STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425359	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - Mauldin	850 E. Butler Rd. Greenville, SC 29607

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 0689 Level of Harm - 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** Based on review of facility policy, interview, and record review, the facility failed to ensure Resident (R)78 was free of accidents by an improper transfer for 1 of 9 residents reviewed for accidents. This failure resulted in R78 sustaining a closed fracture of the mid left humeral shaft (a broken upper arm bone where the skin remains intact). Findings include:Review of the facility policy titled, Consequences for failure to adhere to the Plan of Care, effective 06/01/2010, revealed, All nursing partners are required to follow the individual resident fall prevention care plans located in the Vanderbilt/Falls book on each unit. Adhering to the plan of care involves using all equipment correctly. Mechanical lifts require the presence of two partners at all times, NO EXCEPTIONS. If a resident falls because the plan of care was not followed, the following consequences have been established: 1. Written Counseling: If the POC was not followed regardless of resident activity. 2. 1 day suspension: If the POC was not followed and the resident falls. 3. Termination: If the POC was not followed and the resident falls and sustains an injury. PLEASE NOTE: Failure to follow any part of the patient's plan of care can result in loss of certification, legal action including but not limited to abuse charges, monetary fines and even jail time.Review of the facility policy titled, Hoyer Lift with a revision date of 02/2010, revealed, Purpose: To enable staff to lift and move a resident safely with as little effort as possible.Review of R78's admission Record revealed the facility admitted R78 on 01/01/21. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of osteoporosis, left hand contracture, and chronic pain syndrome.Review of R78's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/18/25, revealed R65 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated the resident had severe cognitive impairment. The MDS also indicated the resident was dependent on staff for transfer assistance.Review of R78's Care Plan Report, included a problem area initiated on 01/01/21, that indicated the resident had a risk for falls due to impaired mobility and cognition. Approaches directed staff to use Hoyer lift for Transfer, initiated on 07/01/24.Review of R78's Progress Notes dated 09/30/25 at 3:49 PM, written by the Unit Nurse Licensed Practical Nurse (LPN)1, revealed, Resident had Acute c/o pain in left arm/ Elbow Tylenol given at 240pm with little effect, daughter at facility to visit resident made aware of her c/o pain NP [name] aware of residents pain ordered x ray of left arm then notified that resident daughter would like her sent to St [NAME] Eastside. EMS here to pick resident up for transport.Review of a Five-Day Follow-Up Report dated 10/06/25, revealed Certified Nurse Aide (CNA)2 performed a stand pivot transfer with R78, resident arm/hand caught between her chair armrest and body. The report revealed in summary, after returning back from the beauty shop, the resident was transferred from her chair to the bed using a stand pivot transfer. The resident's arm/hand caught between the chair armrest and her body causing a pull/twisting motion. The resident has a diagnosis of Osteoporosis which helped contribute to the fracture.Review of R78's Emergency Provider Report dated 09/30/25, revealed the resident was seen due to fracture of shaft of left humerus, initial encounter for closed fracture.During an interview on 06/16/26 at 12:46 PM, Licensed Practical Nurse (LPN)1 revealed she became aware of the alleged incident of CNA doing an (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 0689 Level of Harm - Actual harm Residents Affected - Few	improper transfer that led to injury of the resident, from a Certified Nurse Aide (CNA), although she does not recall which CNA it was and it was not the CNA involved in the alleged incident. LPN1 was not aware that hoyer lift was not used in the transfer of the resident from her chair to the bed and was done without another staff member, which was not the proper procedure. LPN1 stated she reported the alleged incident to Registered Nurse (RN)1. The facility was going to do an in-house X-Ray of the resident's arm; however, resident's mother preferred it to be done at the hospital. LPN1 stated that staff are fully aware of the proper procedures for transferring residents using the Hoyer lift. She informed the surveyor that staff can verify a resident's specific transfer orders using five different methods. First, staff can check for an identifier magnet placed above the resident's bed or reference a chart located inside the resident's closet. Additionally, this information is available in a designated reference book at the nurse's station and is updated on the facility's electronic health records system, which all staff can access. Finally, transfer orders are detailed in the resident's care plan-with a physical copy kept at the desk-and are routinely reviewed during daily stand-up shift reports.During an interview on 06/16/26 at 11:33 AM, R78's Daughter revealed, she came to see her mother shortly after the alleged incident occurred. She stated her mother was in bed and her mother's left arm was hurting, she could tell her mother was in pain. Her mother told her that her arm was hurting, and she stated, the lady picked me up. The resident's daughter reported this to the Director of Nursing and 2 nurses. She asked them to send her mother to the hospital.Telephone interview attempts were made to CNA2 on 06/16/26 at 11:52 AM,11:53 AM, 11:56 AM, and 1:59 PM, CNA2 did not answer and voicemail had not been set up.During an interview on 06/16/26 at 12:38 PM, CNA1 revealed she worked on the day of the incident but did not witness the incident. She informed the surveyor that facility policy and procedure strictly require two staff members for all Hoyer lift transfers, emphasizing that a single-person transfer is never permitted under any circumstance. When asked how staff identify a resident's transfer requirements, CNA1 explained that transfer needs are discussed during daily stand-up meetings. She also noted that staff utilize visual job aids, including a magnet placed above the resident's bed and a chart located inside the resident's closet, both of which the surveyor and CNA1 verified during an observation. Lastly, CNA1 stated that these transfer orders are accessible at the nurse's desk and within the electronic computer systems.During an interview on 06/16/26 at 1:07 PM, RN1 revealed that LPN1 reported to her that R78 was experiencing significant pain. RN1 stated that CNA2 admitted to lifting R78 into bed manually without using the required mechanical lift, despite knowing there are three separate visual reminders in place to signal the need for a lift transfer. RN1 stated that CNA2 said she bypassed the equipment because she did not have enough time. RN1 then escorted CNA2 to the Director of Nursing's (DON) office, where CNA2 repeated her statement, leading the DON to terminate her employment immediately. Following the incident, the facility ordered an X-ray for R78, but the resident's daughter declined the service. The resident's daughter later called the facility to report that the resident's arm was fractured.During an interview on 06/16/26 at 3:10 PM, the DON stated that the resident's daughter reported her mother's arm was hurt by a staff member. According to the daughter, the resident stated that a CNA picked her mother up manually to transfer her, during which her arm became caught in the wheelchair, though it remains unknown if the arm was stuck or struck against the chair. The daughter requested that the resident be sent to the hospital. When investigating the incident, the DON interviewed the CNA in the presence of another staff member. When confronted with allegations of transferring the resident without a Hoyer lift, the CNA claimed she did not have anyone available to help her. The DON responded that the CNA should have left the resident safely in the chair rather than performing a solo manual transfer. The DON noted that care plans are located in the resident's chart, but the CNA admitted she did not look at them. The proper procedures are also in the resident's room on a magnet above the residents bed and on a chart in the residents closet. Additionally, when the DON went in the resident's room the DON observed that the Hoyer lift pad was still sitting unused in the chair during.