

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2024
NAME OF PROVIDER OR SUPPLIER  Pruitthealth- Blythewood		STREET ADDRESS, CITY, STATE, ZIP CODE  1075 Heather Green Drive Columbia, SC 29229	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>43648</p> <p>Based on observation, interviews, record review, and facility document and policy review, the facility failed to ensure an allegation of abuse was reported to the administrator of the facility and to the state survey agency within two hours for 1 (Resident (R)2) of 3 sampled residents reviewed for abuse. Specifically, on 02/14/2024, R2 reported to Licensed Practical Nurse (LPN)5 that Certified Nursing Assistant (CNA)7 was rough when providing care. LPN5 failed to notify the Administrator immediately; subsequently, the allegation was not reported to the State Agency until 02/15/2024 at 7:08 PM, the day after the incident occurred.</p> <p>Findings included:</p> <p>A review of the facility policy titled Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, revised on 07/29/2019, revealed, 1. Any allegation, suspicion, or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of an unknown source, should be immediately reported to the Administrator of the provider entity. The policy revealed, The state survey agency and the state agency for adult protective services should be notified in accordance with state law through established procedures of any allegation of abuse, neglect, exploitation or mistreatment, including injuries of an unknown source and misappropriation of patient property, within 2 hours after the allegation is made if the events upon which the allegation is based involve abuse or results in serious bodily injury, and not later than 24 hours if the events upon which the allegation is based do not involve abuse and do not result in serious bodily injury.</p> <p>A review of R2's Resident Face Sheet revealed the facility readmitted the resident on 06/20/2023. The Resident Face Sheet revealed the resident had diagnoses that included cognitive communication deficit, anemia, muscle weakness, difficulty walking, bone marrow transplant status, chronic pain syndrome, myelodysplastic syndrome (a group of disorders caused by blood cells that are poorly formed or do not work properly. Symptoms may include easy or unusual bruising and pinpoint-sized red spots just beneath the skin that are caused by bleeding), immunodeficiency, a disorder of iron metabolism, excoriation (skin-picking) disorder, and anxiety disorder.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 425400
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/12/2023 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed R2 had no behavioral symptoms during the assessment period. The MDS revealed R2 had no impairment in upper body range of motion but had impairment in the lower extremity on one side. The MDS revealed the resident required partial/moderate assistance with rolling left and right and was incontinent of bowel and bladder.</p> <p>A review of R2's Care Plan revealed a Problem area dated 06/21/2023 that indicated the resident was at risk for skin discoloration related to excoriation (skin-picking) disorder and an iron metabolism disorder. The facility developed interventions that directed staff to anticipate the resident's needs, meet activities of daily living (ADL) needs, and turn and reposition frequently during rounds and as needed. The Care Plan revealed a Problem area dated 07/03/2023 that indicated the resident had a history of osteoporosis and was at risk for injury. The Care Plan revealed a Problem area dated 07/03/2023 that indicated the resident had a risk of a decline in activities of daily living (ADL). The facility developed interventions that directed staff to provide safe positioning and transfers.</p> <p>During an observation on 04/15/2024 at 9:00 AM, R2 was in bed. The resident's hands and arms were observed to be largely discolored with purplish/brownish spots. The resident's skin appeared thin.</p> <p>During an interview on 04/15/2024 at 9:00 AM, R2 stated the CNA they had in February 2024 seemed to be rougher when turning them causing their arm to be discolored. R2 stated they had no areas of redness and their arms stayed discolored.</p> <p>A review of the facility's Initial Report dated 02/15/2024 revealed R2 stated during ADL care on 02/14/2024 at dinner time, CNA7 attempted to roll them over and caused discoloration to the upper left arm. The report revealed the allegation was reported to the state agency on 02/15/2024 at 6:35 PM, the day after the allegation occurred.</p> <p>A review of a typed statement dated 02/15/2024, signed by CNA7 revealed CNA7 provided care for R2 on 02/14/2024 and indicated she did not hurt or harm R2. The statement revealed she assisted the resident with ADL care on 02/14/2024 and changed R2 when the resident was soiled. The statement revealed the resident did not have any complaints during care but reported to the nurse that CNA7 was rough with the resident.</p> <p>During a phone interview on 04/15/2024 at 12:52 PM, CNA7 stated she was passing out dinner trays when R2 called her name. She stated she answered R2's call light and the resident stated they did not know why she did not know how to clean them correctly. CNA7 stated R2 told her to get out of their room. CNA7 stated she reported the incident to the nurse (LPN5), who checked on the resident. CNA7 stated R2 told the nurse that she was rough with them before dinner and asked the nurse to check their arm because she hurt their arm. CNA7 stated she had not provided care for R2 when the incident occurred because the resident had told her to leave the room. CNA7 stated the resident's skin normally appeared bruised. She stated the nurse asked the resident if they wanted her to continue to care for them, and the resident said yes. CNA7 stated that after the incident, she provided incontinence care for R2 during the night, and the resident had no concerns when she provided care.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of electronic mail (email) sent from LPN5 to the Director of Nursing (DON) on 02/15/2024 at 7:08 PM revealed that on 02/14/2024, LPN5 was called to R2's room to look at the resident's arm for bruising. The email revealed R2 stated they felt the CNA was rough. The email revealed LPN5 informed the resident they did not see anything on their arm and was going to find another CNA to work with the resident.</p> <p>During a phone interview on 04/15/2024 at 2:39 PM, LPN5 stated R2 had her look for a bruise; however, she did not see anything. LPN5 stated she never saw hand marks or finger marks on R2. She stated she told R2 she could have another CNA care for them, and the resident said no. LPN5 stated she considered the incident as a bedside manner issue and possibly that the CNA had not explained care prior to rolling the resident or that the CNA possibly held the resident's arm too hard. LPN5 stated she did not report to anyone but told CNA7 to make sure she was gentle with the resident. LPN5 stated she did not think this was an abuse allegation, especially since R2 wanted to keep the CNA that night. LPN5 stated R2 had thin skin, and their skin appeared bruised at all times.</p> <p>During an interview on 04/15/2024 at 1:58 PM, the DON stated they learned of the incident when R2 asked her and the previous Administrator to come to their room. The DON stated R2 told her what happened and that they wanted to make a report. The DON stated the resident's concern was that the CNA handled them roughly. The DON stated the resident said the first time CNA7 came into their room, they kicked the CNA out. The DON stated then later, the resident wanted CNA7 to take care of them. The DON stated the resident's skin stayed discolored due to their diagnosis of myelodysplastic syndrome and the medications they received. The DON stated the resident had generalized discoloring; however, they had no bruises from fingerprints. The DON stated LPN5 should have reported the allegation immediately.</p> <p>During a follow-up interview on 04/16/2024 at 11:48 AM, the DON stated she would expect any abuse allegation or concern to be reported immediately to the abuse coordinator.</p> <p>During an interview on 04/16/2024 at 11:50 AM, the Administrator stated if there was suspected abuse or abuse it should be reported to the Administrator. The Administrator stated residents had a right to be protected from any type of abuse.</p>		