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	05/01/2026

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document and policy review, the facility failed to ensure an assessment was completed for 1 (Resident (R)67) of 1 sampled resident reviewed for an injury of unknown origin when the resident experienced a change in condition. Specifically, on Friday, 03/27/26, Certified Nurse Assistant (CNA)15 discovered R67 had a red, swollen left arm and informed the Unit Manager (UM) of the resident's change in condition. There was no evidence that the facility assessed R67's arm until Monday, 03/30/26, when an x-ray revealed R67 had a displaced fracture of the left humerus (the long bone in the upper arm). Records revealed that prior to the discovery of the fracture, pain assessments completed every shift indicated R67 had a pain level of 0 (on a scale of 0-10, with 0 being no pain and 10 being the worst possible pain), except for two incidences of moderate pain, once on 03/29/26 and once on 03/30/26, which was relieved with acetaminophen (an analgesic/pain reliever). Findings included: A facility policy titled, Acute Condition Changes - Clinical Protocol, dated 03/2018, specified, in the section Assessment and Recognition that, 2. In addition, the nurse shall assess and document/report the following baseline information: a. Vital signs; b. Neurological status; c. Current level of pain, and any recent changes in pain level; d. Level of consciousness; e. Cognitive and emotional status; f. Resident's age and sex; g. Onset, duration, severity; h. Recent labs; i. History of psychiatric disturbances, mental illness, depression, etc. [et cetera, and other similar things]; j. All active diagnosis; and k. All current medications. The policy also specified, 7. Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician; for example, the history of present illness and previous and recent test results for comparison. a. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. An admission Record revealed the facility admitted R67 on 06/14/23. According to the admission Record, the resident had a medical history that included diagnoses of unspecified protein-calorie malnutrition, severe intellectual disabilities, vascular dementia, contracture of unspecified muscle and joint, muscle weakness, hypomagnesemia (low magnesium levels in the blood), hypokalemia (low potassium levels in the blood), and hypothyroidism. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/26, revealed R67 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). The MDS indicated R67 was dependent on staff assistance for oral hygiene, toileting hygiene, showering and bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated R67 was also dependent on staff assistance to roll left and right, to move from sitting to lying, for chair-to-bed and bed-to-chair transfers, and for tub and shower transfers. The MDS indicated that R67 had a feeding tube. R67's undated Care Plan Report included a focus area that indicated the resident had limited physical mobility related to contractures of the left arm and bilateral lower extremities, intellectual disabilities, and vascular dementia. Interventions (undated) directed staff: - to turn and reposition the resident as needed; - to utilize a mechanical lift, the assistance of two staff members, and an extra-large sling for (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 0684 Level of Harm - Actual harm Residents Affected - Few	transfers; - that the resident was maximally dependent on one staff for locomotion; and - to monitor, document, and report as needed any signs or symptoms of immobility, contractures forming or worsening, thrombus formation, skin breakdown, and fall related injuries. R67's undated Care Plan Report also included a focus area that indicated the resident was nonverbal but could point, smile when happy, and cry to alert staff of a perceived issue or need. Interventions (undated) directed staff to observe nonverbal cues. R67's Order Recap Report, dated for the timeframe starting 04/01/25 through 04/30/26, revealed: - Document Pain Level every shift for pain monitoring, started 07/17/23, and - Acetaminophen Tablet 326 MG [milligrams] Give 2 tablet[s] via PEG [percutaneous endoscopic gastrostomy tube, a tube from the abdomen to the stomach] Tube every 6 hours as needed for pain, started 07/25/24. R67's Medication Administration Record [MAR], dated 03/26, revealed: - On 03/27/26, 03/28/26, and 03/29/26 during the Day and Nigh[t] shifts and on 03/30/26 during the day shift the resident's pain level was assessed as 0 on a scale of 0 - 10; - On 03/29/26 at 6:08 AM, the resident's pain was 5, on a scale of 0 - 10, staff administered 650 mg of acetaminophen, and the medication was effective; and - On 03/30/26 at 3:11 PM the resident's pain was 4, on a scale of 0 - 10, staff administered 650 mg of acetaminophen, and the medication was effective. R67's Skin Monitoring: Comprehensive CNA Shower Review, dated 03/27/26, revealed that CNA15 informed the floor nurse that she noticed the resident's arm was red and swollen. A late entry UM's Progress Note[s], dated 03/27/26, at 3:46 PM, indicated a CNA reported that R67's arm appeared swollen. The Progress Note indicated that the observation was reported to the Nurse Practitioner (NP) while the NP was present at the facility. The Progress Note indicated that the NP was contacted by telephone to follow up regarding the reported swelling. The Progress Note indicated the NP acknowledged the report and stated they would evaluate the resident upon return to the facility on the following Tuesday. The Progress Note indicated that no new orders were given at that time. There was no documented evidence that the facility assessed R67's arm on 03/27/26. An order administration Progress Note[s], by Licensed Practical Nurse (LPN)14, dated 03/29/26 at 6:08 AM, indicated R67 received two tablets of 325 mg acetaminophen, via a PEG tube for signs and symptoms of pain. There was no documentation that the location of the pain was assessed. A review of UM's Progress Note[s], dated 03/29/26 at 8:47 AM, indicated the administration of the acetaminophen was effective, and R67's pain was 0 on a scale of 0 -10. A nurse's Progress Note[s], by LPN13, dated 03/30/26 at 3:11 PM, indicated R67 was in bed grabbing their left arm. The note revealed the resident's arm was swollen from the elbow to the shoulder, the arm was slightly warm to touch, and the resident had facial grimacing with range of motion of the left arm. The Progress Note indicated LPN13 notified the NP and received a new order for a venous doppler (non-invasive ultrasound) of R67's left arm and an x-ray of the resident's left shoulder, humerus, and elbow. The Progress Note indicated Tylenol (Brand name for generic acetaminophen) was given to R67 for pain. A nurse's Progress Note[s], by LPN13, dated 03/30/26 at 5:33 PM, indicated the administration of the acetaminophen was effective, and R67's pain was 0. An SBAR (Situation Background Assessment Recommendation) Summary for Providers Progress Note[s], dated 03/30/26 at 7:00 PM, indicated R67 experienced a change in condition, and nursing observations included facial grimacing. The SBAR Progress Note revealed a primary care provider recommendation to send R67 to an emergency room. A nurse's Progress Note[s], by LPN13, dated 03/30/26 at 7:00 PM, indicated R67 had a fracture of the right humerus, and the radiology technician stated a formal report would be sent to the facility. A nurse's Progress Note[s], by LPN13, dated 03/30/26 at 10:54 PM, indicated a correction was made to indicate R67's fracture was to the left humerus. A nurse's Progress Note[s], dated 03/31/26 at 9:30 PM, indicated R67 was hospitalized . R67's hospital admission H & P [History and Physical], in the section Objective revealed: - a CT [Computed Tomography] Humerus Left wo [without] Contrast, dated 03/31/26, indicated the resident had an acute comminuted [a broken bone with multiple pieces] and displaced fracture of the distal [away from the center of the body] humerus; - an XR [x-ray] Shoulder 2+ Vw [two views] Left, dated 03/30/26, indicated the resident had a displaced (continued on next page)

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