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	07/02/2026

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** Based on review of facility policy, record review, and interview, the facility neglected to provide services and care to Resident (R)15. Specifically, the facility failed to monitor and prevent inappropriate touching of R15 by R14, for 1 of 27 residents reviewed for abuse.Findings include:Review of the facility's policy titled Abuse Prevention Program with a revised date of December 2016, revealed, Our residents have the right to be free from abuse, neglect, . This includes but is not limited to . sexual or physical abuse . As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: . other residents .Review of R15's Face Sheet revealed R15 was admitted to the facility on [DATE], with diagnoses including, but not limited to, Dementia, essential hypertension, depression and Pure Hyperglyceridemia.Review of R15's Medication Administration Record (MAR) revealed an order for Donepezil 10mg give 1 tablet by mouth at 2100, Drisdol 1.25mg tablet give 1 tablet by mouth every day at 09:00.Review of R15's Quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated severe cognitive impairment.Review of R15's Care Plan with a start date of 06/24/26 documented, Resident has an actual or potential psychosocial well-being problem related to dependent behavior, distractibility/inability to concentrate, inability to problem solve, and social isolation secondary to cognitive impairment/dementia, as evidenced by impaired memory, decreased ability to make appropriate decisions, reliance on others for assistance with daily needs, limited social interactions, and difficulty maintaining attention and participating in meaningful activities. On 06/24/26, staff reported an alleged inappropriate interaction with a male resident. Due to the resident's cognitive impairment, she was unable to consistently describe the incident or express how it affected her emotionally. No physical or emotional distress was observed or reported. Facility staff Implemented interventions to ensure the resident's safety.Review of R14's Face Sheet revealed R14 was admitted to the facility on [DATE], with diagnoses including, but not limited to, hypertension, left above the knee amputation, anxiety disorder, neurogenic bladder and Chronic Obstructive Pulmonary Disease.Review of R14's Medication Administration Record (MAR) revealed an order for Hydralazine 75mg give 1 tablet by mouth at 09:00, Carvedilol 12.5mg tablet give 1 tablet by mouth every day at 17:00, Amlodipine Besylate 10mg tablet give 1 tablet by mouth at 09:00.Review of R14's admission MDS revealed a BIMS score of 11 out of 15, which indicated moderate cognitive impairment.Review of R14's Care Plan with a start date of 06/24/26 documented, Resident exhibits impaired cognition: Resident will experience a and/or altered perception resulting in supportive environment where inconsistent reporting of events, inaccurate concerns are addressed statements, and difficulty distinguishing respectfully, and staff will between actual and perceived respond to reports in a manner occurrences, which may affect that promotes dignity, reduces relationships, care planning, and problem distress, and maintains the resolution. I display inappropriate social resident's psychosocial well-behavior (unwanted hand holding, attempts being through the next review at kissing, touching) period. 06/24/26 Allegation of inappropriate touching involving another resident. Resident denied the allegation and was educated on personal boundaries, consent, and reporting (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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(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	concerns to staff. Facility interventions remain in place to ensure resident safety and provide ongoing psychosocial support. During a phone interview on 07/02/26 at 4:08 PM, R15's Resident Representative (RR) revealed they visited R15 after they were notified on 06/25/26; during this visit, the RR stated R15 appeared withdrawn and not her normal happy self, which is typically her baseline. The RR further stated that when she spoke with the facility staff on 06/25/26, they weren't very forthcoming with the details on this situation and refused to provide her with a copy of the police report and would not say who the staff member/nurse was that witnessed this incident and did not adequately report this situation. RR finally stated that she would like the resident to transfer to another facility because she does not believe that facility has enough staff to adequately supervise residents. During a phone interview on 07/02/26 at 5:13 PM, Licensed Practical Nurse (LPN)1 revealed, I was doing med rounds, the RN (registered nurse) from the other end came over and told me that [R14] touched [R15] inappropriately in the dining room. I took [R15] back to her room first. I then assisted [R14] back to his room. I discussed personal boundaries with him and how his actions were inappropriate. [R14] said that he thought [R15] was a visitor and not a resident and he apologized.During an interview on 07/02/26 at 3:30 PM, the Social Services Director revealed, It was reported to me on 06/24/26 that on 06/22/26 a nurse said that she saw [R14] touch [R15] on the outside of her clothes in between her legs. I immediately got statements. When [R15] was asked about the incident, [R15] revealed, Yes, that man who lives over there. The resident was pointing at another resident. [R15] then indicated areas of her body where she reported being touched. [R15] pointed to her upper chest to her knees as being touched.During an interview on 07/02/26 at 5:45 PM, the Director of Nursing (DON) revealed, I have worked here since May of 2025. On Wednesday of last week, 06/24/26, I was made aware by the nurse that witnessed the events of an incident that took place a couple of nights prior. A male resident and a female resident were in the dining room. The male resident was facing the female resident and he was leaning forward. The female resident carries a baby doll around with her. The nurse thought the resident was looking at or talking to the doll. The nurse moved closer to get a better look at what was going on and observed the male resident rubbing the female resident's vaginal area on the outside of her clothing. The nurse immediately separated the residents. [R14] was taken to his room on 200 hall. [R15] was taken to her room on 100 hall. The nurse reported to the nurse assigned to the residents what occurred. On Wednesday when I found out, I made the Administrator and my consultant aware. A psychosocial assessment was performed on both residents. A head-to-toe assessment was completed on [R15] to check for injuries. [R14] was moved to the 400 hall far away from [R15]. We initiated one on one with [R14]. [R14] continues on one on one. Staff are aware that the Administrator is the abuse coordinator. They know that they are to report abuse immediately. If we are not here, they should notify myself and the on-call nurse and we will notify the administrator. [R14] also had a tele-visit with psyche this week.During an interview on 07/02/26 at 5:50 PM, the Administrator revealed, we suspended one nurse and terminated the other. The nurse that was suspended separated the residents when the incident occurred and reported it to the nurse assigned to the residents. She was correct up to that point. The nurse assigned to the residents did not report the incident. I was disappointed that this was not reported to me immediately. Staff have been educated to report witnessed or suspected abuse immediately.

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F 0609 Level of Harm - Minimal harm or potential for actual harm 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 the facility policy, record review, and interview, the facility failed to report an allegation of abuse within the regulated timeframe, for 2 of 27 residents reviewed for abuse.Findings include:Review of the facility's policy, with a copyrighted date of 2001, titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revealed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation: Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury: or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.Review of R15's Face Sheet revealed R15 was admitted to the facility on [DATE] with diagnoses including, but not limited to: Dementia, essential hypertension, depression and Pure Hyperglyceridemia.Review of R14's Face Sheet revealed R14 was admitted to the facility on [DATE] with diagnoses including, but not limited to: hypertension, left above the knee amputation, anxiety disorder, neurogenic bladder and Chronic Obstructive Pulmonary Disease.During an interview on 07/02/26 at 3:30 PM, the Social Services Director revealed, It (incident involving R14 and R15) was reported to me on 06/24/26, that on 06/22/26, a nurse said that she saw R14 touch R15 on the outside of her clothes in between her legs. The Social Services Director stated, I immediately got statements. When R15 was asked about the incident, R15 stated, Yes, that man who lives over there. The resident was pointing at another resident. R15 then indicated areas of her body where she reported being touched. R15 pointed to her upper chest to her knees as being touched.During a phone interview on 07/02/26 at 4:08 PM, R15's Resident Representative (RR) revealed that they were not notified about this incident with R15 and R14 until last Wednesday (06/24/26); however, this incident occurred on 06/22/26. The RR further stated that when she spoke with the facility staff on 06/25/26, they weren't very forthcoming with the details on this situation and refused to provide her with a copy of the police report and would not say who the staff member/nurse was that witnessed this incident and did not adequately report this situation. RR finally stated that she would like the resident to transfer to another facility because she does not believe that facility has enough staff to adequately supervise residents. During a phone interview on 07/02/26 at 5:13 PM, Licensed Practical Nurse (LPN)1 revealed, I was doing med rounds, the RN (registered nurse) from the other end came over and told me that [R14] touched [R15] inappropriately in the dining room. I took [R15] back to her room first. I then assisted [R14] back to his room. I discussed personal boundaries with him and how his actions were inappropriate. [R14] said that he thought [R15] was a visitor and not a resident and he apologized. I did not report it. I thought the RN was going to report it to the Director of Nursing since she saw it.During an interview on 07/02/26 at 5:45 PM, the Director of Nursing (DON) revealed, On Wednesday of last week 06/24/26, I was made aware by the nurse that witnessed the events of an incident that took place a couple of nights prior . The nurse observed the male resident rubbing the female resident's vaginal area on the outside of her clothing. The nurse immediately separated the residents. The nurse reported to the nurse assigned to the residents what occurred. On Wednesday when I found out, . Staff are aware that the Administrator is the abuse coordinator. They know that they are to report abuse immediately. If we are not here, they should notify myself and the on-call nurse and we will notify the administrator.During an interview on 07/02/26 at 5:50 PM, the Administrator revealed, we (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspended one nurse and terminated the other. The nurse that was suspended separated the residents when the incident occurred and reported it to the nurse assigned to the residents. She was correct up to that point. The nurse assigned to the residents did not report the incident. I was disappointed that this was not reported to me immediately.