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	01/16/2026

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 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. Based on facility policy review, record review, and interviews, the facility failed to protect the Resident (R)19's rights to be free from sexual abuse, from R79, for 1 of 7 residents reviewed for abuse. This failure had the likelihood of causing physical, mental, and psychosocial harm.On 01/14/26 at 3:45 PM, the Administrator and Director of Nursing (DON) were notified that the failure to protect a resident from sexual abuse constituted Immediate Jeopardy at F600.On 01/14/26 at 3:45 PM, the survey team provided the Administrator with a copy of the CMS IJ Template and informed the facility IJ existed as of 12/09/25. The IJ was related to 42 Code of Federal Regulations (CFR) 483.12 - Freedom from Abuse, Neglect, and Exploitation.On 01/16/26 at 3:04 PM, the facility provided an acceptable IJ Removal Plan. On 01/16/26 the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at a lower scope and severity of D. An extended survey was conducted in conjunction with the Recertification and Complaint Survey for non-compliance at F600, constituting substandard quality of care.Findings include:Review of the facility policy titled Abuse, Neglect, Exploitation, or Mistreatment revised on 10/23/2019, indicated, . 1. The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of a patient's/resident's property and/or funds . Definitions . 1. Abuse is the willful infliction . Instances of abuse of all residents, irrespective of any mental or physical condition . It includes verbal abuse, sexual abuse . Review of R79's Face Sheet revealed the facility admitted R79 on 07/30/24 with diagnoses including but not limited to: dementia, depression, anxiety disorder, personal history of transient ischemic attack (TIA) and cerebral infarction (a stroke) without residual deficits, and a cognitive communication deficit. Review of R79's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/06/25, indicated that R79 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident had moderate cognitive impairment. The MDS revealed that the resident exhibited other behavioral symptoms not directed toward others during the assessment period. The MDS indicated that such behaviors could include hitting, scratching self, pacing, public sexual acts, disrobing in public, or verbal/vocal symptoms such as screaming. Review of R79's 1 Psychiatric Follow-Up Evaluation (Addendum), dated 10/17/25, revealed that staff had reported that the resident was exhibiting hypersexual behaviors, frequently entering rooms of residents of the opposite sex. Per the record, there had been no witnessed incidents or assaults, and the resident had been easy to redirect. The record included an Addendum that indicated that the report was based on nursing staff reporting that the resident had engaged in sexually inappropriate behaviors. Review of R19's Face Sheet revealed the facility admitted R19 on 04/19/25 with diagnoses including but not limited to: vascular dementia, psychosis, anxiety, and cognitive communication deficit. Review of R19's Quarterly MDS, with an ARD of 10/23/25, revealed R19 had a BIMS score of 3 out of 15, which indicated the resident had severe cognitive impairment. Review of R19's Care Plan included a problem statement initiated on 04/27/25, that indicated the resident had impaired decision-making related to vascular dementia. Interventions directed staff to encourage the resident to verbalize feelings, concerns, and fears (initiated (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	04/27/2025). Review of R19's Resident Progress Notes dated 12/09/25 at 12:02 PM, revealed Unit Manager (UM)1 documented that a resident-to-resident incident occurred at approximately 10:55 AM on 12/09/2025 in the Unit 2 day room. Per the notes, a housekeeper was walking by and saw R19 was seated on a couch and R79 sitting directly in front of R19 in a wheelchair, fondling R19's breasts with their right hand. The notes revealed the housekeeper immediately called for nursing staff assistance. According to the notes, a certified nursing assistant (CNA) responded and saw R79 remove their hand from the front of R19's shirt. The notes revealed the CNA communicated to R79 that they could not touch another resident without consent, and R79 became verbally aggressive but left the dayroom via wheelchair on their own. Per R19's Resident Progress Notes, the CNA reported the incident to the medication cart nurses, who notified the UM and Administrator. The note revealed the UM obtained and documented statements from staff who were present during the incident. Review of a facility Initial Report dated 12/09/25, revealed at 10:55 AM, two staff members observed R79 with their right hand up under the shirt of [R19] touching [the resident's] breast. Review of a facility Five-Day Follow-Up Report, dated 12/12/25, revealed that after a thorough and complete investigation, including record review and review of staff and witness statements, the facility concluded that R79 inappropriately touched R19. Review of R79's Resident Progress Notes included a 1 Psychiatric Follow-Up Evaluation note, dated 12/12/25 at 12:00 AM, that indicated the resident had vascular dementia with hypersexual behaviors. The note indicated the condition was chronic, recurrent, and moderate in severity and was managed with medications and staff support. On 12/16/2025 at 10:30 AM, CNA5 stated that Housekeeper (HSK)4 came to her and told her that R79 was in the day room with their hand in R19's shirt, fondling the resident. Per CNA5, when she arrived at the day room, she told R79 that they were not supposed to do that and told the resident to remove themselves. During an interview on 01/12/26 at 8:20 AM, the Social Services Director (SSD) stated she had become aware that R79 had touched R19 about four to five weeks prior. She stated that she found out from a housekeeper. The SSD stated that the housekeeper saw R79 place their hands under R19's shirt, placed on the resident's stomach. The SSD stated that after the incident, the facility staff tried to keep R79 with residents of the same sex in order to protect residents of the opposite sex. During an interview on 01/12/26 at 9:56 AM, UM1 stated that within minutes of the incident between R19 and R79, R79 was removed and taken to their room. UM1 stated that R19 lacked capacity to be interviewed. He stated that initially, R79 denied the incident, but the Administrator told him that after he had questioned R79 more, R79 confirmed they had placed their hand under R19's shirt. The UM stated R79 had been moved to Unit 1 to remove the resident from being near R19. During an interview on 01/13/26 at 8:31 AM, HSK4 stated that she observed R79's right hand touching R19's breast. She stated that she yelled, and CNA5 responded and told R79 that what they were doing was not right. During a telephone interview on 01/13/26 at 2:33 PM, R19's Responsible Party (RP)7 stated that they were notified by the Administrator that a housekeeper had observed a resident with their hand up R19's shirt. RP7 stated that after the incident, they moved the other resident to a different area of the facility.During an interview on 01/13/26 at 10:30 AM, the Director of Nursing (DON) stated she had been unaware of any allegations of sexual abuse from residents in October 2025 or November 2025 and confirmed interventions to protect residents from R79 had not been initiated until December 2025, after the incident with R19. The DON stated that the intervention was to move R79 from Unit 2 to Unit 1.During an interview on 01/14/26 at 8:41 AM, the Administrator stated that the first intervention for R79, implemented in December 2025 when the incident with R19 occurred, was to transfer R79 from Unit 2 to Unit 1. He stated that was to place distance between R79 and R19 and to allow R19 to freely wander on Unit 2.On 01/16/26 at 3:04 PM. The facility presented an approved removal plan which included the following: 1. Residents #9, #19, #20, #34, #80, #106, #116 will have a head to toe assessment completed on 1/14/2026 by a licensed nurse. A psychosocial evaluation will be completed on identified residents by the licensed social worker on 01/14/2026. Identified residents #9, #19, #20, #34, #80, #106 and #116 will have referrals completed for psychological services and/or (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revisits completed by 01/15/2026. 2. Resident #79 was placed on 1:1 supervision on 01/10/2026 and will remain on 1:1 supervision while at the facility. Resident #79 will be seen by psychology and psychiatry on 01/15/2026. This will be completed by 01/15/2026 3. Administrator/Designee interviewed alert and orientated residents to identify possible allegations of abuse on 01/10/2026. The Director of Nursing/Designee will assess cognitively impaired residents for signs and symptoms of abuse by 01/15/2026. Residents identified will have psychosocial assessments completed and referrals made as appropriate by 01/15/2026. This will be completed by 01/15/2026. 4. A review of grievances and incident reports from 08/01/2025 through 01/15/2026 has been completed by 01/15/2026 by the Director of Nursing or Administrator to identify possible allegations of abuse or neglect. Any identified will be reported per policy and investigated by the Director of Nursing and Administrator. 5. The Facility Leadership Staff, which includes the Administrator, Director of Nursing, Unit Managers (2), Social Services Director, Social Services Assistant, Activity Director, Human Resources Director, Business Office Manager, Scheduler, Dietary Manager, Staff Development Coordinator, Maintenance Director, Therapy Director were re-educated by the Clinical Consultant on 01/14/2026 on the Abuse, Neglect and Misappropriation policy including: Identification of abuse or neglect, by observable and objective evidence, witness reports of unusual occurrence or patterns or 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 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 law Conducting a prompt, thorough investigation of any allegation of abuse or neglect and grievances and appropriate actions taken to protect the resident Investigations should be prompt, comprehensive and responsive to the situation and contain founded conclusions Staff and/or residents may contact the Clinical Consultant, Regional [NAME] President and/or the anonymous compliance line at any time to report Abuse coordinator, Grievance Officer, Clinical Consultant, Regional [NAME] President and anonymous compliance line numbers are posted throughout facility 6. The facility staff will be re-educated by the Administrator/Designee by 01/15/2026 on the Abuse, Neglect and Misappropriation policy including: Identification of abuse or neglect, by observable and objective evidence, witness reports of unusual occurrence or patterns or 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 Conducting a prompt, thorough investigation of any allegation of abuse or neglect and grievances and appropriate actions taken to protect the resident Staff and/or residents may contact the Clinical Consultant, Regional [NAME] President and/or the anonymous compliance line at any time to report Abuse coordinator, Grievance Officer, Clinical Consultant, Regional [NAME] President and anonymous compliance line numbers are posted throughout facility This reeducation began immediately and will be completed by 01/15/2026. Any, including as needed (PRN), staff not receiving this education prior to this date (01/15) will receive education prior to their (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	next scheduled shift. This education will be presented to agency staff and new hires. 7. A Resident Council meeting will be held on 01/15/2026 by the Activity Director and the Administrator to review abuse, including the below. During the Resident Council, input will be requested, and questions will be answered. types of abuse reporting of abuse Abuse Coordinator in the facility as well as postings throughout the facility with this information and additional phone numbers of people that may be contacted for reporting. Clinical Consultant, Regional [NAME] President and anonymous compliance line facilities responsibility in reporting and investigating allegations of abuse. 8. The Administrator and Director of Nursing will review incident reports and grievance reports completed from the prior day in morning meeting daily beginning 01/16/2025 for seven days then Monday through Friday ongoing 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. 9. The Clinical Consultant will review incident reports and grievances for allegations of abuse beginning 01/15/2026 for 90 days validating immediate action has been taken to protect the victim and provide psychosocial support; interventions are put in place to prevent further abuse and a thorough investigation is completed and reported timely per policy. 10. The Administrator/Designee and the Director of Nursing/Designee will each interview 4 random residents daily beginning 01/16/2026 for one week validating residents feel safe, free from abuse and have no care concerns, then 4 residents randomly per week for 4 weeks. 11. The Director of Nursing/Designee will assess 4 cognitively impaired residents daily beginning 01/16/2026 for 1 week to identify any signs and symptoms of abuse, then 4 residents per week for 4 weeks. 12. Human Resources will interview 3 random employees daily beginning 01/16/2026 for one week to validate transfer of knowledge of education provided, then 3 employees weekly for 4 weeks. 13. Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held on 01/14/2026 with the Administrator, Director of Nursing, Unit Managers (2), 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 01/14/2026. Allegation of compliance 1/16/26

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review and policy review, the facility failed to ensure dietary staff followed proper personal hygiene practices to prevent food contamination when serving food for residents and failed to ensure food items were labeled appropriately and that the refrigerator was maintained at a proper temperature in 1 (Unit 100) of 3 snack/nourishment room refrigerators. Findings include:1. Review of a facility policy titled, Nutrition Policies and Procedures, Subject: Sanitation and Safety in Food and Nutrition Services, revised 10/15/25 revealed, The Certified Dietary Manager (CDM) will assume responsibility for the food safety and sanitation of the Nutrition Culinary Department. Procedures: 1. Infection control and sanitation practices are followed to minimize the risk of contamination of food and prevent food borne illness. During the initial observation of the kitchen on 12/15/25 at 8:45 AM, Dietary Aide (DA) 14 and DA 15 were observed plating and arranging food on residents' breakfast trays. DA 14 and DA 15 were observed with facial hair and were not wearing beard nets. During the same observation, DA 15 was observed arranging food on residents' plates and was not wearing gloves. During an interview on 12/19/25 at 2:44 PM, DA 15 stated that the kitchen staff had to wear a beard net every time they came into the kitchen. He also stated gloves should be worn when staff touched food. DA 15 stated he had probably forgotten to wear a beard net on 12/15/25. During an interview on 12/19/25 at 2:56 PM, DA 14 stated that beard nets were supposed to be worn anytime staff were in the kitchen. DA 14 stated that he should have been wearing a beard net on 12/15/25, but he was running late and forgot to put it on. During an interview on 12/19/25 at 4:07 PM, the Administrator (ADM) stated that he completed weekly sanitization checks in the kitchen. The ADM stated he expected dietary staff to wear beard nets and gloves consistently and every single time they were necessary.2. Review of a facility policy titled, Nutrition Policies and Procedures Subject: Food Safety in Receiving and Storage revised 10/15/25, revealed, 3. Check and record refrigerator temperatures at least 2 times per day (Refer to Refrigerator/Freezer Temperature Log). Temperatures not in the appropriate range are reported to the Certified Dietary Manager or maintenance. 4. Maintain the ambient temperature of refrigerators at 34 to 40 [degrees Fahrenheit (F)]or per state regulations. Review of a facility policy titled, Nutrition Policies and Procedures Subject: Food From Outside Sources, Safe Handling of revised 04/14/21, indicated, 5. Foods are labeled to identify the patient/resident's name, container contents, and the date it was prepared. Food items are stored in disposable, tightly covered containers, or sealable plastic bags. Items will be stored for three (3) days. Expired and unlabeled items will be discarded. The policy also revealed, 8. No foods and/or beverages are returned to the pantry area or communal resident's refrigerator once taken into a resident's room. These food items should be discarded if unable to be stored safely in the resident's room. During an observation of Unit 100's snack/nourishment room refrigerator on 12/19/25 at 10:30 AM, revealed the thermometer in the refrigerator indicated the temperature was 50 degrees F. During the observation, a fast-food milkshake with a straw was observed unlabeled in the refrigerator door. Review of a temperature log in the Unit 100 snack/nourishment room revealed the AM fridge temperature on the 19th (no month or year documented) was 42. The PM fridge temperature for the 18th was incomplete. During an observation of Unit 100's snack/nourishment room on 12/19/25 at 2:48 PM, an Out of Order sign was observed on the refrigerator. During an interview on 12/19/25 at 2:05 PM, Licensed Practical Nurse (LPN) 17 stated it was the kitchen staff's responsibility to monitor the refrigerator temperature in the unit snack/nourishment room. She stated that it was the nurse's responsibility to label items like drinks used for multiple residents with the date as it expired in three days. LPN 17 stated no employee personal items were supposed to be stored in unit snack/nourishment room refrigerators.During an interview on 12/19/25 at 11:18 AM, the Certified Dietary Manager (CDM) stated the dietary department was responsible for completing temperature logs in the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	snack/nourishment rooms and for making sure that all food items that they delivered were labeled. She stated the dietary department was also responsible for making sure the food items the department placed in the unit refrigerators had not expired. The CDM stated that the nursing department was responsible for labeling any other resident food items they placed in the refrigerators. During an interview on 12/19/25 at 3:18 PM, the Director of Maintenance (DOM) stated staff were responsible for monitoring the temperatures of the snack/nourishment room refrigerators. He stated that if there was an issue with the refrigerator temperature, staff were supposed to notify the maintenance department. The DOM stated the CDM notified him that the snack/nourishment room refrigerator was not at the correct temperature on 12/19/25 (exact time unknown) and he turned up the refrigerator temperature. An observation of the Unit 100 snack/nourishment room refrigerator temperature during the interview revealed it was 42 degrees F. During an interview on 12/19/25 at 2:24 PM, the Director of Nursing (DON) stated it was the responsibility of nursing staff to date/label resident items placed in the refrigerator and discard them after three days. The DON stated that dietary and nursing staff should have monitored and completed the temperature logs, and if there was an issue with the temperature, they should notify her, maintenance staff, or a supervisor. During an interview on 12/19/25 at 4:07 PM, the Administrator (ADM) stated that dietary staff were responsible for checking refrigerator temperatures in the snack/nourishment rooms. The ADM stated that he expected staff to check them daily and to immediately notify a supervisor if there was an issue.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on facility policy review, observation, and interview, the facility failed to protect residents' personal information for 5 Residents (R)27, 70, 78, 107, and 121of 23 sampled residents. Specifically, staff left a computer monitor that was on a medication cart unsecure where resident protected health information (PHI) was displayed for anyone to see.Findings include:Review of a facility policy titled, Safeguarding Electronic Protected Health Information, last revised 04/29/22, revealed, All employees safeguard electronic protected health information in an effort to fulfill their duty to maintain the confidentiality and integrity of patient/resident health information as required by law, professional ethics and accreditation requirements. Access to and the use and disclosure of electronic protected health information is limited to the minimum necessary to fulfill the employee's obligations and duties. When accessing systems or applications that contain electronic protected health information including systems or applications administered by health plans or other providers; the following procedures must be followed. Whenever possible, the de-identified information will be used. The policy revealed the Procedures included, H. Employees log off the network or, at a minimum, lock their workstation when leaving the work area, and J. Computer monitors are positioned so that unauthorized persons cannot easily view information on the screen.Observation and interview on 12/16/25 at 8:31 AM revealed a medication cart unattended in the hallway, with the computer screen unlocked. The unlocked computer screen displayed personal and medical information for R 107, including allergies and medication use, and listed the names and code statuses of Residents 78, 121, 107, 70, and 27. Unit Manager (UM) 3 observed the deficient practice, entered Resident 107's room and verbally instructed RN 9 to step away and lock the computer screen. At 8:42 AM, the computer screen remained unlocked. UM 3 returned and instructed RN 9 to correct the issue. At 8:45 AM, RN 9 locked the computer screen, RN 9 stated the screen was not within her line of sight and acknowledged staff were required to lock the screen or log out of the computer when stepping away, to protect residents' PHI.During an interview on 12/16/25 at 8:52 AM, RN 2 stated the computer screen on the medication cart should be locked when unattended and stated that doing so prevented unauthorized viewing of residents' personal and medical information by visitors, staff, or other residents.During an interview on 12/16/25 at 9:01 AM, UM 3 stated nurses were required to lock medication cart computer screens to protect residents' personal information and prevent unauthorized access. UM 3 further stated that staff had been educated to lock the screen whenever stepping away from the workstation.During an interview on 12/18/25 at 4:31 PM, the Director of Nursing (DON) stated that computer screens must be secured by locking the screen, positioning the cart to prevent viewing, or closing the laptop. The DON stated nursing staff were expected to protect residents' PHI.During an interview on 12/18/25 at 5:12 PM, the Administrator (ADM) stated that all staff were expected to follow the Health Insurance Portability and Accountability Act (HIPAA) requirements and lock computer screens to protect residents' PHI. The ADM further stated that agency staff received the facility's privacy policies and completed a pre-test prior to working at the facility.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on record review, observation, and interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 Resident (R)103 of 1 resident reviewed for bowel and bladder incontinence. Findings include:Review of R103's Resident Face Sheet revealed the facility admitted R103 on 03/17/23. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of vascular dementia, disorientation, and muscle weakness. Review of R103's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/25, revealed R103 had a Brief Interview of Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident required partial to moderate assistance with activities of daily living (ADLs). The MDS indicated the resident was frequently incontinent of urine. The MDS indicated that the resident required partial/moderate assistance with toileting hygiene. Review of R103's Care Plan included a problem area initiated 03/29/23, that indicated the resident was at risk of skin breakdown related to impaired cognition, communication, mobility, and bowel/bladder incontinence. Interventions directed staff to provide toileting/incontinence care as needed (initiated 03/29/23). Review of R103's Care Plan included a problem area initiated 03/29/23, that indicated the resident was at risk for complications related to the need for support with ADL care. Interventions directed staff to provide incontinence care as needed (initiated 03/29/23). During an observation on 12/15/25 at 9:56 AM, R103 was observed awake, lying in bed, dressed in a pajama top, and was wearing an incontinent brief. A visible urine stain under the resident's bed pad was observed, which was underneath the resident. R103 stated they were unsure of when their bed was last changed. During an observation on 12/15/25 at 10:45 AM, R103 was observed lying in bed sleeping and the urine stain was still visible on the resident's bed pad and bed sheet. During an observation on 12/15/25 at 1:00 PM, R103 was observed sitting on the side of their bed, eating from their lunch tray, which had been placed on the resident's bedside table. The resident's bed still had not been changed and was in the same condition as before. R103's bed pad was still on the bed, and the bed sheets still had the same large urine stain visible. During an interview on 12/15/25 at 10:04 AM, Certified Nursing Assistant (CNA) 19 stated he was not assigned to R103 but was assigned to the other resident in the room. CNA 19 stated he had not seen any issues with R103 that morning, but the resident had been sleeping, and he had not really looked at the resident. During an interview on 12/15/25 at 1:05 PM, Unit Manager (UM) 1 stated his expectation was CNAs checked on residents every two hours and more often as needed. During the interview, UM 1 was taken to R103's room and shown the condition of the resident's bed sheets and the stain on the bed. UM 1 agreed that the stain looked like urine and stated it was unacceptable. He stated the resident's bed should have been taken care of earlier. UM 1 stated he had been in the resident's room earlier in the day but had not noticed the state of the resident's bed. He stated that the CNA assigned to R103 was CNA 8, and she was currently in another resident room. UM 1 stated he would let the CNA know R103's bed needed to be changed.During an interview on 12/15/25 at 1:30 PM, CNA 8 stated that she worked through a contracted nursing staffing agency and had not provided care to R103 before. CNA 8 stated that she checked on R103 at 7:00 AM that morning and asked if they were okay. She stated that she had not noticed any urine stains on the resident's bed. She stated that she also checked on the resident before her break at 11:00 AM and had not noticed any urine stains on the bed. During an interview on 12/16/25 at 1:48 PM, The DON stated that the frequency of resident rounding was based on the resident's care plan. She stated there was no set time schedule for resident rounding and expected the CNAs to frequently round on the residents. The DON stated her expectation of the care for R103 was that the CNA assigned to the resident should have observed the resident and identified any care issues. During an interview on 12/18/25 at 8:34 AM, The ADM stated that the facility did not have an actual time frame for the staff to round on the residents, but the (continued on next page)

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	01/16/2026

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rounding should have been done as quickly as possible and as often as needed to meet the needs of the residents. He stated the facility staff did not lock themselves down to a particular time frame. The ADM stated he had been made aware of the situation with R103. The ADM stated his expectation was that once the situation with R103 was brought to the attention of the staff, the staff should have gone in and addressed the situation with the resident or any other resident who needed assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, record review, facility document review, and policy review, the facility failed to ensure that the safety locks on a shower chair were properly locked and secure for 1 of 5 residents (R)1 reviewed for accident hazards. This failure resulted in R1 experiencing a fall without injury.Findings include:Review of a facility policy titled Fall Management dated 05/05/23 revealed, 3. The facility provides assistive devices based on individual resident needs to facilitate mobility and prevent falls. Review of a facility document titled Staff Education/Orientation Policies and Procedures competency for a Shower, revised 01/12/24, revealed performance criteria included, 1. Evaluates the patient/resident's ability to assist with or participate in any part of the shower. Encourages participation where appropriate. 2. Explains procedure to patient/resident. 3. Provides for privacy. 4. Gather hygienic aides, toiletry items and linens. 5. Assist with removing robe, gown, or pajamas. 6. Perform hand hygiene and applies gloves and assist with washing. The policy/procedure did not address safety measures for assistive devices, including a shower chair.Review of R1's Face Sheet indicated the facility admitted R1 on 02/28/25. According to the admission Record, the resident had a medical history that included diagnoses of osteoarthritis and repeated falls. Review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/05/25, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required set up or clean-up assistance (helper sets up or cleans up and assists only prior to or following the activity) with showers/bathing. R1's Care Plan included a problem statement, started 03/08/25, that indicated the resident had a history of falling related to debility, osteoarthritis, and poor safety awareness. The Care Plan also revealed a problem statement, started 03/08/25, that indicated the resident had self-care deficits related to poor activity tolerance and weakness. An intervention started on 03/08/25, directed staff to bathe the resident per facility protocol. R1's Morse Fall Scale, dated 02/28/25, indicated the resident was a high fall risk. Review of a Patient/Resident Incident/Accident Investigation Worksheet, dated 06/13/25, revealed a Certified Nursing Assistant (CNA) reported that R1 was in the shower and tried to sit down on the shower chair and fell. Per the facility's investigation, the resident sustained no injury. The investigation worksheet revealed the CNA was educated related to ensuring the shower chair was locked prior to residents getting up or sitting down on the shower chair. During an interview on 12/15/25 at 11:12 AM, R1 stated that the staff member who gave them a shower did not lock the shower chair. R1 stated that as they were sitting down, the shower chair rolled backward. During an interview on 12/17/25 at 2:02 PM, CNA 20 stated that she did not lock the shower chair when she assisted R1 with a shower. She stated that when R1 attempted to sit down, the shower chair moved out from under them. She stated that the chair rolled backwards, and the resident fell on their back and buttocks. During an interview on 12/17/25 at 1:47 PM, Licensed Practical Nurse (LPN) 21 stated that CNA 20 notified her that R1 fell on the floor. She stated she asked CNA 20 if the shower chair was locked, and the CNA revealed that it was not locked. LPN 21 stated that the resident also confirmed that the shower chair was not locked. During an interview on 12/18/25 at 1:12 PM, the Director of Nursing (DON) stated that the root cause of R1's fall was the staff member's failure to lock the wheels on the shower chair. She stated her expectation was for staff to lock the wheels on the shower chair. During an interview on 12/18/25 at 2:50 PM, the Administrator stated he expected staff to lock the shower chair wheels. He stated that the CNA should have locked the wheels on the shower chair for R1.^