STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425175	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Physical Rehabilitation and Wellness Center of Spa	8020 White Avenue Spartanburg, SC 29303

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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 record reviews and interviews, the facility failed to ensure a resident (R)1, who was on NPO (nothing by mouth) status, was adequately supervised to prevent the resident from receiving a cereal bar and a cup of water. Resulting in the resident experiencing symptoms of projectile vomiting and clamminess, which resulted in hospital transfer.On 02/19/26 at 03:45 PM, the State Agency (SA) 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 02/20/26 at 09:35 AM, the Administrator was notified that failure to ensure a resident who was on NPO status was adequately supervised to prevent the resident from receiving a cereal bar and cup of water constituted Immediate Jeopardy (IJ) at F689.On 02/20/26 at 09:35 AM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility that IJ existed as of 02/07/26. The IJ was related to 42 CFR 483.25 - Free of Accident Hazards/Supervisions/Devices.On 02/20/26 at 11:02 AM, the facility provided an acceptable IJ Removal Plan. On 02/20/26 at 11:52 AM, the survey team validated the facility's corrective actions and removed the IJ, confirming the facility had put forth good faith attempts to correct the deficiency prior to survey, warranting the IJ at Past-noncompliance, effective 02/10/26.Findings include:A review of the facility policy titled, Food from Outside Sources, Safe Handling of, with a complete revision date of 08/01/20, states: 3. To the extent possible, nursing staff monitor the food provided for patients or residents by outside sources to verify safe handling, storage, and appropriateness for the recommended dietary needs of the individual patient/resident.R1 was admitted to the facility on [DATE] at 10:13 AM with diagnoses including but not limited to vomiting, convulsions, essential (primary) hypertension, and gastrostomy status.A review of R1's Physician's orders revealed an active order for Dietary Order-NPO with a start date of 01/07/2026. A review of R1's care plan with a start date of 02/07/23 revealed that [R1] is at high nutrition risks r/t [related to] Dysphagia with dependence on EN [enteral nutrition] for 100% nutrient/energy needs; Functional Quadriplegia/Hx [history] of SAH; Epilepsy.A review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/26 revealed R1 had not been assessed for a Brief Interview of Mental Status (BIMS). In addition, R1 had a memory problem and had modified independence. R1 has a nutritional approach, which was a feeding tube.A review of R1's Interact SBAR completed by Licensed Practical Nurse (LPN)1 dated 02/08/26 at 02:12 AM, which states that the event started on 02/07/26 with symptoms of vomiting, sweating, clamminess, and grg (gurgling). The resident ate a cereal bar from a church member. Resident is NPO, primary diagnosis dysphagia. Vital signs: BP 184/108.A review of Hospital records from Spartanburg Medical Center with a hospital admission date of 02/08/26 revealed 45 yo [Male] M [history]hx [Intracerebral hemorrhage] ICH w/ residual [left] L-sided deficits, [stroke]CVA, schizophrenia . who presents to SMC ED from SNF for vomiting. He was intubated for airway protection . 1. Suspected Aspiration (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Pneumonia. Care Level: Critical Care. On 02/13/2026 Tracheostomy was done.A phone interview with R1's brother on 02/19/26 at 11:45 AM revealed, My brother is not supposed to have anything by mouth. The facility called me on 02/07/26 and stated visitors from the local church came, and gave pts [patients] snacks and drinks, and his brother was one of them. My brother took the snacks. They called me that day, and told me he ate it, and the nurse stated they would keep an eye on him to see if anything happens during the day on 02/07/26, after midnight going into 02/08/26. He states he received another call stating he was vomiting, and he had to get sent out. He is still in the hospital, in a coma, for the moment.During an interview with Certified Nursing Assistant (CNA)1 on 02/19/26 at 12:11 PM revealed that On the day of 02/07/26, he (R1) was in his room, sitting back on his bed, he had a cereal bar in his mouth. She stated she removed it from his hand. She notified the nurse. She saw the visitors, not his usual visitors, but church members who do missionary work, which is common on weekends.During a phone interview with LPN2 on 02/19/26 at 1:00 PM, LPN2 states she was walking by and noticed a cereal bar (blue wrapper) and a Styrofoam cup. She states she took what he had; he had some in his mouth and some in his hand. Half of the bar was in his mouth, maybe 2 inches left, all smushed up. All of the water was gone. He could not tell her who gave it to him.A phone interview with the Medical Director (MD) on 02/19/26 at 1:15 PM revealed his understanding that the incident occurred on 02/07/26 when an unknown church member or group came in and gave the resident a cereal/granola bar along with some water.A phone interview on 02/19/26 at 1:51 PM with the Nurse Practitioner (NP) revealed she received a call from the nurse that night stating R1 was NPO and that earlier that day, he had received a cereal bar and some water from a church group that visited. The nurse reported symptoms of projectile vomiting and clamminess present; she gave the order for the resident to be sent out. The NP stated that eating and drinking while on NPO (nothing by mouth) can lead to vomiting. She also stated that his blood pressure at the time, 184/100, is considered critically high and an urgent situation.An interview with the Facility Administrator (FA) on 02/19/26 at 3:11 PM revealed that he first heard about the event with R1 on the following Monday, 02/09/26, during the morning meeting, which included a review of nurses' notes, clinical review, and all department heads. He explained that during the day on weekends, the facility has a receptionist present. If she is away from the desk, she informs the nurses so they can monitor visitors. Accushield, the screening tool for visitors, is hit or miss when a group of people enters at the same time. The last update on R1 is that he had a tracheostomy. The expectation is that when he returns, he will be on the rehab side. Immediate actions taken included speaking with staff, implementing bright pink signage to inform visitors not to offer food or drink without consulting nurses due to the resident's condition, and discussions with the clinical team. The facility's removal plan included:The identified resident was assessed by the provider following the incident on 02/07/26 with orders implemented. The resident was discharged to the hospital on [DATE]. Residents in-house who have orders for nothing by mouth were assessed for change in condition, including change in vital signs, respiratory distress, and gastrointestinal distress by the Director of Nursing/Designee on 02/09/26; no concerns identified. A sign was placed at the entrance of the facility for visitors and/or delivery drivers to consult with a nurse prior to delivering and/or providing food or drink to a resident. Residents who have orders for nothing by mouth had signs posted in their rooms identifying them as nothing by mouth and to contact the nurse prior to providing any food or drink to the resident on 2/10/26. Facility Staff were reeducated by the Administrator/Designee beginning 02/09/26 on the policy of food brought in from outside sources Including: Questioning visitors providing food/drink to a resident to check with the nurse first. Requesting visitors to notify the nurse prior to providing food/drink to a resident. The facility (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	will complete audits of food distributed from outside sources, validating proper distribution 3x a week for 1 month, then randomly thereafter. Ad Hoc QAPI was held on 2/10/26. The Medical Director was notified on 02/08/26 and updated with interventions completed. Allegation of Compliance 2/10/26.