STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425360	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C M Tucker Jr Nursing Care Center Roddey Pavilion	2200 Harden Street Columbia, SC 29203

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 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. 19186 Amended 1/9/25 Based on interview, record review, and facility document and policy review, the facility failed to timely report an allegation of abuse to the state survey agency for 1 (Resident (R)4) of 3 sampled residents reviewed for abuse. Findings included: 1. A facility policy titled, Protection From Harm Program, revised 11/2024, indicated the facility will report all incidents of alleged or substantiated abuse to the proper government agencies as outlined by state, federal and local regulations governing the operation of a long-term nursing care facility. The policy revealed DHEC [Department of Health and Environmental Control] requires the reporting of Resident-to-Resident abuse, altercations involving physical contact between two residents. A Face Sheet indicated the facility admitted R3 on 03/21/2023. According to the Face Sheet, the resident had a medical history that included diagnoses of dementia, type 2 diabetes mellitus, encephalopathy, wandering, and schizophrenia. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/2024, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. R3's Care Plan Report included an undated problem statement, that indicated the resident had behavioral symptoms that included being resistant to care; noncompliant with care/medications; combative; hard to redirect; easily agitated by others (yelling out, loud disruptions); unpredictable behaviors with episodes of verbal threats of physical aggression towards staff and peers without provoking; spitting towards staff and peers; ineffective understanding of safety; threatening and taunting behavior with attempts to break facility equipment by punching, kicking, and grabbing materials which are thrown at staff. A Face Sheet indicated the facility admitted R4 on 10/20/2022. According to the Face Sheet, the resident had a medical history that included diagnoses of schizophrenia, schizoaffective disorder, and altered mental status. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS, with an ARD of 09/19/2024, revealed R4 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. An Initial Report, dated 11/16/2024, indicated the facility was informed of an allegation of resident-to-resident abuse on 11/15/2024 at 7:25 PM. A facsimile report dated 11/16/2024, indicated the facility notified the state survey agency of the abuse allegation on 11/16/2024 at 10:51 AM. Per the Initial Report, R3 alleged that R4 pulled their leg and spat on them. During an interview on 12/05/2024 at 12:30 PM, the Director of Nursing stated it was her expectation that facility staff report alleged abuse allegations timely based on facility policy and regulatory guidelines. During an interview on 12/05/2024 at 12:32 PM, the Administrator stated it was her expectation that facility staff report alleged abuse allegations timely based on facility policy and regulatory guidelines.

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NAME OF PROVIDER OR SUPPLIER: C M Tucker Jr Nursing Care Center Roddey Pavilion		STREET ADDRESS, CITY, STATE, ZIP CODE: 2200 Harden Street Columbia, SC 29203	

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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 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** 19186 Based on interview, record review, document review, and facility policy review, the facility failed to provide supervision to prevent accidents for 1 (Resident #3) of 3 sampled residents reviewed for abuse. Specifically, staff were required to keep Resident #3 within line of sight when the resident was out of their room. On 11/15/2024 at approximately 7:25 PM, staff failed to supervise Resident #3 and found the resident in Resident #4's room. Findings included: A facility policy titled, Special Treatment Modalities and Observation Levels effective 09/2024, revealed, This directive defines the process for administering care to resident populations who because of their behavior/condition, require more intensive monitoring within the facility. It is the policy of [the facility] to provide an appropriate level of supervision for those residents who are at significant risk of harm to self and/or others and/or who may create serious disruption in the environment. The policy revealed, Constant Observation-Line of Sight (COLS): Occurs when an individual staff member may be responsible for up to two (2) residents who remains at all times within the line of sight of the assigned staff. A Face Sheet indicated the facility admitted Resident #3 on 03/21/2023. According to the Face Sheet, the resident had a medical history that included diagnoses of dementia, type 2 diabetes mellitus, encephalopathy, wandering, and schizophrenia. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/2024, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. According to the MDS, the resident had physical and verbal behavioral symptoms directed toward others one to three days during the assessment period. The MDS revealed the resident used a manual wheelchair and was independent for sit to stand and chair/bed-to-chair transfer and with walking up to 150 feet. Resident #3's Care Plan Report included an undated problem statement, that indicated the resident had behavioral symptoms that included being resistant to care; noncompliant with care/medications; combative; hard to redirect; easily agitated by others (yelling out, loud disruptions); unpredictable behaviors with episodes of verbal threats of physical aggression towards staff and peers without provoking; spitting towards staff and peers; ineffective understanding of safety; threatening and taunting behavior with attempts to break facility equipment by punching, kicking, and grabbing materials which are thrown at staff. Interventions directed staff to provide special treatment modalities and observation levels per physician orders. The intervention indicated that staff may observe the resident up to ten feet away (initiated 01/01/2023). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Five-Day Follow-Up Report, dated 11/22/2024 revealed it was reported that on 11/15/2024 at 7:25 PM, Resident #3 entered Resident #4's room, during shift change and pulled Resident #4's leg. The report revealed that upon investigation, video footage showed Resident #3 coming down the hall from the nurse's station via wheelchair and going to the doorway of Resident #4's room. Video footage showed Resident #3 stood up and entered Resident #4's room. After approximately 30 seconds, the video footage showed two staff members at the doorway of Resident #4's room directing Resident #3 to come out. Per the facility's report, video footage showed Resident #3 left the room and sat in their wheelchair. The report revealed the two staff members stated that they heard Resident #4 saying not to spit or kick them as the staff approached Resident #4's room. Per the report, when they arrived at Resident #4's room, the staff saw Resident #3 pulling Resident #4's leg. The report revealed Resident #3 had a history of aggression towards peers and staff. Per the report, Resident #4 had a history of agitation, yelling, and being verbally aggressive toward staff and others. According to the report, the facility conducted an investigation that included obtaining staff witness and resident statements, conducting record review, and reviewing camera footage. The report revealed the facility determined that Resident #3 entered Resident #4's room where an inappropriate exchange occurred between the residents and neither resident sustained an injury. Per the report, facility staff quickly intervened once Resident #3 entered the room; psychiatry evaluated Resident #4 and Resident #3 and medication adjustments were made, and Resident #3 would remain on continuous line of sight supervision. Per the report, based on the evidence, the facility could not determine Resident #3's intent when they entered Resident #4's room; subsequently, abuse could not be substantiated. Resident #3's 1:1 Observation Flowsheet-Nursing Service for 11/15/2024, revealed staff should observe [the resident] every hour and [NAME] when out of room due to Risk of Injury to Others. Per the flowsheet, at 7:00 PM on 11/15/2024, Certified Nursing Assistant (CNA) #7 documented that Resident #3 was in the hallway and in the resident's room. The flowsheet revealed no further documentation regarding Resident #3's location until 8:00 PM. During an interview on 12/02/2024 at 1:55 PM, Registered Nurse (RN) #19 stated that Resident #3 required continuous observation when the resident was out of their room. During a telephone interview on 12/03/2024 at 2:14 PM, RN #9 stated he was unable to explain how Resident #3 was able to go into Resident #4's room when Resident #3 was supposed to be supervised when out of their room. During an interview on 12/03/2024 at 4:41 PM, CNA #12 stated she started work on the day of the incident at 7:00 PM. CNA #12 stated during the beginning of shift change she noticed an empty wheelchair in front of Resident #4's room. CNA #12 indicated that she saw Resident #3 standing over Resident #4 pulling the resident's leg as if the Resident #3 was trying to put Resident #4's leg back on the bed. Per CNA #12, Resident #4 stated that Resident #3 kicked and spat on them. CNA #12 indicated that she did not witness Resident #3 spitting or kicking Resident #4. CNA #12 indicated that when Resident #3 was out of their room, a TA was supposed to be observing Resident #3. CNA #12 indicated that there was no TA who sat near the nurse's station when she started work at 7:00 PM. (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 12/04/2024 at 2:50 PM, CNA #8 stated Resident #3 was usually a protector of the residents. CNA #8 indicated that she had never seen Resident #3 go in another resident's room. CNA #8 stated she was not aware she was assigned TA duties on the day of the incident until CNA #7, who was leaving, notified her. CNA #8 indicated that when she came in to work, Resident #4 was in bed and requested assistance to sit in their chair. CNA #8 stated she went to get CNA #12 to assist her with getting Resident #4 to a chair. CNA #8 stated they found Resident #3 was in Resident #4's room. Per CNA #8, CNA #12 redirected Resident #3 out of the room and reported the incident to the RN #9. During an interview on 12/04/2024 at 4:49 PM, CNA #7 stated that on the day of the incident, the TA left early due illness, and she took over the observation of residents until 7:00 PM. CNA #7 indicated that during the time she watched residents in the hallway, Resident #3 did not come out of their room. CNA #7 indicated that she was due to get off at 7:00 PM and was at the nurses' station assisting the nurse when the incident occurred. CNA #7 further indicated that CNA #8, was supposed to be assigned TA duties at 7:00 PM, and was supposed to observe residents that were in the hallway. During an interview on 12/04/2024 at 12:25 PM, the Director of Nursing stated that it was her expectation that the staff follow facility and regulatory guidelines related to preventing abuse and keeping residents safe. During an interview on 12/04/2024 at 12:30 PM, the Administrator stated that it was her expectation that the staff follow facility and regulatory guidelines related to preventing abuse and keeping residents safe.