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	01/23/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F600 Free from Abuse and Neglect - related to sexual abuseBased on observation, interview, and record review, the facility failed to ensure Resident (R)6 remained free from sexual abuse. The facility failed to protect R6, a cognitively impaired female who lacked the capacity to consent, from sexual contact initiated by R119. On 1/17/26, the Administrator was notified that R119 was engaged in inappropriate sexual interactions with R6, when R119 had his hand around R6's wrist, using R6's hand to masturbate R119's p****.Due to the cognitive impairment of R6, the Reasonable Person Approach was utilized to determine the negative effects of this non-compliance. A reasonable person in this same situation would feel serious adverse outcomes of psychosocial harm.On 01/23/26 at 1:36 PM, it was determined that the facility's non-compliance with one or more federal health, safety, and or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death.On 01/23/26 at 1:36 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 01/15/26 when the facility failed to report an elopement to the State Agency. The IJ was related to 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation. On 01/23/26, the facility provided an acceptable IJ Removal Plan. On 01/23/26 the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F600 at a lower scope and severity of D.Review of the facility policy, Abuse, Neglect, Exploitation, or Mistreatment with a complete revision date of 11/01/17, revealed, Policy: The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse . ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and reported immediately. Component: Identification: 2. Types of abuse include BUT ARE NOT LIMITED TO: C. Rape, molestation or other inappropriate sexual behavior against a resident, such as: 4. Inappropriate sexual behaviors displayed by and/or toward an incapable resident.Review of R6's Face Sheet revealed she was admitted on [DATE], with diagnoses of vascular dementia, Parkinsons, and bipolar disorder. Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated moderate cognitive impairment. The resident requires partial/moderate assistance to substantial to max assistance with Activities of Daily Living (ADLs).Review of R119's Face Sheet revealed he had a diagnosis of bipolar disorder. Review of R119's Annual MDS with an ARD of 10/25/25 revealed a BIMS Score of 13, indicating he is cognitively intact. The resident requires set-up or cleanup assistance to supervision assistance with ADLs.Review of the facility's Five Day Report indicated, During an interview on 01/17/26 at 7:39 PM, Licensed Practical Nurse (LPN)2 revealed she had walked over to a dining table where R6 was seated in a Geri chair, and R119 was seated in a wheelchair. R119 was observed with unzipped pants exposing his genitals while holding R6's wrist/hand in his lap. R6 did not appear confused or frightened as reported by LPN2.Review of R6's medical record revealed the resident has difficulty with decision-making at times and requires redirection and daily structured programs.Review of R6's psychiatric progress note dated 12/29/25 (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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	425169	A. Building B. Wing	01/23/2026

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed, She has been reported to the social worker for exhibiting intrusive behaviors, including recently snatching a peer's coloring book, taking items that do not belong to her, etc . Although her speech is clear and normal in rate and tone, she demonstrates impaired judgement and concrete thinking.Review of R119's medical record revealed resident has a history of periods of inappropriate behavior and inappropriate gestures towards staff during his shower in the shower room.Review of R119's Care Plan revealed R119 had a history of inappropriate behavior and inappropriate gestures. Approach directed staff to decrease inappropriate behaviors and gestures include communication.Review of R119's progress notes dated 01/17/26 revealed, Resident involved in sexual encounter and inappropriate touching with another resident. During an interview on 01/22/26 at approximately 3:16 PM, R6 stated, H*** no, I didn't do that.During an interview on 01/22/26 at approximately 4:09 PM, LPN2 revealed she observed R119 sitting in his wheelchair close to R6 in the dayroom/dining room on Unit 300. R119 had a blanket over his lap. LPN2 stated she observed R119 holding R6's wrist under the blanket. LPN2 removed the blanket and observed R119's genitals exposed. LPN2 stated she immediately told R119 to put his genitals back in his pants and zip up his pants. R119 rolled the wheelchair away from the table. LPN2 revealed R119 had previously been reported for inappropriate behaviors in the shower. LPN2 reported she immediately contacted Provider, RP [responsible party], On-call nurse, Psych, Director of Nursing (DON), and the Administrator.During an interview on 01/22/26 at approximately 4:30 PM, R119 stated, [R6] told me she had 15 orgasms. She dropped her crayons, and I tried to help her pick them up, but I couldn't. I did have a blue blanket; I put it over me. She's not to blame; she didn't touch me, she's not the one to blame. We all make mistakes. I don't want to get her in trouble.During an interview on 01/23/26 at approximately 10:50 AM, the DON revealed the incident was reported to her by LPN2 and the on-call supervisor. The DON stated she was told that it appeared R119 had his penis out and R6 had her hand on his penis. In her follow-up to the incident, R6 stated she wanted to masturbate and play with his balls. The DON stated she immediately had R119 moved to hall 100, did bed audits on all nonverbal females, took verbal statements from verbal female residents and staff, called 911 to report it, and psych was made aware. R119 was placed on 1:1 until the provider discontinued. The DON stated her expectations for staff are to immediately separate residents, ensure safety, notify the abuse coordinator, and immediately launch an investigation, dependent on the type of Reportable event, place the resident on 1:1. During an interview on 01/23/26 at approximately 10:57 AM, the Administrator revealed she was called by LPN2, who reported R119 and R6 were sitting closely to each other. R119 had a blanket over his lap. R6's hand was touching R119's genitals, and they were immediately separated. R119 was placed on 1:1, room change, authorities notified, providers contacted, statements were taken from staff, body audits on all female residents, verbal interviews with residents, and body audit on R6. Reports she is unaware of R119 having inappropriate behaviors. Expectations for staff is to separate residents immediately, contact the Abuse Coordinator (Administrator), and follow abuse policy. Removal Plan Included:Springdale F600 1/23/26 Resident #6 had a head to toe assessment completed on 1/17/26 by a licensed nurse. No injuries identified. A psychosocial evaluation was completed on Resident #6 by the Social Services Director on 1/19/26, 1/20/26, and 1/21/26 without negative effect. Resident #6 seen by psychiatrist on 1/21/26 with no negative effects identified. Resident # 119 was placed on 1: 1 supervision beginning 1/17 /26 until seen by medical provider and assessed to be safe to remove from 1: 1 supervision on 1/19/26. Resident #119 has psychosocial follow up by Social Services Director on 1/19/26, 1/20/26 and 1/21/26 without negative effects. Administrator/Designee interviewed alert and orientated residents to identify possible allegations of abuse on 01/17/2026. The Director ofNursing/Designee assessed cognitively impaired residents for signs and symptoms of abuse on O 1/17/2026. No additional residents identified. The facility staff were re-educated by the Administrator/Designee by O 1/17/2026 on the Abuse, Neglect and Misappropriation policy including: Identification of abuse or neglect, by observable and objective evidence, witness eports of unusual occurrence or patterns or (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	trends of potential abuse or neglect 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 of goods or services that are necessary to maintain physical, mental and psychosocial wellbeing. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse Inappropriate sexual behavior displays by and/or toward an incapable resident Immediate identification and removal of the alleged perpetrator Identification and assessment of the alleged victim Implementation of protective measures to maintain physical and psychological safety for alleged victims This reeducation began immediately on 1/17/26. Any staff not receiving this education will receive prior to their next scheduled shift. This education will be presented to agency staff and new hires. The Administrator and Director of Nursing review incident reports and grievance reports completed from the prior day in morning meeting daily Monday through Friday for identification of possible allegations of abuse. The weekend supervisor will review the incident reports and grievances on the weekends to identify possible allegations of abuse. The weekend supervisor will notify the Administrator and the Director of Nursing if any identified for further direction. Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held on 1/23/26 to discuss the Immediate Jeopardy Template and the contents of this plan The Medical Director was notified of the Immediate Jeopardy and the contents of this plan on 01/23/2026.

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	425169	A. Building B. Wing	01/23/2026

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, interview, observation, and record review, the facility failed to report the elopement of Resident (R)13 to the required community agencies. Specifically, on 01/15/26 at approximately 2:30 PM, R13 had a successful, unwitnessed elopement from the facility. The facility failed to report the elopement to the State Survey Agency as required. On 01/22/26 at 11:57 AM, it was determined that the facility's non-compliance with one or more federal health, safety, and or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death.On 01/22/26 at 11:57 AM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 01/15/26 when the facility failed to report an elopement to the State Agency. The IJ was related to 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation. On 01/22/26 at 2:30 PM, the facility provided an acceptable IJ Removal Plan. On 01/22/26 the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F609 at a lower scope and severity of D. Findings include: Review of the facility policy titled Elopement, with a complete revision date of 11/01/17, documented, Policy . A prompt investigation and search will be conducted if a patient/resident is considered missing. Procedures included, . 7. The Director of Nursing or designee notifies the Administrator/designee and notifies the appropriate community agencies, attending physician, and patient's/resident's legal representative.Review of the facility policy titled, Abuse, Neglect, Exploitation, or Mistreatment with a complete revision date of 11/01/17 documented, Policy: . 2. The facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve 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 State Survey Agency and adult protective services . 3. The facility's Leadership will conduct a prompt investigation of any allegation received of suspected abuse, neglect, or exploitation or mistreatment and will implement immediate action to safeguard resident. 4. The facility's Leadership will provide notification to the proper authorities .Review of R13's Face Sheet revealed R13 was originally admitted to the facility on [DATE], with a re-entry date of 09/12/25. R13's diagnoses included, but were not limited to, heart disease, heart failure, Type 2 diabetes, dizziness and giddiness, right below-the-knee amputation, anxiety disorder, major depressive disorder, and post-traumatic stress disorder.Review of R13's Progress Notes for 01/15/26 revealed no nursing notes regarding the elopement. Additionally, no notes were found showing the facility notified R13's medical provider or Responsible Person (RP).During an interview on 01/21/26 at 3:10 PM, R13 stated, Yes, I just rolled right out. It was Friday, no wait, it was last Thursday. I left through the exit the employees use. I got the code from a Certified Nurse Assistant (CNA) who used to work here. I just fiddled with the keypad and got it open. I wanted out of here. I got past the dumpsters on the side and onto the area with the white sand. I was almost to the street. I did this in the afternoon after lunch that day, probably about 3. A bunch of them found me: The Unit Manager, the Housekeeper/Activities person, and the Social Worker. I was going to go next door and get myself a Greyhound ticket. I want out of here.During an interview on 01/21/26 at 3:44 PM, the Medical Social Worker (MSW) stated, What? There are no notes about him leaving? I would have thought someone would have written something. I mean so many people were there - The Unit Manager, the Director of Nursing, a Medical Records staff member, and even a housekeeping person, I think. When asked about reporting the incident, the MSW responded, Yes, I did notify the Administrator right after it happened. That is why we changed his room. On the 300 Hall, we felt he would be safer because the exit doors there are right next to the Nurse's Station.During an interview on 01/21/26 at 3:15 PM, the Director of Nursing (DON) revealed, No, I didn't report it. I (continued on next page)

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	425169	A. Building B. Wing	01/23/2026

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	called the Ombudsman about the room change because he was so upset about the room change.During an interview on 01/21/26 at approximately 4:34 PM, the Administrator stated, No, I didn't report it. I didn't think this incident rose to the level of elopement and needed to be reported since the resident was in line of sight by an employee. On 01/22/26 at 2:30 PM, the facility provided an acceptable IJ Removal Plan, which included the following: 1. Resident #1 was identified outside of the facility on 1-15-2026 at approximately 3:15 pm. Resident #1 exited through the staff door on Unit 100. Staff members observed Resident #1 on facility premises and resident was resistant to return to the facility despite staff redirection. Resident #1 declined for a body audit to be obtained at this time. Resident #1 verbalized no injury. 2. Incident reported to the State Survey Agency and Ombudsman on 1-21-2026. 3. Progress notes from 1/15/2026-1/21/2026 were reviewed for exit seeking behaviors by the Director of Nursing/Designee. None identified.4. Administrator and Director of Nursing re-educated on Elopement and Investigation process by the Clinical Consultant on 1/21/2026 including:a. Root cause analysisb. Validating interventions in place to protect the residentc. Timely reporting per State Agency guidelinesd. Facility to safely and timely redirect patients/residents to safe environmente. A prompt investigation and search will be conducted if a patient/resident is considered missing.f. The Facility will determine a signal code, e.g. Code [NAME] to designate a missing patient/residentg. When the Patient/Resident is located, the Charge Nurse completes a head to toe assessment. The Social Service Designee assesses the patient/resident for emotional distress. The Charge Nurse reports any findings to the Director of Nursing or designee.The Director of Nursing or designee notifies the Administrator/designee and notifies the appropriate community agencies, attending physician and patient's/resident's legal representative.h. Implementation of protective measures to maintain physical and psychological safety for alleged victimsi. The Facility leadership contacts their Regional [NAME] President of Operations and their Clinical Services Director for recommendations at the time of the elopement.j. The Facility will 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 State Survey agency and other in accordance with state lawk. Conducting a prompt, thorough investigation of any allegation of abuse or neglect and grievances and appropriate actions taken to protect the residentl. Investigations should be prompt, comprehensive and responsive to the situation and contain founded conclusions 5. Social Services Director and Social Services Assistant were re-educated on 1-21-2026 by the Clinical Consultant on Elopement and exit seeking behaviors including notifications to Administrator and Director of Nursing. 6. A review of grievance and Incident reports from 10/01/2025-1/21/2026 has been completed by 1/21/2026 by the Director of Nursing or Administrator to identify any exit seeking behavior. None identified. 7. The Facility Staff will be re-educated by the Administrator/Designee by 1/21/2026 on the Elopement policy including:Facility to safely and timely redirect patients/residents to safe environmentA prompt investigation and search will be conducted if a patient/resident is considered missing.The Facility will determine a signal code, e.g. Code [NAME] to designate a missing patient/residentWhen the Patient/Resident is located, the Charge Nurse completes a head to toe assessment. The Social Service Designee assesses the patient/resident for emotional distress. The Charge Nurse reports any findings to the Director of Nursing or designee. The Director of Nursing or designee notifies the Administrator/designee and notifies the appropriate community agencies, attending physician and patient's/resident's legal representative.Re-educating facility staff the expectation that if a door is noticed to be non-functioning to report to management immediately and post an employee at the door until otherwise indicated and redirected by a member of management.Licensed nurses will be re-educated on the elopement risk assessment process/accuracy and putting interventions in place based on the risks identifiedWhen a resident expresses a desire to leave the facility and is alert and responsive, reeducate the resident on the process of signing out utilizing the leave of absence form and document understanding from the resident.Do not share door codes with residents or family (continued on next page)

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	425169	A. Building B. Wing	01/23/2026

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	membersWhen residents verbalize wanting to leave the facility and/or exit seeking behavior staff should immediately notify DON and Administrator This reeducation began immediately and will be completed by 1/22/2026. Any, including PRN, staff not receiving this education prior to this date will receive prior to next scheduled shift. This education will be presented in Agency and New Hire orientation. 8. Administrator and Director of Nursing will review incident reports and grievance reports completed from the prior day in morning meeting daily beginning 1/22/2026 for 7 days then Monday - Friday ongoing for identification of residents with possible exit seeking behaviors. The weekend supervisor will review the incident reports and grievances on the weekends to identify residents with possible exit seeking behaviors. The weekend supervisor will notify the Administrator and Director of Nursing if any identified for further direction. 9. Human Resources will interview 3 random employees daily beginning 1/22/2026 for one week to validate transfer of knowledge of education provided, then 3 employees weekly for 4 weeks.10. Ad Hoc QAPI was held on 1/21/2026 with Administrator, Director of Nursing, Unit Managers x2, Social Services Director, Social Services Assistant, Activity Director, Business Office Manager, Scheduler, Dietary Manager, Maintenance Director, Therapy Director, Staff Development Coordinator and Medical Director in which the Immediate Jeopardy Templates and the contents of this plan were discussed. The Medical Director was notified of the Immediate Jeopardy and the contents of this plan on 1/21/2026.Allegations of compliance 1/21/2026.

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	425169	A. Building B. Wing	01/23/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 review of facility policy, interview, observation, and record review, the facility failed to ensure Resident (R)13 was adequately supervised to prevent him from eloping from the facility on 01/15/26, for 1 of 1 resident reviewed for elopement. Specifically, on 01/15/26 at approximately 2:30 PM, R13 had a successful, unwitnessed elopement from the facility. R13 was found by staff members on a gravel road leading to the main street approximately 200 feet from the door he exited from. Review of R13's medical record showed no clinical notes were written and no clinical assessments were conducted related to the elopement. On 01/22/26 at 11:57 AM, it was determined that the facility's non-compliance with one or more federal health, safety, and or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death.On 01/22/26 at 11:57 AM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 01/15/26 when a resident successfully eloped from the facility. The IJ was related to 42 CFR 483.25 - Quality of Care, F689.On 01/22/26 at 2:30 PM, the facility provided an acceptable IJ Removal Plan. On 01/22/26 the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F689 at a lower scope and severity of D. Findings include:Review of the facility policy titled Elopement with a complete revision date of 11/01/17, documented, Policy: To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. Procedures documented, . 7. When the Patient/Resident is located, the Charge Nurse completes a head-to-toe assessment. The Social Service Designee assesses the patient/resident for emotional distress. Review of R13's Face Sheet revealed R13 was originally admitted to the facility on [DATE], with a re-entry date of 09/12/25. R13 was admitted with diagnoses included, but not limited to, heart disease, heart failure, Type 2 diabetes, dizziness and giddiness, right below-the-knee amputation, anxiety disorder, major depressive disorder, and post-traumatic stress disorder. Review of R13's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25, revealed R13 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R13 had no cognitive deficits. Further review of the MDS revealed R13 used a manual wheelchair independently and needed partial assistance from others for personal care. Review of R13's Care Plan revealed R13 was at risk for elopement and wandered throughout the facility. Approaches to prevent elopement included identifying R13 to staff as an elopement risk, ensuring R13's physical needs were met, and assessing R13 for activities of interest. Review of R13's Elopement Risk Observation dated 09/12/25 revealed R13 had a history of attempting to leave the health care center, had expressed discontent with the health care center, and had a diagnosis that required supervision. Review of R13's Progress Notes dated 01/15/26, revealed no nursing notes regarding the elopement. Additionally, no notes were found showing the facility notified R13's medical provider or Responsible Person (RP) of the elopement. Review of R13's Assessments revealed no clinical assessments were documented post-elopement. Review of the daily temperatures on Weather.com revealed the daytime high for the area on 01/15/26 was 43 degrees Fahrenheit. During an interview on 01/21/26 at 3:10 PM, R13 revealed, Yes, I just rolled right out. It was Friday, no wait, it was last Thursday. I left through the exit the employees use. I got the code from a Certified Nurse Assistant (CNA) who used to work here. I just fiddled with the keypad and got it open. I wanted out of here. I got past the dumpsters on the side and onto the area with the white sand. I was almost to the street. I did this in the afternoon after lunch that day, probably about 3. A bunch of them found me: The Unit Manager, the Housekeeper/Activities person, and the Social Worker. I was going to go next door and get myself a Greyhound ticket. I want out of here. During an interview and observation on 01/21/26 at 3:44 PM, the Medical Social Worker (MSW) revealed, Yes, (continued on next page)

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	425169	A. Building B. Wing	01/23/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[R13] sneaked out. It was the day his room was changed. It was on 01/15/26. He left through the staff exit on the side. I can show you which one. He went all the way past the dumpsters on the dirt road heading towards Battleship Road - the street out front. He left out the side door. It is a door the staff go in and out of. I asked him how he got the code for the door. He said a CNA gave it to him. We had changed the code, I think, so I don't know if that was how he did it. If you push the door long enough, it will open. Once we got to him, we redirected and talked to him. He was mad and upset. We then got him situated in his room. The protocol when this happens is I follow up with the Resident to do a psychosocial note, follow up with psych services, and notify the administrator. Surveyor informed the MSW that there were no notes, the MSW replied, What? There are no notes about him leaving? I would have thought someone would have written something. I mean so many people were there - The Unit Manager, the Director of Nursing, a Medical Records staff member, and even a housekeeping person. During an observation, the MSW showed the Surveyors the door R13 eloped through and pointed to the area R13 was found. The door to the hallway leading to the exit door had a sign on it stating, Staff Only and was located on the 100 Hall next to the Meeting Room. While looking through the exit door window, the MSW revealed, See the dumpsters there? He was way past them. He was on the dirt road beyond the dumpsters. He was going towards the main street, Battleship Road, outside the building. I would say he was at least 200 feet away from the door. During an interview on 01/21/26 at 3:15 PM, the Director of Nursing (DON) stated, [R13] was upset about a room change. He exited through the employee side door. He said that a staff member gave him the code. He was near the kitchen area, behind the dumpster on the gravel going toward the gravel road. The Unit Manager [(UM)1] saw [R13] from a distance and someone from the kitchen saw [R13] leaving the facility. During an interview on 01/21/26 at approximately 4:34 PM, the Administrator stated, [R13] was upset about his room change with his roommate. He told staff that he was going to leave the facility. He was located by the trash dump. [UM1] and a dietary staff member had [R13] in the line of sight leaving the facility. [UM1] was on break or clocking out. I'm not sure how he got out. He exited out the door by the conference room.During an interview on 01/21/26 at approximately 4:45 PM, R13 stated, No, I did not sign myself out when I left. During an interview on 01/22/26 at 8:25 AM, UM1 stated, I pulled up on Thursday at the employee door getting ready to clock out. I went in, clocked out, and he (R13) was at the road with the kitchen staff. He said he wanted to leave. Not sure what went on after that. I didn't see him leave the building. When I pulled up, he was already outside the door. I don't know the name of the kitchen staff that found him. During an interview on 01/22/26 at 8:30 AM, the Kitchen Manager (KM)1 revealed, I wasn't aware my staff found him outside. We had a meeting about this last night. I'll ask my staff. During an interview on 01/22/26 at 8:49 AM, Dietary Aide (DA)1 stated, I was going home. I clocked out and went outside. I saw him, and he was in his wheelchair. He was stuck in a hole near the road. I went to go talk to him, and he told me he was getting the h*** out of here. More staff came out to help, and I stepped back and let them take care of it. I don't remember what he was wearing. On 01/22/26 at approximately 1:10 PM, the Administrator informed the survey team of a discrepancy in the IJ Template related to the 200 feet distance that was revealed during an interview with the MSW. The Administrator stated Maintenance measured the distance to where the resident was found, which measured 82 feet. The Administrator also stated the resident was found on the sidewalk where the sidewalk meets the dirt road. At this time the Administrator also revealed there was video footage of the incident and a copy was requested, however the video footage was never received. On 01/22/26 at 2:30 PM, the facility provided an acceptable IJ Removal Plan which included the following:1. Resident #1 was identified outside of the facility on 1-15-2026 at approximately 3:15 pm. Resident #1 exited through the staff door on Unit 100. Staff members observed Resident #1 on facility premises and resident was resistant to return to the facility despite staff redirection. Resident #1 declined for a body audit to be obtained at this time. Resident #1 verbalized no injury.2. Resident #1's elopement risk evaluation repeated on 1-21-2026. Any resident identified has high risk for elopement had interventions validated and care plans (continued on next page)

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	425169	A. Building B. Wing	01/23/2026

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	updated. No new were identified.3. Grievances reviewed from 10-01-2026-1-21-2026 regarding resident exit seeking behaviors- no concerns identified.4. Progress notes were reviewed from 1-15-2026 through 1-21-2026- no concerns identified.5. Maintenance Director immediately performed an audit on 01-21-2026 to validate facility exits alarms were functioning properly and code for doors was changed. No concerns identified with exit doors.6. Residents at risk of elopement have the potential to be affected.7. The Facility Staff were re-education on 1-21-2026 by the Director of Nursing/Designee regarding the Policy including:a. Re-educate facility staff the expectation that if a door is noticed to be non-functioning to report to management immediately and post an employee at the door until otherwise indicated and redirected by a member of management.b Licensed nurses will be re-educated on the elopement risk assessment process/accuracy and putting interventions in place based on the risks identified.c. Facility to safely and timely redirect patients/residents to safe environmentd. A prompt investigation and search will be conducted if a patient/resident is considered missing.e.The Facility will determine a signal code, e.g. Code [NAME] to designate a missing patient/residentf. When the Patient/Resident is located, the Charge Nurse completes a head-to-toe assessment. The Social Service Designee assesses the patient/resident for emotional distress. The Charge Nurse reports any findings to the Director of Nursing or designee. The Director of Nursing or designee notifies the Administrator/designee and notifies the appropriate community agencies, attending physician and patient's/resident's legal representative.g. Implementation of protective measures to maintain physical and psychological safety for alleged victims.o When a resident expresses a desire to leave the facility and is alert and responsive, reeducate the resident on the process of signing out utilizing the leave of absence form and document understanding from the resident.o Do not share door codes with residents or family members.o When residents verbalize wanting to leave the facility and/or exit seeking behavior staff should immediately notify DON and Administrator.Re-education will be completed by 1-21-2026Any member of target audience not receiving this by this date will receive prior to next scheduled shift, as education has been added to agency staff prior to the start of the next shift.8. Social Services Director and Social Services Assistant re-educated on 1-21-2026 on Elopement and exit seeking behaviors including notifications to Administrator and Director of Nursing.9. Administrator and Director of Nursing re-educated 1-21-2026 by the Clinical Nursing Consultant on the Elopement policy and Investigation process including:Root cause analysisa) Validating interventions in place to protect the resident Facility to safely and timely redirect patients/residents to safe environment.b) A prompt investigation and search will be conducted if a patient/resident is considered missing.c) The Facility will determine a signal code, e.g. Code [NAME] to designate a missing patient/resident.d) When the Patient/Resident is located, the Charge Nurse completes a head to toe assessment. The Social Service Designee assesses the patient/resident for emotional distress. The Charge Nurse reports any findings to the Director of Nursing or designee. The Director of Nursing or designee notifies the Administrator/designee and notifies the appropriate community agencies, attending physician and patient's/resident's legal representative.e) Implementation of protective measures to maintain physical and psychological safety for alleged victims.f)When a resident expresses a desire to leave the facility and is alert and responsive, reeducate the resident on the process of signing out utilizing the leave of absence form and document understanding from the resident.Do not share door codes with residents or family members.When residents verbalize wanting to leave the facility and/or exit seeking behavior staff should immediately notify DON and Administrator.10. New admissions elopement risk assessments will be reviewed in morning meeting daily Monday thru Friday as part of the clinical morning meeting process for accuracy and to validate interventions if indicated. Quarterly elopement risk assessments will be reviewed for accuracy and to validate interventions are in place if indicated as part of the MDS/Care planning process.11. The Director of Nursing will randomly audit a minimum of 5 elopement assessments weekly for 4 weeks then monthly for 2 additional months to validate accuracy.12. The Maintenance director will inspect facility doors 3 times weekly for 4 weeks (continued on next page)

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	425169	A. Building B. Wing	01/23/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	then weekly for 2 additional months.13. The Facility Administrator will make rounds weekly for 4 weeks then monthly for 2 additional months with maintenance director to validate that door are functioning properly.Ad hoc QAPI held on 01-21-2026Medical Director, Dr. Binyue [NAME] was notified of the incident and plan for improvement on 01-21-2026This process will be reviewed in QAPI for a minimum of 3 monthsAllegation of Compliance 1-21-2026

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	425169	A. Building B. Wing	01/23/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review and interview, the facility failed to update and revise Resident (R)25's Care Plan to reflect the resident's election for Do Not Resuscitate (DNR) status for 1 of 3 residents reviewed.Findings include: Review of the facility policy titled Care Plan Process, Person-Centered Care with a complete revision date of [DATE], documented, The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident . Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices . The services provided or arranged by the facility, as outlined by the comprehensive person-centered care plan, will meet professional standards of quality. Procedures: 6. The Interdisciplinary Team (IDT) will review for effectiveness and revise the person-centered care plan after each assessment . 9. Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change off condition dictates the need . Review of the facility policy titled Advance Directives with a complete revision date of [DATE] documented, Policy: The facility recognizes the resident's right to formulate an advance directive. Intent: this policy and procedure provide instruction to Facility staff for obtaining, honoring, and implementing advance directives to the fullest extent of the law. Review of R25's Face Sheet revealed R25 was admitted to the facility on [DATE], with diagnoses including but not limited to: aphasia, Hypokalemia, Hypomagnesemia, lump in the right breast, unspecified quadrant, other specified disorders of bone density and structure, and vascular dementia. Review of R25's Physician Orders revealed an order, Admit to Pathway Hospice and Palliative Care, . Admitting Diagnosis: Vascular Dementia with a start date of [DATE]. Further review of the Orders revealed an order for, CODE STATUS: DNR with a start date of [DATE]. Review of a Telephone Order for R25 dated [DATE] and signed by a physician, revealed under section Medication/Order - DNR. Review of R25's South Carolina Physician Orders for Scope of Treatment (POST), signed on [DATE], revealed under Section A Cardiopulmonary Resuscitation (CPR): Unresponsive, pulseless, & not breathing, the selection Attempt Resuscitation/CPR. Review of R25's South Carolina Physician Orders for Scope of Treatment (POST), signed on [DATE], revealed under Section A Cardiopulmonary Resuscitation (CPR): Unresponsive, pulseless, & not breathing, the selection Do Not Attempt Resuscitation/DNR (Allow Natural Death) was selected.Review of R25's Care Plan with a start date of [DATE] revealed, [R25's] family has chosen to utilize hospice services due to terminal DX of vascular dementia. She is at risk for increased physical needs and psychosocial needs with end of life. The approach directed staff to, Ensure [R25's] care wishes are aligned with written advanced directives or spoken and documented request of care directives. Further review of R25's Care Plan revealed, Problem: Advance Care Planning: Code Status is Full Code with a start date of [DATE]. The approach directed staff to, Advanced directives of [R25's] choice completed and placed on medical record under advanced directive tab or in documents in Matrix , [R25] has completed the following advanced directives and copies are in the medical record (X) Full Code and [R25] will be informed of her right to complete advanced directives to direct her medical care and make his/her values and treatment goals known. Ms. [NAME] Bowles's RP stated desires will be honored.During an interview on [DATE] at 12:04 PM, the Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Coordinator stated, On that usually when code status is changed, social services is supposed to change the code status. They would update that.During an interview on [DATE] at 12:09 PM, Social Services Assistant (SS1) and Social Services Director (SSD) stated SS1 and SSD are responsible for updating code status. SSD did the paperwork for DNR on [DATE], it was scanned in. SS1 defers to SSD when asked about the code status in the R25's Care Plan. The SSD states she was Full code and the family switched her to DNR. (continued on next page)

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	425169	A. Building B. Wing	01/23/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was signed on [DATE]. It could have been a mistake. I will update that right now.During an interview on [DATE] at 12:15 PM, the Administrator stated the expectation is to update them as changes are made.

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	425169	A. Building B. Wing	01/23/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on facility policy review, observation, record review, and interview, the facility failed to maintain accurate narcotic medication records for 2 of 6 medication carts reviewed for medication storage. Findings include:Review of the facility policy titled Medication Management Program with a complete revision date of 05/05/23, revealed, Preparing for the Medication Pass: . 8. Documentation of medications administered is completed according to State and Federal requirements. The initials and verifying signature are generally required . Security and Safety Guidelines: . 9. Controlled substances are accounted for each patient/resident on a Controlled Substance Record (obtained from the contract pharmacy) . Administering the Medication Pass: . 11. Immediately after administering the medication to the resident, the authorized staff or licensed nurse will return to the medication cart and document medication administration with initials on the MAR.During a count of the narcotic medications in one medication cart on the 100 Hall, revealed seven instances of the count of Residents' narcotic medications not matching the number on the Residents' narcotic count sheets.During a count of the narcotic medications in one medication cart on the 200 Hall, revealed two instances of the count of Residents' narcotic medication not matching the number on the Residents' narcotic count sheets.During an interview on 01/22/26 at 1:00 PM, Licensed Practical Nurse (LPN)4 stated, I'm so sorry. I'm so sorry. I don't want to give the medications late, so I go back to document on the narcotic count sheets after I'm all done with my medication pass. I guess I forgot today.During an interview on 01/22/26 at 1:10 PM, Unit Manager (UM)2 stated, The narcotics should be signed out on the sheet as soon as they are given. I think she (LPN4) got nervous with you here.During an interview on 01/22/26 at 2:10 PM, UM3 revealed, The narcotics should be signed out when they are given to the resident.During an interview on 01/22/26 at 2:20 PM, UM3 revealed, If [LPN3] was an employee, I would start the Performance Management process and corrective action. She is from an agency. I haven't worked with her before. She usually works nights. I will have to ask the Director of Nursing about what to do in this case.During an interview on 01/22/26 at 2:45 PM, LPN3 stated, I was distracted. [R99] was asking for BioFreeze. So much was going on. I normally sign the narcotic sheets as soon as I give the medications.During an interview on 01/22/26 at an unspecified time, the Director of Nursing (DON) revealed, I just want to show you that [LPN4] had already received verbal counseling about not documenting on the narcotic count sheets. I have given her a final warning based on the findings today of her not documenting those seven instances of giving narcotic medications.During an interview on 01/23/26 at 11:00 AM, the DON stated, My expectation is the nurses document giving narcotics as soon as they are given. That involves documenting on the narcotic sheets and in the electronic record. I expect at change of shift, the nurses verify the counts and sign the sign out/sign in sheets. They need to look at the narcotic medication cards and the narcotic count sheets to verify the counts are the same. Yes, I am aware of the second nurse who didn't document on the narcotic sheets. I had walked up when it was discovered when you were doing the counts with the Unit Manager. She is an agency nurse. I provided education to her yesterday regarding the situation.

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	425169	A. Building B. Wing	01/23/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on review of the facility policy, observation, record review and interview, the facility failed to ensure a medication administration rate of less than 5 percent for 3 out of 29 opportunities for error. The medication administration error rate was 10.34 percent. Findings include:Review of the facility policy titled Medication Administration - Insulin Pen under Preparing the Pen documented, . 2. Removes the external pen cover and inspects the excessive air in the cylinder and that the internal screw mechanism is attached to the internal plunger. 3. Wipes the rubber stopper on the end of the pen with an alcohol pad. 4. Removes the tabbed paper seal from the outer cap of a new single-use safety insulin pen needle. 5. Screws the needle into the rubber stopper unit it stops . Priming the Pen: 1. Removes the outer needle cap and dials 2 units. 2. Points the pen up and presses the plunger button to expel 2 units of insulin. 3. Repeats these steps as needed until a drop of stream of insulin appears at the needle tip.Review of the facility policy titled Medication Administration, Liquids documented, 5. Measures dosage precisely using a medicine cup or syringe. 6. Dilutes medication according to pharmacy and or manufacturer's specification.Review of Resident (R)11's Face Sheet revealed the facility admitted R11 with diagnoses including but not limited to, Diabetes Mellitus.During an observation on 01/22/26 at 8:18 AM, Licensed Practical Nurse (LPN)1 failed to prime the insulin pen for R11, receiving 5 units of Aspart Insulin (Novolog) via a kwik pen.During an interview on 01/22/26 at 8:20 AM, LPN1 confirmed that she had not primed the insulin pen, prior to administering the 5 units of insulin.During an observation and interview on 01/22/26 at 8:18 AM, of the oral medications for R11, LPN1 administered Miralax 17 grams. LPN1 mixed the medication in 3 ounces of water instead of the 6 - 8 ounces required to promote the efficacy of the medication. LPN1 confirmed that she had not used the 6 to 8 ounces of liquid to promote the desired results from the Miralax for R11. Review of R85's Face Sheet revealed the facility admitted R85 with diagnoses including, but not limited to, Diabetes Mellitus. During a second observation of the administration of Lantus Insulin 24 units for R85 by LPN1, LPN1 failed to prime that insulin pen, LPN1 confirmed that she failed to prime the insulin pen for R85.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on review of the facility policy, observation and interview, the facility failed to ensure Resident (R)85 and R11 were free from significant medication errors related to insulin administration via a Kwik Pen, for 2 of 2 residents observed receiving insulin by Licensed Practical Nurse (LPN)1.Findings include:Review of the facility policy titled Medication Administration - Insulin Pen under Preparing the Pen states, . 2. Removes the external pen cover and inspects the excessive air in the cylinder and that the internal screw mechanism is attached to the internal plunger. 3. Wipes the rubber stopper on the end of the pen with an alcohol pad. 4. Removes the tabbed paper seal from the outer cap of a new single-use safety insulin pen needle. 5. Screws the needle into the rubber stopper unit it stops . Priming the Pen: 1. Removes the outer needle cap and dials 2 units. 2. Points the pen up and presses the plunger button to expel 2 units of insulin. 3. Repeats these steps as needed until a drop of stream of insulin appears at the needle tip.Review of R11's Face Sheet revealed the facility admitted R11 with diagnoses including but not limited to, Diabetes Mellitus.During an observation on 01/22/26 at 8:18 AM, LPN1 failed to prime the insulin pen for R11, who received 5 units of Aspart Insulin (Novolog) via a kwik pen.During an interview on 01/22/26 at 8:20 AM, LPN1 confirmed that she had not primed the insulin pen, prior to administering the 5 units of insulin.Review of R85's Face Sheet revealed the facility admitted R85 with a diagnoses including, but not limited to Diabetes Mellitus. During an observation and interview on 01/22/26 at an unspecified time, of the administration of Lantus Insulin 24 units for R85 by LPN1, LPN1 failed to prime that insulin pen, even after an interview earlier when she (LPN1) administered the insulin for R11 and had not primed the pen. LPN1 confirmed that she failed to prime the insulin pen for R85.During both interview with LPN1, she could not confirm that R85 and R11 had received the correct dosage of insulin due to failing to prime the insulin pens.

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	425169	A. Building B. Wing	01/23/2026

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Springdale Healthcare Center	146 Battleship Road Camden, SC 29020

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, record review and interview, the facility failed to ensure the facility were free of pests in 3 resident rooms on 2 different units.Review of the facility policy titled Pest Control with a complete revision date of 06/20/23, documented, Facility will maintain an effective pest control program to prevent or eliminate infestation of pests and rodents. Review of a Service Report from Ecolab with a service date of 01/22/26, revealed, Inspected selected areas. Inspected and treated selected areas. Rooms serviced today: 113 331. Rooms maybe returned to service after sitting one hour and a thorough deep clean. PEST ACTIVITY FOUND. Further review of the Service Report revealed, AREA Patient/Guest Rooms - Interior - Interior FINDINGS Bed Bugs noted during treatment 311 ACTION NEEDED/TAKEN This area was inspected and serviced. The last section of the Service Report revealed, MATERIAL MATERIAL APPLIED: Finito QTY USED: 92.0 OZ REGULATORY NUMBER 25B APPLICATION TARGET PEST: Bedbugs APPLICATION METHOD: Crack & Crevice. During an observation and interview on 01/21/26 at 2:25 PM, of room [ROOM NUMBER] revealed what appeared to be roaches crawling in the sanitizer station near the resident's bathroom. The resident stated, There are always bugs in here, they are in the lights, the sanitizer container and on the ceilings. They came in to spray for the bugs 2 days ago. During an observation on 01/22/26 at approximately 4:30 PM, of room [ROOM NUMBER] revealed the residents' belongings were packed in trash bags and placed on top of the residents' bed.During an observation on 01/23/26 at 10:23 AM, of room [ROOM NUMBER] revealed the residents' belongings were placed in the hallway, in front of the room, on a rack. The belongings included bags of clothes, a walker, and plastic bins.During an interview on 01/23/26 at 10:26 AM, R56, who lives across the hall in room [ROOM NUMBER], stated he doesn't like all this junk in front of his room. R56 further stated he thinks there are rats or water bugs in the room and they are cleaning it out.During an interview on 01/23/26 at 10:29 AM, the Floor Tech stated we pulled everything out to deep clean that room. The Floor Tech further stated, I was not aware of any pest control issues in that room. During an interview on 01/23/26 at 10:31 AM, Housekeeper 1 stated they might be doing a deep clean or stripping the floor. Housekeep 1 further stated, I've worked over there and knew nothing about bed bugs or pest. During an interview on 01/23/26 at 10:38 AM, the Maintenance Director (MD) stated we sprayed the room (room [ROOM NUMBER]) cause the resident stated he saw a roach in the room, so we removed his belongings and sprayed the room. The MD further stated, I haven't seen any roaches even after the spray treatment. During an interview on 01/23/26 at 11:30 AM, the Administrator stated in full transparency we had an issue with bed bugs in room [ROOM NUMBER]. The Administrator further stated the room has been treated and is now under control. It was isolated to room [ROOM NUMBER]. During an interview on 01/23/26 at 11:42 AM, R87 stated they have roaches sometimes but not a whole lot of them. They are the little roaches not the big ones. People come out to spray. During an interview on 01/23/26 at 11:46 AM, R120, who lives in room [ROOM NUMBER], stated, I've noticed bugs in here. Roaches that's about it. I see them crawling through the day room. I don't know where it came from. This was sometime last year. During an interview on 01/23/26 at 11:47 AM, R60, who lives in room [ROOM NUMBER], stated, We got little black bugs about the size of rice. They came out the ceiling. I caught one, one night and it got a hard shell. If you leave food out, it comes down and lands on the food, even if you leave water out. To me that's nasty. I see them every night. During a follow up interview on 01/23/26 at 12:39 PM, the MD stated, They spotted a couple bed bugs in room [ROOM NUMBER], they notified me on Wednesday. I had a guy come from Ecolab to spray yesterday. I am not aware of any other issues with bed bugs throughout the facility. During an observation on 01/23/26 at 2:50 PM, while the survey team was conducting a team meeting in the meeting room, a roach was observed crawling across the meeting room table. This was observed by multiple surveyors.