

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Rock Hill Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 159 Sedgewood Dr Rock Hill, SC 29732	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document and policy review, the facility failed to protect a resident's property from misappropriation for one of three residents (Resident (R) 96) reviewed for resident rights out of a total sample of 23. This failure had the possibility of negatively impacting all residents residing at the facility due to residents' property not being safeguarded against theft. Findings include: Review of the facility's Inservice Attendance Record, dated 04/04/25, indicated, Course Title: Resident Reported Theft/Loss . Subject: Theft/Loss by Residents: Theft of patient property is a form of abuse and should be reported to facility administration immediately. If the theft/loss is greater than \$50.00 a police report must be filed. Employees could be subject to termination and/or legal consequences if found guilty of theft of resident property regardless of declared value .Review of the facility's policy titled, Abuse Prevention and Prohibition, dated 09/2023, indicated, . It is the policy of this facility that each resident has the right to be free from abuse, neglect, and misappropriation of resident property, and exploitation . Investigation: All identified events are reported to the Administrator/Designee immediately and will [be] thoroughly investigated . The facility will analyze occurrences and determine what changes are needed, if any, to the policies and procedures to prevent further occurrences . Review of R96's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R96 was originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of type II diabetes, traumatic subdural hemorrhage, cognitive communication deficit, heart failure, fatty liver, dementia, major depressive disorder, Alzheimer's disease, and osteoporosis. R96 was discharged from the facility on 09/05/25. During R96's stay at the facility she resided on Hall 100. Review of R96's undated Inventory of Personal Effects indicated an inventory was taken of R96's personal effects that included: five blouses, five brassieres, two dresses, one pair of eyeglasses, three pajamas, five shirts, two shoes, and five socks. A staff member did not sign the inventory. There was no jewelry listed on this inventory sheet. Review of R96's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 09/03/25 and located under the RAI (Resident Assessment Instrument) tab, indicated R96 required set up assistance for eating and oral hygiene; partial/moderate assistance for upper body dressing and personal hygiene; and substantial/moderate assistance for bed mobility, toileting hygiene, lower body dressing, and bathing. The MDS indicated R96 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated R96 was cognitively intact. Review of R96's Progress Note, dated 06/30/25 and located in EMR under the Progress Notes tab and written by Licensed Practical Nurse (LPN) 4, indicated, . Rt [resident] stated that on Friday night a young black lady told her that her fingers were swollen and that she needed to remove her rings and she would put them up. Called husband to verify that she returned to the facility with her rings on as well as verified with [Licensed Practical Nurse (LPN)3]. [LPN3] and I did do a thorough search of the room and did not find the rings. Also verified if rt recognized us as we were her nurses that night. Statement was made and filled out by CNA [Certified Nursing Assistant] who the rings were reported missing to as well as myself and [LPN3].Review of R96's Progress Note, dated 07/01/25 and located in EMR under the Progress Notes tab, indicated, SS [Social Services] called and made a police report about (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents missing rings. Talked with officer . Case Id# is 2507010020 .Review of the facility's investigation regarding R96's missing rings indicated a written statement by LPN3, dated 07/01/25, which indicated, I . did the admission assessment on [R96] when she returned from the hospital on [DATE]. During her skin assessment, she was noted with two rings on her left ring finger, both gold in color . The rings were included in her inventory upon admission. I was also the nurse working the floor from 7:00 PM until 11:00 PM. Unfortunately, I did not pay attention to whether or not the rings were still on during that time. On Monday, June 30th at 1745 [5:45 PM], I was informed by the floor nurse . that [R96] stated her wedding ring was missing. I immediately informed my supervisor . searched [R96]'s room with [LPN4]. Still unable to locate rings . Review of the facility's investigation regarding R96's missing rings indicated an undated written statement by LPN4 which indicated, I . worked with R96 the night of June 27th from 11-7a but I did not notice if the resident was or was not wearing any rings .Review of the facility's investigation form titled, Five-Day Follow-Up Report, dated 07/07/25, indicated, . Immediate corrective action/assessment following Reportable Incident: Resident room searched, husband notified on details of police investigation. Showed resident pictures in an attempt to identify who asked her to remove her rings due to her fingers swelling, but she was unable to positively identify anyone . Interventions by Facility to prevent future Injury/Alleged Abuse: Facility has posted signage around the building and in resident rooms encouraging residents to send valuables home. Facility also acquired a safe and created a process for nursing to log and secure any valuables that resident is unable to send home but wants stored at the facility. Summary Report of Facility Investigation: The facility does feel that this was a case of theft, but unable to prove who or exactly when the theft occurred .During an interview on 09/11/25 at 9:25 AM, the Administrator stated they now discourage Residents from bringing jewelry into the facility. The Administrator stated they posted signs around the facility about not keeping jewelry on site. The Administrator stated they hadpurchased a safe to enable them to store resident's jewelry securely. The Administrator said it was difficult to prove a case of theft.During an interview on 09/11/25 at 9:36 AM, Resident Representative (RP) 96 stated R96 had to go to the hospital for eight or nine days, and when R96 returned to the facility [R96] said some lady told her she needed to take the rings off due to her hands swelling. RP96 stated the following day a friend of R96 came to visit R96, and R96 asked her to locate the rings but she was unable to find them. RP96 stated the facility did make a police report and did show R96 pictures of staff that was working during that night. RP96 stated the facility staff had not offered any form of compensation for the missing rings. RP96 explained he had purchased replacement rings for R96. During an interview on 09/11/25 at 12:30 PM, the Director of Nursing (DON) confirmed he was involved with the investigation of R96's missing rings. The DON explained initially R96's room was searched, and after the rings were not located in R96's room or at her home, a report was made to the police department, staff was interviewed, and additional residents were interviewed. The DON stated as a result of the missing property, they put into place that the admission coordinator will discourage new residents from bringing jewelry with them into the facility. The DON also stated that during the admission process, when the Resident Inventory is being completed, there was now going to be a focus on jewelry items, and the documentation will be more detailed. The DON stated he watched hours of camera footage of people going in and out of R96's room but did not see anything out of the ordinary. During an interview on 09/11/25 at 1:45 PM, Occupational Therapy Assistant (OTA) confirmed he was familiar with R96 but did not remember if R96 had any rings on during her stay at the facility. During an interview on 09/11/25 at 1:55 PM, Speech Therapist (ST) 1 stated she was familiar with R96 but did not recall if R96 was wearing any rings.During an interview on 09/11/25 at 2:00 PM, Case Manager (CM) stated she did not remember seeing rings on R96's hand. CM stated R96 was admitted to the hospital and wondered if the rings were misplaced at the hospital.During an interview on 09/11/25 at 2:05 PM, CNA1 stated she was close to R96 and confirmed that R96 was wearing rings during her stay at the facility.During an interview on 09/11/25 at 2:15 PM, R96 stated on the night of the incident, someone (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told her to remove her rings due to her hands swelling. R96 stated she could not remember who the person was. R96 confirmed the facility staff did not offer any type of compensation for the missing rings.		

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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. Based on observations, interview, and facility policy review, the facility failed to administer medications in a manner to prevent cross-contamination for five out of six residents (Resident (R)14, R65, R87, R97, and R98) observed during medication administration. This had the potential to cause the spread of infection in the facility. Findings: Review of facility's undated policy titled, Infection Control Prevention and Control Program - Hand Hygiene revealed, . This facility considers hand hygiene the primary means to prevent the spread of infections . 3. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations:a. When hands are visibly soiled; and . 4. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:a. Before and after coming on duty;b. Before and after direct contact with residents;c. Before preparing or handling medications .l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident;m. After removing gloves .5. Hand hygiene is the final step after removing and disposing of personal protective equipment6. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . Review of undated policy titled, Medication Administration, revealed, . Hand hygieneLicensed nurse will foam in and out between residents unless resident is under enteric contact precautions or hands are visibly soiled then licensed nurse will wash hands with soap and water . 1. On 09/11/25 at 8:30 AM, Registered Nurse (RN) 1 was holding a cup of R97's medications. One pill accidentally dropped on the floor, and RN1 immediately picked it up with a bare hand, discarded the pill in the trash receptacle of the medication cart, and failed to perform hand hygiene after. RN1 walked into R97's room holding the medication cup and gave the medications to R97. RN1 walked away to retrieve a replacement for the pill that was dropped. 2. On 09/11/25 at 9:06 AM, RN1 was dispensing a pill into a medication cup. RN1 dropped the pill on the medication cart. RN1 picked up the pill with a bare hand and placed it back in the medication cup. RN went ahead to give the pill to R98. During an interview on 09/11/25 at 9:09 AM, RN1 stated he had sanitized the medication cart at the beginning of medication pass and did not need to discard the medication. 3. On 09/11/25 at 9:10 AM, RN performed hand hygiene and donned a pair of gloves to administer eye drops to R65. On 09/11/25 at 9:12 AM, RN1 exited R65's room, wearing the same gloves. RN1 discarded the gloves in the medication cart's trash receptacle. RN1 did not perform hand hygiene. RN1 touched his computer mouse, keyboard, reached into his pocket for cart keys, opened the medication cart, and continued to dispense medications for the next resident (R87). 4. On 09/11/25 at 9:13 AM, without performing hand hygiene, RN1 entered R87's room with a cup of medications. R87 requested that his big pills be broken into two. On 09/11/25 at 9:18 AM, RN1 donned a pair of gloves while in R87's room without first performing hand hygiene, returned to the medication cart, broke some pills in the medication cup in two, and returned to R87's room to give the medications to R87. At 9:22 AM, wearing the same gloves, RN1 exited R87's room, doffed his gloves, and did not perform hand hygiene. 5. On 09/11/25 at 9:23 AM, RN1 touched the medication cart, the computer keyboard, mouse, and some paperwork on the cart. RN1 reached into his pocket for cart keys, opened the cart, and retrieved medications from the medication cart. RN1 accidentally dropped three pills on the medication cart. RN1 retrieved the pills with a bare hand and returned the pills into a medication cup. At 9:26 AM, RN1 entered R14's room and gave R14 the medications that had been picked off the medication cart. RN did not perform hand hygiene before entering R14's room. On 09/11/25 at 9:26 AM, RN1 performed hand hygiene upon exiting R14's room. During an interview on 09/11/25 at 9:28 AM, RN1 stated he had been performing hand hygiene. When told that he had entered several resident's rooms without performing hand hygiene, had donned and doffed gloves without performing hand hygiene, had not performed hand hygiene in between residents' rooms, and had picked up dropped pills with bare, unwashed hands, RN1 acknowledged these observations. During an interview on 09/11/2025 at 3:31 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, the Infection Preventionist (IP) stated it was her expectation for RN1 to perform hand hygiene before donning and after doffing gloves. The IP stated RN1 should not have picked up dropped medications with bare hands and should have discarded dropped medications and not put them back in the medication cup for administration.		