their last round when the attempted to provide Activities of Daily Living (ADL) care for R102.</p> <p>A phone interview on 08/28/24 at 5:05 PM with CNA3 (3rd shift CNA) revealed that the resident at times can be combative but has never physically hit them or any other staff that they are aware of. Interview with CNA3 further revealed that staff assist resident to bed around 8:00 PM - 9:00 PM and at times resident will get back up and will become verbally aggressive with staff if they attempt to redirect. CNA3 further stated that they were R102 assigned CNA for last night/this morning (08/28/24) when they attempted to get the resident up for the day around 6:30 AM the resident refused to be provided ADL care and became verbally aggressive with him and the nursing staff.</p> <p>An interview with the Director of Nursing (DON) on 08/28/24 at 5:36 PM revealed that residents have a right to self-determination and refusal of treatment and services.</p> <p>Record review of R102 Care Plan last revised 11/20/23 revealed Refusal of Care - Resident refuses care and services within their rights as manifested by non-compliance/refusal of nursing care, has episodes of removing brief. Interventions include: behavioral and psychological services as indicated; determine resident's experiences and preferences to eliminate/mitigate triggers to the extent possible; encourage active participation in care; reapproach when refusing care to the extent possible.</p>		