STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425114	A. Building B. Wing	01/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocotaligo River Health and Rehab	3147 Sumter Hwy 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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document review, the facility failed to ensure a safe transfer for 1 (Resident (R)2) of 4 residents reviewed for accidents. Specifically, R2 was transferred without the use of a sit to stand lift by a Certified Nursing Assistant (CNA) resulting in fractures to the resident's left ankle. Findings included: An admission Record revealed the facility admitted R2 on 06/19/2023. According to the admission Record, the resident had a medical history that included diagnoses of rheumatoid arthritis, anemia, diabetes, right hip osteoarthritis, muscle weakness, anxiety, depression, hypertension, neoplasm of the colon, repeated falls, low back pain, unsteadiness of feet, muscle weakness, radiculopathy, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/11/2025, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated R2 was dependent on staff assistance for transfers and moving from sitting to standing. The MDS indicated R2 had one fall with no injuries since admission/entry or re-entry or their prior assessment. R2's Care Plan Report included a focus area, initiated 11/27/2024, that indicated the resident needed assistance with their activities of daily living self-performance and functional mobility needs due to impaired balance. Interventions directed staff that R2 was to complete functional transfers utilizing a sit to stand lift (initiated 01/27/2025). A quarterly Fall Risk Evaluation, dated 08/11/2025, indicated R2 was a high risk for falls. A nursing Health Status Progress Note[s], dated 08/15/2025 at 9:31 AM, revealed R2 had pain and swelling in their left foot and ankle. The Progress Note indicated that a nurse practitioner (NP) was notified, and orders were obtained for an x-ray of the resident's left foot and ankle. R2's Radiology Report, dated 08/15/2025 at 6:09 PM, indicated an x-ray was completed to left ankle which revealed oblique fractures (bone break in a diagonal angle across the bone's shaft) involving the distal tibia (lower end of the shin bone that forms the top of the ankle joint) and fibula (slender outer bone of the lower leg that provides muscle attachment points and stabilizes the ankle) with minimal callus (stabilization allowing primary bone healing) and modest displacement (bone fracture where the bone pieces shifted from alignment). A handwritten, untitled facility document, dated 08/15/2025, revealed a witness statement by CNA3. The witness statement indicated that the night prior to CNA3 had assisted transferring R2 to bed, around 10:30 PM, using a stand to pivot technique from the resident's wheelchair to their bed. A handwritten Employee Statement, dated 08/15/2025, by Licensed Practical Nurse (LPN)2 indicated that when LPN2 was completing medication administration around 7:03 AM, R2 asked LPN2 for a pain pill. The Employee Statement indicated R2 stated My leg is hurting so bad and I think I broke my leg, while rubbing their left leg. The Employee Statement indicated LPN2 asked R2 how their leg was broken if the resident did not walk. The Employee Statement indicated R2 stated that, when a girl put them to bed the prior night, the resident hit their foot, and the resident gestured toward the area beside the resident's bed indicating (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 0689 Level of Harm - Actual harm Residents Affected - Few	where they hit their foot. The Employee Statement revealed R2 had a history of leg pain and was administered an as needed dose of oxycodone (an opioid medication used for pain management) as requested by the resident. The Employee Statement indicated LPN2 reported R2's complaint to the unit manager. A handwritten Employee Statement, dated 08/15/2025, by Unit Manager (UM)1 indicated they were notified of R2's complaints of foot pain by LPN2. The Employee Statement indicated R2 had swelling to their left ankle. The Employee Statement revealed R2 heard a pop when they were transferred on the night shift. The Employee Statement indicated that the NP was notified, and orders were obtained to complete an x-ray. A hospital admission H&P [History and Physical], dated 08/16/2025 at 5:07 PM, indicated R2 was admitted to the hospital on [DATE] at 7:45 AM with a closed fracture of the left tibia and fibula. The record revealed orthopedic services evaluated R2 and recommended nonsurgical management with splinting, a non-weight bearing status to the left lower extremity, and a recommendation to follow-up with orthopedic clinic for casting and continued management of the fracture. A Five-Day Follow-up Report, dated 08/20/2025, revealed a Reportable Incident that occurred on 08/15/2025 at 5:30 PM. The Five-Day Follow-up Report indicated on 08/15/2025 at 7:03 AM, R2 requested a pain pill from a nurse for foot pain. The Five-Day Follow-up Report indicated R2 revealed that while being placed in bed the previous night, 08/14/2025, the resident hit their foot on the side of the bed. The Five-Day Follow-up Report indicated R2 had swelling and a UM notified the provider, who ordered x-rays. The Five-Day Follow-up Report indicated a night shift CNA reported that Resident #2 stated they heard a pop when they were placed on the bed. The Five-Day Follow-up Report indicated the CNA reported she thought the noise was the Velcro strap on the resident's shoes because R2 did not complain of pain. The Five-Day Follow-up Report indicated R2's left foot and ankle were swollen and tender to touch. The Five-Day Follow-up Report indicated an x-ray revealed a left tibia/fibula fracture. The Five-Day Follow-up Report indicated R2 was admitted to the hospital, underwent surgery to the left leg, and remained in the hospital. The Five-Day Follow-up Report indicated that interventions in place prior to the incident included, resident is a lift stand transfer. R2's hospital Discharge Summary, dated 08/22/2025 at 11:09 AM, indicated a discharge diagnosis of closed fracture of the left tibia and fibula. The Discharge Summary revealed that on 08/18/2025 R2 had undergone a left tibia intramedullary rod insertion (a metal rod placed inside the hollow bone marrow cavity to stabilize and align fractured bone fragments). During an interview on 01/11/2026 at 1:16 PM Resident #2 stated they recalled hurting their foot a few months prior when a female staff member put them to bed one night. R2 stated the staff member lifted the resident under the resident's arms and around the resident's chest to place the resident in the bed. R2 stated that during the transfer, there was a loud noise like a gunshot, but the resident stated they did not have any pain at the time. R2 stated the next morning they notified the nurse that their leg was hurting badly. R2 stated they went to the hospital and had surgery. During a telephone interview on 01/10/2026 at 6:55 PM, LPN2 stated she recalled working from 7:00 PM on 08/14/2025 until 7:00 AM on 08/15/2025 and was assigned to care for R2. LPN2 stated she recalled entering R2's room to administer morning medications and check the resident's glucose levels when the resident informed her they were experiencing pain in their foot and thought their foot may be broken. LPN2 stated R2 accused the CNA of breaking the resident's foot while placing the resident in the bed. LPN2 stated CNAs should know a resident's transfer status from the Kardex (a quick reference patient care document), or they could ask her, and she would look it up on the computer. During a telephone interview on 01/10/2026 at 7:07 PM, UM1 stated she was notified by LPN2 of a complaint of foot pain made by R2. UM1 stated she assessed R2's foot and identified one foot to be more swollen than the other. UM1 stated she was notified by LPN2 of a complaint of foot pain made by R2. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	UM1 stated she assessed R2's foot and identified one foot to be more swollen than the other. UM1 stated when she performed a range of motion check and palpated the foot R2 informed her the area was sore. UM1 stated when a CNA had helped R2 into bed the night before, a noise was heard, and the resident and the CNA thought the noise was from the resident's sandal straps. UM1 stated she informed R2's provider and obtained an order for x-rays to be completed. UM1 indicated that when the mobile x-ray technician was completing the x-rays, the technician notified her they were able to see an area of concern and showed UM1 the images obtained. UM1 stated she again contacted the provider and was given orders to complete x-rays with additional views. UM1 stated the provider also provided orders to send R2 to the hospital while waiting for the radiologist confirmation of the suspected fracture. UM1 stated that the facility contacted emergency medical services, and R2 was transported to the local hospital.