

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Pocotaligo River Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 5583 Summerton Highway Manning, SC 29102	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>31846</p> <p>Based on review of facility policy, record reviews, and interviews, the facility failed to ensure Resident (R)1 was free from verbal abuse for 1 of 2 residents reviewed for abuse. Specifically, R1 was verbally abused during care by a Certified Nursing Assistant (CNA).</p> <p>Findings include:</p> <p>Review of the undated facility policy titled, Abuse Policy, states, The facility recognizes that each resident has the right to be free from all types of abuse including verbal . The facility also recognizes that the residents must not be subjected to abuse by anyone, including, but not limited to staff . Willful, as used in the definition of Abuse, means the individual must have acted deliberately, not that the individual intended to inflict injury of harm . Mental Abuse, is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. Verbal Abuse, may be considered a type of mental abuse. It is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability . Examples of verbal and mental abuse includes, but are not limited to: harassing a resident; mocking, insulting, ridiculing; yelling or hovering over a resident with the intent to intimidate.</p> <p>Review of R1's Face Sheet revealed the facility admitted R1 on 12/05/23 and readmitted R1 on 06/26/24, with diagnoses including, but not limited to: dementia, anxiety disorder, restlessness and agitation, major depressive disorder, insomnia, violent behavior, obstructive sleep apnea, and mild intellectual disabilities.</p> <p>Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date of 07/02/24, revealed a Brief Interview for Mental Status (BIMS) score of 8 out of 15 indicating R1 was moderately cognitively impaired. Further review of the MDS revealed R1 is understood and understands verbal content and reacts and answers appropriately, speech is clear and hearing is adequate.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of CNA1's Notice of Disciplinary Action dated 07/29/24, revealed, CNA was terminated from employment for Resident Abuse and Violation of Company Policy/Procedure/Rules. Further review of the Notice of Disciplinary Action revealed remarks which documented, CNA used profanity and was yelling at a resident. This was witnessed by the nurse. CNA stated Sit your a** back in the chair, if you fall your a** on the floor you gonna stay on the d*** floor. Move your d*** hand. Review of the Employee Remarks documented, I didn't said any of that.</p> <p>During an interview on 09/12/24 at 10:25 AM, CNA1 stated, [R1] was up in her wheel chair all night, the CNA on the evening shift should have put her to bed. I know that is their choice if they do not want to go to bed. [Licensed Practical Nurse (LPN)1] was on the phone. She had called me to help get the resident in bed, and then she was on the phone. I was charting when the nurse called me, then I could not find her to help me. She said, I cursed the resident, but I did not, I did say that if she fell on the floor I was not going to pick her up. I knew I could not get her back to bed by myself.</p> <p>During an interview on 09/12/2024 at 10:40 AM, LPN1 stated, The resident was yelling for help, so I went to see what she needed. I called for the CNA to help me put her to bed but she did not come right away. I was on the phone with the nurse on the other unit. The next thing I knew, the CNA was yelling for me to come and help her get [R1] back to bed. I carried the phone in the resident's room and the nurse could hear what was being said. The resident was sitting on the edge of the wheelchair seat and yelling. [CNA1] has always been loud and rough. The CNA told me she did not know why the resident was yelling so I tried to talk to the resident and calm her down. She calmed down and the CNA started yelling and cursing at her. LPN1 stated that she asked the CNA to go and get the sit-to-stand lift so they could get the resident in bed. CNA1 went and got the lift and came back into the room and started yelling at the resident and cursing her again. LPN1 further stated, [R1] was upset at that point, so all I was focused on was getting the resident in bed, cleaned up and comfortable. After getting the resident back in bed, I called the Director of Nursing [DON], I believe it was between 4:00 AM and 5:00 AM, and reported the incident. The DON told me to tell the CNA to clock out and go home. She called the administrator because she came in early to talk to the resident and make sure she was alright.</p> <p>During an interview on 09/12/24 at 12:48 PM, LPN2, the nurse that was on the phone, stated she overheard CNA1 telling the resident to Get your d*** a** in the bed. LPN2 stated that she heard that CNA1 talks rough to the residents.</p> <p>During an interview on 09/12/24 at 1:42 PM, the DON stated that CNA1 came in the next day to tell her side of the story. The DON stated that CNA1 said she was ruff with the resident, but she did not curse. The CNA came in only for an exit interview, and to sign the termination form and then I escorted her out of the facility and reported her to the state registry.</p> <p>During an interview and observation on 09/12/24 at 3:12 PM, R1 stated CNA1 curses at her all the time. R1 stated, Look at my arms they are bruised all over, that is from them grabbing me to turn me over, I guess I do not move quickly enough for them. This surveyor observed R1's arms and did not see the bruising she was referring to, but did report the allegation to the Administrator. R1 began talking about places she has lived in the past, and how she loved to cook. R1 continued telling me about her family, while laughing, and was happy. R1 did not have any concerns.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 09/12/24 at 3:30 PM, with random interviewable residents on the same hall, revealed they did not have any concerns with staff or any abuse concerns. Residents stated they were happy with the staff caring for them and the nurses were good to them.		