

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Nhc Healthcare - Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE 1305 Boiling Springs Road Greer, SC 29650	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>20960</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to implement care plan interventions for 1 (Resident (R)3) of 3 sampled residents reviewed for falls.</p> <p>Findings include:</p> <p>Review of an undated facility policy titled, Fall Safety indicated, Purpose: To assess resident for risk of falls and initiate appropriate interventions. The policy further indicated, Review situation regarding the fall and initiate the appropriate intervention as necessary.</p> <p>Review of a Resident Face Sheet revealed the facility admitted R3 on 11/27/23. Per the Resident Face Sheet, the resident had a hospital stay from 04/28/24 through 05/02/24. According to the Resident Face Sheet, R3 had diagnoses including but not limited to: fracture of the right femur, a history of falling, and dementia.</p> <p>Review of a Resident Census form revealed, when R3 returned to the facility from the hospital on 05/02/24, the resident was moved to a different room/unit of the facility.</p> <p>Review of R3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/08/24, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident had severe cognitive impairment. The MDS indicated the resident utilized a wheelchair for mobility, required substantial/maximal assistance to stand from a sitting position, and was dependent on staff for transfers to/from a chair. The assessment further revealed that R3 had a fall in the month prior to admission and a fall resulting in a fracture in the six months prior to admission.</p> <p>Review of R3's Care Plan included a problem area, with a start date of 11/28/23, that indicated the resident was at risk for falls/injury due to a history of falls with injury, decreased mobility, cerebrovascular accident (stroke) with right side hemiplegia and hemiparesis, a history of diuretic therapy, aspirin therapy, incontinence, and a right hip fracture. Per the care plan, the resident sustained falls on 04/27/24 and 04/28/24. The care plan further indicated R3's bed was moved against the wall for space following the fall on 04/27/24, and Anti rollbacks were added to the resident's wheelchair after the fall on 04/28/24. These interventions were created by Licensed Practical Nurse (LPN)6, who documented the problem area for falls was reviewed on 05/01/24.</p> <p>(continued on next page)</p>

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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 06/12/24 at 12:20 PM, R3 was in a wheelchair in the hallway of the facility. R3's wheelchair was observed without an anti-rollback device. Staff transported the resident into their room for the lunch meal, locked the wheelchair brakes, and left the room. The resident remained in the wheelchair without an anti-rollback device in place. R3's bed was not against the wall.</p> <p>During an interview on 06/12/24 at 2:12 PM, Certified Nursing Assistant (CNA)3 stated R3 was at risk for falls due to having a history of a fall with a fracture. CNA3 stated maintenance staff positioned the bed, and the CNA did not know how they determined the best position for the bed in the room. CNA3 observed R3's wheelchair and confirmed the resident's wheelchair did not have an anti-rollback device.</p> <p>During an interview on 06/12/24 at 2:25 PM, CNA4 stated R3 was a risk for falls and wore a yellow bracelet to indicate the risk. CNA4 stated she did not know the resident's bed needed to be against the wall or that the resident needed an anti-roll back device on their wheelchair. CNA4 stated therapy staff placed anti-roll back devices on wheelchairs and confirmed R3's wheelchair did not have a device in place.</p> <p>During an interview on 06/12/24 at 2:35 PM, Licensed Practical Nurse (LPN)2 stated R3's bed was not against the wall. According to LPN2, LPN6 took care of interventions to prevent falls.</p> <p>During an interview on 06/12/24 at 3:25 PM, the Assistant Director of Nursing (ADON) stated R3 was at risk for falls and had sustained a fall with major injury. The ADON stated nursing and therapy staff had access to care plans and should review them. The ADON stated the facility had a nurse who also monitored fall prevention interventions (LPN6).</p> <p>During an interview on 06/12/24 at 3:37 PM, LPN6 stated she and the CNAs monitored to ensure care plan interventions were implemented. LPN6 stated when R3 was readmitted from the hospital, they were admitted to another unit in the facility, and their bed was not against the wall and the anti-rollback device was not on their wheelchair. LPN6 said these interventions were not carried forward when the resident changed rooms, and no one noticed.</p>		