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	08/21/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure 1 resident or resident representative (RP) of 1 resident (Resident (R)6) reviewed for hospitalization, received written notice that specified the duration of the bed hold policy. Specifically, the facility failed to include the current rate for the reserve bed payment in the event the resident did not return within ten (10) days, leaving the resident without all the necessary decision-making information.Findings include:Review of the facility's undated policy titled, "Bed Hold Notice" indicated that "It is the policy of this facility to provide written information to the resident and/or the resident representative bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave . 'Reserve Bed Payment' refers to payments made by a State to the facility to hold a bed during a resident's temporary absence from a nursing facility . The facility will provide this written information to all facility residents, regardless of their payment source ."Review of R6's "admission Record" located in the electronic medical record (EMR) under the "Resident" tab indicated she was originally admitted to the facility on [DATE].Review of R6's entry tracking "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/06/25 indicated the resident was re-admitted from a short-term general hospital.Review of R6's "Notice of Resident Transfer or Discharge" dated 07/02/25 confirmed that R6 was transferred to the hospital due to " . needs cannot be met in this facility ."Review of R6's "Bed Hold Notice" dated 07/02/25 confirmed R6 was transferred to the hospital on [DATE] and did not include the "basic per diem rate." Additionally, the notice indicated that "The State bed-hold period is 10 days consecutive for hospital stay ."During an interview on 08/21/25 at 12:32 PM, the Administrator and Social Services Director (SSD) stated that the SSD filled out all "Bed Hold Notice" forms and confirmed that the "basic per diem" rate was not included in the "Bed Hold Notice" dated 07/02/25. The SSD stated that when residents were admitted , the bed hold rates were reviewed with the resident/RP. The SSD provided R6's admission documents indicating the bed hold rate as of 02/28/22 was $240.00 per day and as of 11/01/24 the rate increased to $297.00 per day. The SSD stated that the rate increase was mailed to all RP's on 10/01/24 but was not included on the "Bed Hold Notice" and that she was not aware that it was required.

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	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 review of facility policy, the facility failed to ensure staff performed adequate hand hygiene while washing dishes in 4 of 5 kitchens and failed to ensure kitchen staff thoroughly air-dried pans prior to storage in the main kitchen. Failure to perform adequate hand hygiene before touching clean dishes and not thoroughly drying pans can have the potential to lead to contamination and the increased risk of foodborne illness. This had the potential to affect 74 of 77 residents in the facility who received dietary services.Findings include:Review of the facility's undated policy titled, Dishwashing Manual and Dishwashing: Machine Operation revealed, Policy: . 6. The pots and pans will be drained and air-dried on the drain counter or designated drying rack . f. Use clean, washed hands to pull out clean racks, and allow to air dry before putting dishes away for storage. Place glasses, cups, pots, and pans upside down on the drying rack .1. During an observation on 08/19/25 at 1:35 PM in the Palmetto Dining Room, Dietary Aide (DA)4 along with a new dietary aide, DA6, were using the dishwasher in the kitchen area. DA4 was handwashing dirty dishes in the sink, then moved to the dishwasher and pulled clean dishes out without performing hand hygiene.During an observation on 08/20/25 at 9:47 AM in the main kitchen revealed DA1 handwashing dishes. DA1 moved from the dirty dish sink to the dishwasher, removing clean dishes and placing them on the clean racks. DA1 handled the clean dishes without performing hand hygiene.During an interview on 08/20/25 at 10:05 AM, DA1 confirmed she was touching clean dishes with dirty hands for a while and did not realize she was doing that.During an observation on 08/20/25 at 12:45 PM in the Dogwood Dining Room revealed DA2 was washing dishes by hand and then removed clean dishes out of the dishwasher without performing hand hygiene.During an observation on 08/20/25 at 1:25 PM in the Cypress Dining Room revealed DA5 was washing dirty dishes and then walked over to the dishwasher and, without performing hand hygiene, removed clean dishes from the dishwasher and placed them to dry.During an interview on 08/20/25 at 12:50 PM, the visiting Dietary Manager (DM) revealed her expectation was that staff should wash hands before handling clean dishes coming out of the dishwasher. The Dietary Manager Assistant (DMA) confirmed that the facility's policy Dishwashing: Machine Operation, required hand hygiene before handling clean dishes.2. During an observation in the main kitchen on 08/19/25 at 8:43 AM revealed five metal pans that had been washed and placed on storage racks had water standing on them.During an interview and observation on 08/20/25 at 9:45 AM in the main kitchen revealed there were five metal pans 6 inches by 12 inches by 2 inches and four plastic lids 6 3/4 inches by 4 1/4 inches that had water on them and were stored ready for use. The pans were found to have been stacked wet and not allowed to air dry. The DM and DMA stated all dishes were to be dry before stored on the shelf. The DM stated there should be a separate place to place pans and items that need longer to air dry before placing them on storage shelves.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure 2 of 11 residents (Resident (R) 6 and R17) observed received care performed with the proper use of personal protective equipment (PPE). Specifically, R6 was on enhanced barrier precautions (EBP) for indwelling catheter/wound status, and a staff member did not wear a gown during a bed bath, and R17 was on contact and droplet precautions for Covid-positive status, and a staff member did not wear gloves or eye protection during medical administration. This failure increased the risk for spread of COVID-19 and other infections to residents and staff.Findings include:Review of the facility's policy titled "Enhanced Barrier Precautions" revised on 06/02/24 indicated that " . It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms [MRDO] . EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities . An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds . ii . MDRO . high-contact resident care activities include: . bathing . providing hygiene . changing linens . device care or use: . catheters . "Review of the facility's policy titled "Isolation - Categories of Transmission-Based Precautions" revised on 10/20/28 indicated that " . Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected . Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items . staff and visitors will wear gloves . wear a disposable gown . Droplet precautions may be implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets . masks will be worn when entering the room . gloves, gown, and goggles should be worn "Review of the facility's policy titled, "COVID-19 Prevention, Response and Reporting revised on 12/31/24 indicated that " . HCP [healthcare personnel] who enter the room of a resident with suspected or confirmed SARS-CoV-2 [COVID-19] infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection ."1. Review of R6's "admission Record" located in the electronic medical record (EMR) under the "Resident" tab indicated she was admitted to the facility on [DATE] with diagnoses including but not limited to pressure-induced deep tissue damage of left heel, proteus mirabilis, disorder of the kidney and ureter, obstructive and reflux uropathy, and extended spectrum beta lactamase (ESBL, antibiotic) resistance.Review of R6's five-day "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/12/25 included indwelling catheter and wound status.Review of R6's "Care Plan" provided by the facility and initiated on 01/12/25 included the use of enhanced barrier precautions related to urinary catheter and ESBL.Review of R6's "Order Summary Report" located in the EMR under the "Orders" tab included an order for enhanced barrier precautions initiated on 07/23/25 related to urinary tract infection and ESBL resistance.During an observation and interview on 08/19/25 at 10:40 AM, Certified Nursing Assistant (CNA)1 was providing a bed bath to R6. CNA1 was wearing gloves and a surgical mask. CNA1 confirmed that R6 was on EBP and that she had not put on a gown but should have. At the time of the observation, R6 was lying in bed, the linens were draped over the foot of the bed, and a trash bag of soiled linens was on the floor next to the wall. CNA6 then exited the room and went to retrieve a gown. R6 had Center for Disease Control and Prevention (CDC) signage outside of the room indicating the need for EBP, stating, "Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities, dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: . urinary catheter ."During an interview on 08/21/25 at 12:49 PM, the Director of Nursing (DON) was made aware of the observation of R6 and CNA1 on 08/19/25 and confirmed that R6 was on EBP for urinary catheter and wound status. The DON confirmed that CNA1 should have been wearing a gown during the procedure.2. Review of R17's "admission Record" located in the EMR under the "Resident" tab indicated that she was admitted to the facility on [DATE] with a primary diagnosis of hyperlipidemia. The admission Record did not include COVID-19 status.Review of R17's "Care Plan" provided by the facility and revised 08/18/25 included COVID-19 positive status with the need for droplet and contact precautions. Review of R17's "Order Summary Report" located in the EMR under the "Orders" tab, included an order dated 08/19/25 for droplet and contact precautions for ten days due to testing positive for COVID