STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425310	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hollow of Sumter Rehabilitation Center	1761 Pinewood Road Sumter, SC 29154

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 - Actual harm 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** 47914 Based on interview, record review, facility document review, and facility policy review, the facility failed to protect the resident's right to be free from physical abuse by another resident for 2 (Resident (R)5 and R6) of 5 residents reviewed for abuse. Specifically, R4, who had a history of physical aggression, physically abused and injured R5. Additionally, R4 physically abused R6. Findings included: An undated facility policy titled, Abuse Prevention Program indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required treat the resident's symptoms. R4's Admission Record indicated the facility admitted the resident on 10/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of paranoid schizophrenia, vascular dementia with other behavioral disturbance, psychophysiologic insomnia, violent behavior, and generalized anxiety disorder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/04/2024, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident exhibited delusions during the assessment timeframe. Per the MDS, the resident exhibited physical behavioral symptoms and verbal behavioral symptoms directed towards others one to three days during the assessment timeframe. The MDS indicated the resident's behavioral symptoms put the resident and others at risk for physical illness or injury. R4's care plan included a focus area initiated 11/01/2024, that indicated the resident had a potential to be physically aggressive related to a history of harm to others and poor impulse control. Interventions directed staff to administer medications as ordered (initiated 11/01/2024); and to analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document (initiated 11/01/2024). Interventions also indicated the resident's physical aggression was triggered by verbal abuse and indicated that the resident's behaviors were de-escalated by therapeutic communication (initiated 11/10/2024). Further review revealed that the interventions of Depakote and medication review were initiated on 11/19/2024. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R4's [Previous Nursing Facility] Continuity of Care record, dated 10/16/2024, revealed the resident had diagnoses of paranoid schizophrenia (effective 08/14/2023) and violent behavior (effective 05/28/2024). R4's Level II South Carolina Mental Health Authority Determination, dated 08/15/2024, revealed R4 had a serious mental illness. The Level II evaluation revealed R4 would require close monitoring, some structured socialization, assistance with activities of daily living (ADLs), memory care, medication therapy, and monitoring of medication therapy. The [NAME] II evaluation also revealed R4 had a history of intermittent agitation, including hitting others, and would likely require hospitalization for medication adjustments and behavioral control. R4's Progress Notes revealed a Health Status Note, dated 10/29/2024 at 2:26 PM, that indicated the resident admitted to the facility from another nursing facility. 1. R5's Admission Record indicated the facility admitted the resident on 03/22/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, vascular dementia with behavioral disturbance, bipolar disorder, and depression. A quarterly MDS, with an ARD of 10/03/2024, revealed R5 had a BIMS score of 11, which indicated the resident had moderate cognitive impairment. Per the MDS, the resident did not exhibit any physical or verbal behavioral symptoms directed toward others during the assessment period. R5's care plan included a focus area initiated 04/01/2024, that indicated the resident had impaired cognitive skills as evidence by deficits in short-term and long-term memory with a BIMS score of 12. The care plan indicated that the resident was understood and could understand. Interventions directed staff to provide cues and prompting if the resident was unable to complete a task independently (initiated 04/01/2024) and anticipate and meet the resident's needs (initiated 04/01/2024). R4's Progress Notes revealed a Health Status Note, dated 10/30/2024 at 11:40 PM and created by Licensed Practical Nurse (LPN) #18, that revealed R4 struck their roommate in the face over their roommate's wheelchair and personal bag. The note indicated that the residents were separated an hour before the incident. Per the note, the residents were separated, and R4 was sitting on the bed eating a sandwich and snack and R5 was brought to the dining room area. R4's Progress Notes revealed a Health Status Note, dated 10/31/2024 at 12:46 AM, that revealed R4 was sent to the emergency room (ER) for an evaluation and treatment related to aggressive behavior. The note indicated that R4 struck their roommate in the face with their fist, over the roommate's wheelchair and personal bag. A handwritten witness statement dated 10/30/2024 signed by Certified Nursing Assistant (CNA)4 revealed that on the night of 10/30/2024, she was helping another resident when she heard CNA26 yell out no [ma'am/sir] you can not do that. The statement revealed CNA4 did not witness what happened but was told by CNA26 and by R5 that R4 had punched R5 in the face knocking the resident's glasses off their face and knocking them back in the bed. The statement revealed CNA4 stated that she noticed R5 looked fearful of R4. The statement revealed R4 was trying to take R5's wheelchair because they were under the impression it was theirs. The statement revealed CNA4 and CNA26 redirected R4 and informed them that the wheelchair was not theirs but was R5's. The statement revealed R4 stated rude remarks to R5 and R5 stated that they did not feel safe being in the room with R4 anymore. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R5's Skin Only Evaluation, dated 10/30/2024, revealed R5 had pain to their right eye from being struck in the face by a fell ow resident. R5's Pain Interview, dated 10/30/2024, revealed the resident had a pain level of 5, on a scale from 0-10, to the right eye and was given acetaminophen with effective results. R5's Progress Notes revealed a Health Status Note, dated 10/31/2024 at 11:15 AM, that indicated the resident had purple discoloration under their right eye in the periorbital area below eye. The note indicated that the resident complained of tenderness upon palpation of the area, but did not report pain. During an interview on 12/19/2024 at 1:27 PM, R5 stated they were sitting on the side of their bed, doing a puzzle on the bedside table. R5 stated that their wheelchair was in front of the table, and R4 came up and said that it was their wheelchair. R5 stated they did not say anything, but the staff in the hall kept telling R4 that it was not their wheelchair. R5 stated that R4 unexpectedly hit them. R5 stated they had a black eye from the incident and had to go to the doctor. R5 stated staff made R4 come out of the room. R5 stated they were moved to a different room that day. R5 stated that was the first time they had encountered the resident and did not know the resident was new there. During an interview on 11/21/2024 at 1:28 PM, Former Administrator #20 stated she got a call from LPN18 on 10/30/2024 that R4 and R5 had an altercation because R4 thought a wheelchair was theirs. Former Administrator #20 stated a CNA was checking on residents, heard something, and then separated the residents. She stated that R4 was sent to the hospital because the resident would not calm down. She stated the Director of Nursing (DON) talked to R5's family, and R5 was moved to a different room that night based on the family's request. During an interview on 11/21/2024 at 3:18 PM, LPN18 stated she was the nurse at the time of the incident between R4 and R5. LPN18 stated that R4 and R5 were roommates at the time of R4's admission. She stated that when R4 was first admitted , R4 and R5 got along fine. LPN18 stated R4 was in bed and R5 came into the room, got out of their wheelchair, and into bed. LPN18 stated R4 got up and went to get the wheelchair and a bag that was on the back of the wheelchair. She stated that she tried to calm R4 and explain that it was not their wheelchair and put the resident back to bed, but the next thing she knew, R5 reported that R4 had hit them. LPN18 stated the residents were immediately separated, and a room change was completed for R5 following the incident. During an interview on 12/20/2024 at 8:22 AM, Physician #29 stated he recalled seeing R4 on 10/31/2024, and stated the resident had a history of schizophrenia, most likely chronic paranoid schizophrenia. Physician #29 stated R4 was on a high dose of antipsychotic medications, and he would sometimes prescribe benzodiazepine to help calm the resident down. Physician #29 stated he had gotten a lot of calls on the resident, and he felt the resident was not familiar with the facility because they came from another facility. Physician #29 stated the resident had their days and nights mixed up, so he had put the resident on some medication to help the resident sleep at night and to help with their behaviors. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/20/2024 at 1:16 PM, the DON stated for residents that came in with a known psychiatric history, he would monitor the resident upon entry. The DON stated they monitored all residents upon initial entry, completed assessments, and CNAs documented their behaviors every shift. The DON stated part of the plan of care documentation included whether any types of behaviors were noticed during the shift. The DON stated behaviors were reported to nurses, and they would follow up. The DON stated R4 was admitted two days after he started working at the facility, so he did not approve the resident's admission to the facility and did not know the resident's history. The DON stated he was made aware after the incident on 10/30/2024, and he reviewed their chart and realized the resident had a Level II evaluation. The DON stated, going forward, since he had started, they clinically reviewed residents more thoroughly and refused residents with known behavioral issues. The DON stated he had not clinically approved of anyone with a violent history or any known history that had caused them to become violently aggressive. 2. R6's Admission Record indicated the facility admitted the resident on 08/28/2018. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis) and hemiparesis (one-side muscle weakness) on the left side and vascular dementia. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/15/2024, revealed R6 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Per the MDS, the resident did not exhibit any physical or verbal behavioral symptoms directed toward others during the assessment period. R6's care plan included a focus area initiated 03/30/2021, that indicated the resident was at risk for developing traumatic stress reactions related to exposure to a motor vehicle accident. Interventions directed staff to allow the resident to express concerns and feelings (initiated 03/30/2021). R4's Progress Notes revealed a Behavior Note, dated 11/10/2024 at 8:20 PM and created by Licensed Practical Nurse (LPN)18, that revealed R4 punched another resident in the face after being repeatedly called a derogatory name by the fell ow resident as they were attempting to pass them going to their room. The note indicated that the residents were separated. R4's Progress Notes revealed a Health Status Note, dated 11/10/2024 at 10:07 PM and created by LPN18, that revealed R4 was sent to the emergency room for an evaluation and treatment related to striking another resident in the face with their fist. R4's Psychiatry Follow Up Note, dated 11/15/2024, indicated that R4 was seen for a follow-up visit for ongoing management. The record indicated that the resident punched two residents in the previous month. R6's Skin Only Evaluation, dated 11/10/2024 at 9:36 PM, revealed the resident did not have any new skin issues. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/21/2024 at 3:18 PM, LPN18 stated she was on the 400 Hall administering medications when R4 came up the hall from the dining room. LPN18 stated R4 was trying to hurry and get to their room to go to the bathroom. LPN18 stated R6 was coming in front of the cart at the same time. LPN18 stated when R4 asked R6 to move out of their way, R6 called the resident a derogatory name. LPN18 stated before she had a chance to react, R4 made a fist and hit R6. LPN18 stated once the incident occurred, she separated them. LPN18 stated R6 was normally on the 300 Hall but had walked down to the 400 Hall.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47914 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure a complete and thorough investigation was completed for 1 (Resident (R)1) of 4 residents reviewed for accidents. Specifically, R1 sustained a fall on 09/21/2024 from a mechanical lift when the sling strap broke while being transferred from the bed to a wheelchair by Certified Nursing Assistant (CNA)7 and Licensed Practical Nurse (LPN)8. R1 sustained another fall on 09/28/2024 from a mechanical lift when the shower harness strap broke while being transferred from a shower chair to the bed by CNA13 and CNA14. There was no evidence CNA13 had received re-education on mechanical lift safety after the 09/21/2024 incident. There was also no evidence of an investigation for the 09/28/2024 incident. Findings included: An undated facility policy titled, Investigating Injuries, indicated, The Administrator will ensure that all injuries are investigated. An undated facility policy titled, Hoyer Lift: Operation Instructions and Proper Use, indicated, Only trained personnel should operate the Hoyer [mechanical] lift. An undated facility policy titled, Safe Lifting and Movement of Residents, indicated, 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. The policy also indicated, 6. Only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents. 7. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques. R1's Admission Record indicated the facility admitted the resident on 07/20/2020. Review of the Admission Record, the resident had a medical history that included diagnoses of diffuse traumatic brain injury (TBI) with loss of consciousness of unspecified duration, hemiplegia (paralysis) affecting the right dominant side, and muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had impairment on one side to both the lower and upper extremity, utilized a wheelchair, and was dependent on staff to transfer to and from a bed to a chair, and was dependent on staff to transfer in and out of a tub and shower. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan included a focus area initiated 04/20/2021, that indicated the resident was at risk for falling related to epilepsy, hemiplegia, history of repeated falls, incontinence, TBI, and impaired safety awareness. Interventions directed staff to transfer the resident with a mechanical lift with two-person assistance (initiated 09/15/2023). The care plan included a focus area initiated 04/20/2021, that indicated the resident was at risk for falling related to epilepsy, hemiplegia, a history of repeated falls prior to admission, incontinence, TBI, and impaired safety awareness. The focus area further revealed that on 09/21/2024 the resident had a fall with an intervention dated 09/21/2024 for a therapy screen as indicated. Further review revealed the resident sustained a fall on 09/28/2024 where the resident was lowered to the floor with a bruise and skintear [sic], with an intervention dated 09/28/2024 of the mechanical lift pad changed. A Health Status Note, dated 09/21/2024 at 12:02 PM, revealed R1 was being transferred from their bed to the wheelchair with a mechanical lift. The Health Status Note revealed when the resident was above the wheelchair, the blue strap broke, and the resident hit their head on the arm of the wheelchair. The Health Status Note further revealed, the resident was sent to the emergency room (ER). An ED [Emergency Department] Provider Note, for R1 dated 09/21/2024, revealed the residents visit diagnoses included a concussion and cervical strain. The note revealed the resident had a contusion in the lower back posterior head. Per the note, the resident's computed tomography (CT) scan revealed no acute injury, but the provider documented that they believed the resident had a mild concussion. An Accident/Incident Reporting Form, revealed that on 09/21/2024, CNA7 and LPN8 were assisting R1 with the mechanical lift, transferring the resident from their bed to their wheelchair. According to the Accident/Incident Reporting Form, while lowering the resident to the chair, the sling strap broke, causing the resident to fall into the wheelchair and hit the back left side of their head on the arm of the wheelchair. The Accident/Incident Reporting Form indicated staff had been re-educated on resident abuse, neglect and exploitation and on proper techniques on using a mechanical lift. A Staff Education Sign In Sheet, included with the facility's investigation documents revealed staff signatures dated 09/21/2024, 09/24/2024, and 09/30/2024 that indicated they had received education on Hoyer Lift & [and] Sling training. CNA7 and LPN8 had signed the document on 09/21/2024 to indicate they had received the education. The Staff Education Sign In Sheets revealed there was no documented evidence CNA13 had received the re-education prior to the 09/28/2024 incident. A document titled 354 Other, dated 09/28/2024 at 11:43 PM, revealed the shower harness strap broke while R1 was being transferred from the shower chair to the bed. The document revealed the CNA used their right leg to guide the resident to the floor. The document revealed the immediate actions taken included assessing that the resident was safe, obtaining the resident's vital signs, and the nurse and two CNAs assisted getting the resident off the floor and onto their bed safely. The document indicated the resident sustained an open area to the left ankle and a bruise to the upper back. During an interview on 11/21/2024 at 10:03 AM, LPN12 stated that on 09/28/2024, it was brought to his attention that the shower sling broke for R1. LPN12 stated he completed the incident report. LPN12 stated that was the first time he had heard of any slings breaking and he was not sure if an investigation was done. LPN12 stated the CNA involved in the incident was CNA13. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 10:08 AM, CNA13 stated that on 09/28/2024, he made an incident report to LPN12. CNA13 stated it was on a Saturday, and they had gotten the resident (R1) up from the bed, transferred them to the shower chair, and gave the resident a shower. CNA13 stated that while transferring the resident back to bed from the shower chair, the straps around the leg started to pop. CNA13 stated he put his leg under the resident to brace the resident. CNA13 said they got the nurse, and the nurse did a body audit. CNA13 stated they got another sling, got it up under the resident, and lifted the resident up into the bed. CNA13 stated that when using slings, they would inspect them and make sure everything was working. CNA13 stated that during the incident, the loops broke, not the sling. CNA13 stated he was not aware of any other times that slings had broken. CNA13 stated he had been a CNA for [AGE] years and had received training on using mechanical lifts. CNA13 stated he had two trainings the current year. During an interview on 11/21/2024 at 3:05 PM, Former Admissions Director #23 stated for the incident that occurred on 09/28/2024, she was not present but did remember getting a phone call from CNA13 because he had gotten injured while at work. Former Admissions Director #23 stated she remembered calling Former Administrator #20 to inform her of what happened, but stated she was not involved in the investigation and was unaware if one was completed. During an interview on 11/21/2024 at 9:44 AM, the Director of Nursing (DON) stated every incident needed to be investigated. During a follow-up interview on 12/20/2024 at 1:16 PM, the DON stated they were not sure why all staff were not in-serviced after the 09/21/2024 incident. The DON said all nursing staff received mechanical lift training upon hire and annually. The DON stated there was no additional documentation available for the 09/28/2024 incident. During an interview on 11/21/2024 at 8:35 AM, the Interim Administrator stated they did not have an investigation report for the 09/28/2024 incident for R1. The Interim Administrator stated all she could find was the training provided from 09/21/2024 through 09/30/2024.