STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425169	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springdale Healthcare Center	146 Battleship Road Camden, SC 29020

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43648 Based on interviews, record reviews, document reviews, and facility policy review, the facility failed to protect the residents' right to be free from physical and verbal abuse perpetrated by staff for 2 (Resident (R)1 and R3) of 3 sampled residents reviewed for abuse. Findings included: A review of the facility policy titled, Abuse, Neglect, Exploitation, or Mistreatment, revised on 10/23/2019, revealed, 1. The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of patient's/resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately. The policy specified, 1. Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 1. A review of R1's Resident Face Sheet revealed the facility admitted the resident on 06/27/2023, with diagnoses that included diabetes mellitus, neuropathy, and paraplegia. A review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/04/2024, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Five-Day Follow-Up Report dated 01/26/2024, revealed R1 alleged that during the night shift on 01/21/2024, Certified Nursing Assistant (CNA)3 made offensive and inappropriate comments to them and began to curse and yell at them after they requested their coffee to be heated up. Per the Five-Day Follow-Up Report, the resident's allegation of verbal abuse was substantiated as Licensed Practical Nurse (LPN)2 stated she did witness CNA3 yell and argue back and forth with the resident but did not recall what was said by CNA3. The Five-Day Follow-Up Report revealed the facility terminated the employment of CNA3. During an interview on 04/08/2024 at 8:33 AM, R1 stated there had been a CNA that worked in the facility in January 2024, and they felt the CNA was just a mean individual. R1 stated they could not really state why the altercation occurred, but acknowledged they shouted at each other. R1 stated the facility resolved the issue when they got rid of (terminated the employment of) the CNA. During a telephone interview on 04/08/2024 at 2:29 PM, LPN2 stated R1 and CNA3 had a verbal disagreement as she could hear both the resident and CNA3. LPN2 stated she did not hear what was being said, but both were loud. LPN2 stated she pulled CNA3 from the resident's room and asked the resident to calm down. According to LPN2, the resident was upset over a cup of coffee. During a telephone interview on 04/08/2024 at 4:28 PM, CNA3 stated she usually fixed the resident two cups of coffee and that night she was orienting another CNA. CNA3 stated R1 yelled and screamed that they wanted their coffee, so she informed the resident that it would be a minute because she was orienting a new employee. CNA3 stated the nurse, LPN2, came down to the room because she heard the yelling, and she left the room. According to CNA3, the resident cursed at her. CNA3 stated she did not curse at the resident and the facility terminated her employment due to unprofessionalism. During an interview on 04/08/2024 at 11:45 AM, the Administrator stated CNA3 had a bad attitude and was terminated for being unprofessional. During an interview on 04/08/2024 at 2:03 PM, R1's roommate, R4, stated they recalled R1 hollering, but they could not tell what any of it was about or who said what. R4 stated R1 and the CNA were both loud. R4's quarterly MDS with an ARD of 01/13/2024, revealed the resident had a BIMS score of 13, which indicated the resident was cognitively intact. 2. A review of R3's Resident Face Sheet revealed the facility admitted the resident on 01/10/2022, with diagnoses that included chronic pain syndrome, osteoarthritis, and anxiety disorder. A review of R3's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/14/2024, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed the resident was dependent on staff for toileting hygiene and was always incontinent of bowel and bladder. A review of an undated Patient/Resident Incident/Accident Investigation Worksheet, completed by Registered Nurse (RN)12, revealed on 02/06/2024, R3 reported Certified Nursing Assistant (CNA)10 had been rough during care on 02/02/2024. Per the document, the resident sustained a skin tear to their left arm. The document revealed the CNA stated when the resident tried to swing at her, she put her arm up to keep her from being hit. The document revealed the resident acknowledged they swung at the CNA because the CNA tossed them during incontinence care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Five-Day Follow-Up Report, dated 02/09/2024, revealed upon investigation, the facility found that the CNA did grab the resident by their arm to stop the resident from hitting her and did not willfully inflict injury to the resident. The Five-Day Follow-Up Report revealed, the resident had evidence of discoloration to their left forearm as related to the incident. Per the Five-Day Follow-Up Report, the CNA would not return to the facility. During an interview on 04/08/2024 at 1:57 PM, R3 stated when the CNA turned them over during incontinence care, they felt the CNA was rough when they turned them in bed. R3 acknowledged the CNA grabbed their forearm as they swung their arm back at the CNA. According to R3, the nurse applied some cream on their arm, the CNA did not work anymore that evening, and had not provided care to them since. R3 stated they were fine, and the incident did not make them feel bad or anything. The surveyor attempted to interview CNA10 on 04/08/2024 at 12:59 PM, 04/08/2024 at 2:38 PM, and 04/08/2024 at 4:12 PM. Each time there was a fast busy signal and no voicemail. During a telephone interview on 04/08/2024 at 4:13 PM, RN12 stated she did not witness the event, but it occurred on 02/02/2024. She stated R3 informed her that the CNA scratched them. Per RN12, the CNA stated that she went in to provide incontinence care and when she rolled R3 over, the resident swung at them, and they put up their arm to block the swing. RN12 stated she removed the CNA from the room and assigned another aide to work with R3. RN12 stated she cleaned the skin tear and applied ointment and a covering. She stated there was no bruising to the area when assessed, only the skin tear. During an interview on 04/08/2024 at 12:12 PM, the Administrator stated she would expect residents to be protected from any type of abuse. During an interview on 04/08/2024 at 1:06 PM, the previous Director of Nursing (DON) stated once the incident was reported an investigation was started. The previous DON stated the CNA was removed from direct resident care, placed on suspension pending the investigation, and once the investigation was completed, the CNA was not allowed back in the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43648 Based on interviews, record review, document review, and facility policy review, the facility failed to timely report an allegation of physical abuse to the state survey agency for 1 (Resident (R)3) of 3 sampled residents reviewed for abuse. Findings include: The facility policy titled, Abuse, Neglect, Exploitation, or Mistreatment, revised on 10/23/19, revealed, 2. The Facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. A review of R3's Resident Face Sheet revealed the facility admitted the resident on 01/10/22, with diagnoses that included chronic pain syndrome, osteoarthritis, and anxiety disorder. A review of R3's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/14/24, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed the resident was dependent on staff for toileting hygiene and was always incontinent of bowel and bladder. A review of an undated Patient/Resident Incident/Accident Investigation Worksheet, completed by Registered Nurse (RN)12, revealed on 02/02/24, R3 reported Certified Nursing Assistant (CNA)10 had been rough during care on 02/02/24. Per the document, the resident sustained a skin tear to their left arm. The document revealed the CNA stated when the resident tried to swing at her, she put her arm up to keep her from being hit. The document revealed the resident acknowledged they swung at the CNA because the CNA tossed them during incontinence care. A review of the Initial Report, revealed R3 alleged a staff member exerted excessive force during incontinence care. Per the Initial Report, the state survey agency was notified of the abuse allegation on 02/06/24 at 5:07 PM, which was not submitted to the state survey agency timely. During a telephone interview on 04/08/24 at 4:13 PM, RN12 stated she did not witness the event, but it occurred on 02/02/24. She stated R3 informed her that the CNA scratched them. Per RN12, the CNA stated that she went in to provide incontinence care and when she rolled R3 over, the resident swung at them, and they put up their arm to block the swing. RN12 stated she removed the CNA from the room and assigned another aide to work with R3. RN12 stated she cleaned the skin tear and applied ointment and a covering. She stated there was no bruising to the area when assessed, only the skin tear. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/08/24 at 12:12 PM, the Administrator stated RN12 did not report the incident that occurred on 02/02/24 until 02/06/24 because she felt it was more resident behavior than abuse. The Administrator stated once she became aware, the allegation was reported to the state agency. The Administrator acknowledged the allegation of abuse should have been reported to the state agency 02/02/24. think the incident was abuse, but more of a resident behavior. During an interview on 04/08/24 at 1:06 PM, the previous Director of Nursing stated the allegation of abuse should have been reported to the state agency on 02/02/24.