STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425390	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Hills Skilled Nursing Facility	110 Summit Hills Drive Spartanburg, SC 29307

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review, interview, and facility policy review, the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) form in the required time frame for 2 (Resident (R)18 and R50) of 3 residents reviewed for beneficiary notices. Findings included: A facility policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised 09/2022, revealed 1. If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS [Centers for Medicare and Medicaid Services] form 1012) is issued to the resident at least two calendar days before benefits end. A Face Sheet revealed the facility admitted R18 on 11/14/25. According to the Face Sheet, the resident had a medical history that included diagnoses of aftercare following joint replacement surgery with the presence of a left artificial shoulder joint. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/18/25, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. R18's Notice of Medicare Non-Coverage indicated the last covered day of skilled services was 01/22/26, and the resident's Power of Attorney (POA)/family was notified verbally by phone on 01/21/26. A Face Sheet revealed the facility admitted R50 on 11/06/25. According to the Face Sheet, the resident had a medical history that included diagnoses of pneumonitis due to inhalation of food and vomit, pleural effusion, and gastrostomy status. An admission MDS, with an ARD of 11/12/2025, revealed R50 had a BIMS score of 11, which indicated the resident had moderate cognitive impairment. R50's Notice of Medicare Non-Coverage indicated the last covered day of skilled services was 12/12/2025, and the resident's family was notified verbally on 12/11/2025. During an interview on 01/30/26 at 12:49 PM,ˆthe Social Worker stated she would talk to the residents and Responsible Party about discharge several days before their last covered day but did not issue the form until the day before. She said she thought it was timely.ˆ During an interview on 01/30/26 at 1:14 PM, the Administrator stated that the NOMNC should be issued two days (48 hours) before the last covered day (LCD) of skilled services. The Administrator stated that the Social Service Department was responsible for issuing the NOMNCs. He reviewed R18's and R50's NOMNCs and confirmed that they were done 24 hours, not 48 hours, before the LCD.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and facility policy review, the facility failed to develop individualized person-centered care plans for 2 (Resident (R)17 and R19) of 2 residents reviewed for respiratory services. Specifically, the facility failed to ensure care plans addressed the use of a non-invasive mechanical CPAP (Continuous Positive Airway Pressure) ventilator for R17 and the use of oxygen for R19. Findings included: 1. A facility policy titled, Care Plans, Comprehensive Person-Centered, dated 03/2022, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy also indicated, 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. A Face Sheet indicated the facility admitted R17 on 12/19/25. According to the Face Sheet, the resident had a medical history that included diagnoses of pneumonia, respiratory failure, disorders of the lung, and chronic obstructive pulmonary disease (COPD). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/25/25, revealed R17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received oxygen therapy, and the use of a non-invasive mechanical ventilator was not coded. R17's hospital Discharge Summary dated 12/19/25 revealed discharge/follow up instructions that included CPAP use at bedtime. R17's Clinical Admission record, dated 12/19/25, indicated the use of oxygen and CPAP. A nurse practitioner's encounter Progress Note[s], dated 12/23/25 at 3:09 PM, indicated R17 had obstructive sleep apnea, and the resident stated they were trying to be compliant with the CPAP. A physician's encounter Progress Note[s], from 12/25/25 and dated 01/04/26 at 1:37 PM, indicated R17 had obstructive sleep apnea and used CPAP at night. R17's Care Plan Report, included a focus area, initiated 12/22/25, that indicated the resident had an altered respiratory status related to difficulty breathing related to COPD, respiratory failure, and congestive heart failure. Interventions directed staff to: administer medications as ordered and monitor for effectiveness and side effects; monitor for changes; monitor for signs and symptoms of respiratory distress and report to the physician as needed; position the resident with proper alignment for optimal breathing; and use pain management as appropriate. R17's Care Plan Report, included a focus area, initiated 12/22/25, for oxygen therapy related to ineffective gas exchange. Interventions directed staff tochange the resident's position every two hours to facilitate lung secretion movement and drainage; give medications as ordered; give oxygen if the resident ate but in a different manner, e.g. [exempli gratia, for example], changing from a mask to a nasal cannula, and returning the resident to their usual oxygen delivery method after the meal; monitor for signs of respiratory distress and report to the physician as needed; and to ensure oxygen settings via nasal at 2 l [liters]. R17's Care Plan Report did not include the use of the CPAP. Observations on 01/28/26 at 1:28 PM, 01/29/26 at 12:06 PM, and 01/30/26 at 10:35 AM revealed a CPAP machine on R17's nightstand with the mask lying on top of the machine in a plastic bag. During an interview on 01/30/26 at 10:35 AM, R17 stated they were wearing the CPAP mask every night for as long as they could, and it was getting easier to wear. During an interview on 01/30/26 at 12:48 PM, the Director of Nursing (DON) stated that the use of the CPAP should have been included in R17's care plan. During an interview on 01/30/26 at 3:16 PM, the Administrator stated that he expected CPAP use to be included in the care plan. 2. A Face Sheet indicated the facility admitted R19 on 07/10/2018. According to the Face Sheet, R19 had a medical history that included a diagnosis of Alzheimer's disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/04/25, revealed R19 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. A Director of Nursing's (DON) Long Term (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Evaluation, Progress Note[s], dated 01/07/26 at 1:21 PM, indicated R19 used oxygen via a nasal cannula (flexible tubing to deliver oxygen to the nose) with an oxygen saturation of 98%.A nursing Progress Note[s], dated 01/11/26 at 4:54 AM, indicated R19 was currently on 2 liters of continuous oxygen. R19's Care Plan Report did not include the use of oxygen. An observation on 01/28/26 at 1:04 PM revealed R19 lying in bed, their oxygen concentrator was on at 2 liters, the humidifier bottle was dated 01/02/26, and the tubing was dated 01/23/26. During an interview on 01/30/26 at 12:48 PM, the DON stated the use of oxygen should be included in the care plan and confirmed that it was not included in R19's care plan. During an interview on 01/30/26 at 3:16 PM, the Administrator stated that he expected the use of oxygen to be included in the care plan.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a physician order was in place for respiratory services for 2 (Resident (R)17 and R19) of 2 residents reviewed for respiratory care. Specifically, the facility failed to have physician orders in place for the use of a non-invasive mechanical CPAP (Continuous Positive Airway Pressure) ventilator for R17 and for the use of oxygen for R19. Findings included: 1. A facility policy titled, CPAP/BiPAP [CPAP/Bilevel Positive Airway Pressure] Support, revised 03/2015, specified, 3. Review the physician's order to determine the oxygen concentration and flow, and the PEEP [positive end-expiratory pressure] pressure for the machine. A Face Sheet indicated the facility admitted R17 on 12/19/25. According to the Face Sheet, the resident had a medical history that included diagnoses of pneumonia, respiratory failure, disorders of the lung, and chronic obstructive pulmonary disease (COPD). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/25/25, revealed R17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received oxygen therapy, but the use of a non-invasive mechanical ventilator was not coded. R17's Care Plan Report included a focus area, initiated 12/22/25, that indicated the resident had an altered respiratory status related to difficulty breathing related to COPD, respiratory failure, and congestive heart failure. Interventions directed staff to: administer medications as ordered and monitor for effectiveness and side effects; monitor for changes; monitor for signs and symptoms of respiratory distress and report to the physician as needed; position the resident with proper alignment for optimal breathing; and use pain management as appropriate. R17's Care Plan Report included a focus area, initiated 12/22/25, for oxygen therapy related to ineffective gas exchange. Interventions directed staff to: change the resident's position every two hours to facilitate lung secretion movement and drainage; give medications as ordered; give oxygen if the resident ate but in a different manner, e.g. [exempli gratia, for example], changing from a mask to a nasal cannula, and returning the resident to their usual oxygen delivery method after the meal; monitor for signs of respiratory distress and report to the physician as needed; and to ensure oxygen settings via nasal at 2 l [liters]. R17's hospital Discharge Summary dated 12/19/25 revealed discharge/follow up instructions that included CPAP use at bedtime. The Discharge Summary specified AutoCPAP [auto-titrating CPAP] with a home setting of 10-15 centimeters of water (pressure level setting) at bedtime. R17's Clinical Admission record, dated 12/19/25, indicated the use of oxygen and CPAP. R17's Order Recap Report, for the timeframe of 12/01/25 through 01/29/26, revealed no orders for CPAP therapy. A nurse practitioner's encounter Progress Note[s], dated 12/23/25 at 3:09 PM, indicated R17 had obstructive sleep apnea, and the resident stated they were trying to be compliant with the CPAP. A nurse's Progress Note[s], dated 12/23/25 at 5:25 AM, revealed R17 was resting in bed with their CPAP in place. A physician's encounter Progress Note[s], from 12/25/25 and dated 01/04/26 at 1:37 PM, indicated R17 had obstructive sleep apnea and used CPAP at night. A nurse's Progress Note[s], dated 01/09/26 at 12:45 AM, revealed R17 was resting in bed, and their CPAP was in place. A nurse's Progress Note[s], dated 01/10/26 at 3:02 AM, revealed R17 was resting in bed, and their CPAP was in place. Observations on 01/28/26 at 1:28 PM, 01/29/26 at 12:06 PM, and 01/30/26 at 10:35 AM revealed a CPAP machine on R17's nightstand with the mask lying on top of the machine in a plastic bag. During an interview on 01/30/26 at 10:35 AM, R17 stated they were wearing the CPAP mask every night for as long as they could, and it was getting easier to wear. During an interview on 01/30/26 at 12:48 PM, the Director of Nursing (DON) confirmed that R17 did not have an order for the CPAP. The DON stated that orders should include the settings, when to use the device, and the amount of oxygen. The DON stated the admitting nurse was responsible for transcribing orders at admission, and the unit manager or the DON would double-check the orders within 24 hours. The DON stated she did not know what happened to the orders for R17's CPAP. During an interview on 01/30/26 at 2:41 PM, Licensed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse (LPN)1 stated that when admitting a resident, they followed hospital discharge instructions, but CPAP orders were usually entered by the Nurse Practitioner (NP) after their assessment. LPN1 did not recall completing R17's admission or if CPAP orders were available at that time. During an interview on 01/30/26 at 2:55 PM, the NP stated that if a resident arrived with CPAP orders from the hospital, the facility should continue those orders. The NP stated that if no orders were present, but the resident used a CPAP, she would enter the orders after her assessment. The NP stated that nurses were expected to call her to review all orders for confirmation. The NP stated she was aware that R17 had a CPAP but did not know that orders were missing. The NP stated that orders should include the settings, even if they were home settings, and instructions for when to use the device. During an interview on 01/30/26 at 3:16 PM, the Administrator stated that he expected CPAP orders to be in place and reviewed by a clinician. 2. A Face Sheet indicated the facility admitted R19 on 07/10/2018. According to the Face Sheet, R19 had a medical history that included a diagnosis of Alzheimer's disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/04/25, revealed R19 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. R19's Care Plan Report, did not include a respiratory focus or the use of oxygen therapy. R19's Order Recap Report, dated from 01/01/26 through 01/29/26, contained an order, started 10/01/25, for oxygen tubing and humidifier change at bedtime every Thursday. The Order Recap Report revealed no order for oxygen therapy administration, including the prescribed liters of oxygen and the method of delivery. A Director of Nursing's (DON) Long Term Care Evaluation Progress Note[s], dated 01/07/26 at 1:21 PM, indicated R19 used oxygen via nasal cannula (flexible tubing to deliver oxygen to the nose) with an oxygen saturation of 98%. A nursing Progress Note[s], dated 01/11/26 at 4:54 AM, indicated R19 was currently on 2 liters of continuous oxygen. An observation on 01/28/26 at 1:04 PM revealed R19 lying in bed, and their oxygen concentrator was on at 2 liters. The humidifier bottle was dated 01/02/26, and the tubing was dated 01/23/26. During an interview on 01/30/26 at 12:48 PM, the Director of Nursing (DON) stated R19 did not have an oxygen order, but only an order for tubing changes. The DON stated R19 should have an order specifying oxygen usage, liters, monitoring every shift, and filter and tubing changes. The DON stated the facility switched to a new electronic health record (EHR) on 10/01/2025, and the nurse managers were responsible for entering orders into the new EHR system. The DON stated R19's oxygen order was located in the previous system, dated 03/04/24, for 1-3 liters of oxygen per minute per nasal cannula to maintain an oxygen saturation of greater than or equal to 88 percent. During an interview on 01/30/26 at 3:16 PM, the Administrator stated that he expected oxygen orders to be in place and reviewed by a clinician.