STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425403	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home of SC - Foothills	205 Bud Nalley Drive Easley, SC 29642

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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interviews, the facility failed to ensure that the arbitration agreement signed by all facility residents, with a current census of 19 residents, provided for the selection of a venue that was convenient to both parties. Additional information documented in the admission Agreement revealed a stipulation related to the South Carolina Code of Laws that was not further clarified in this signed contract. Specifically, the facility failed to ensure that a neutral venue available to both parties was documented within the arbitration agreement and that potential Arbitration Agreement exempts existed within this form. The exclusion of providing a mutually agreed upon neutral venue location, and providing additional information about a South Carolina Arbitration Agreement exemption placed facility residents and families at an unknown disadvantage to potential future disputes. Findings include:Review of the facility provided admission Agreement, dated August 2024, revealed a Header that included, NOTICE REQUIRED BY SECTION 15- 48-10 OF THE SOUTH CAROLINA CODE OF LAWS, 1976, IS HEREBY GIVEN THAT THE FOLLOWING AGREEMENT IS SUBJECT TO ARBITRATION. Review of the facility provided admission Agreement, dated August 2024, again revealed, 11. Dispute Resolution.11.2 Federal Arbitration Act: .Therefore, the Arbitration Agreement, if signed, is subject to enforcement under the Federal Arbitration Act. If a court of competent jurisdiction determines that the Federal Arbitration Act does not apply, the Arbitration Agreement, if signed, is enforceable under the South Carolina Uniform Arbitration Act.Review of the facility provided admission Agreement and Arbitration Agreement failed to include additional clarification of the South Carolina Code of Laws, 1976, for the signee to review.Review of the admission Agreement, dated August 2024, revealed under, 11. Dispute Resolution.11.5 Location of Arbitration: The arbitration proceeding will be conducted in the county where the Community is located.Review of the admission Agreement, dated August 2024, and located under Exhibit C revealed that . any legal disputes, controversies, demands or claims . shall be resolved exclusively by binding arbitration to be conducted in [NAME] South Carolina .During an interview on 03/05/26 at 4:46 PM, Case Manager (CM) stated any arbitration disputes would be conducted in [NAME], South Carolina at the company office. During an interview on 03/05/26 at 5:39 PM, the Executive Director stated that the admission Agreement had been updated at the end of 2024. The Executive Director confirmed that arbitration could occur anywhere and stated they would review the current documentation.During an additional interview on 03/05/26 at 6:00 PM, Executive Director confirmed that the admission Agreement showed that arbitration would take place in [NAME], South Carolina, and the same document also showed that it would take place in the specific county. The Executive Director stated they would have to revise the form.

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility policy review, review of the Food and Drug Administration (FDA) guidelines and review of Manufacturer's Instructions for Use (MIFU), the facility failed to ensure bed frames, electrical components, and bed rails if present, were inspected and maintained by MIFU for the 19 current residents in the facility. This deficient practice has the potential for bed malfunction, contributing to possible resident injury.Findings include:Review of the facility provided Med [NAME] User Manual, page 13 Maintenance provided by the facility revealed: Maintenance and Service, Notice: Recommended to perform preventative maintenance every 12 months for best performance. 1. Inspect the frame for weld cracks or tears. 2. Check that all bolts, pins and fasteners are still in working order. 3. Perform functional test on the frame. 4. Inspect the casters for wear and tear. In a column titled Preventative Maintenance Inspection was a list of items: Inspect bed frame for cracks, tears, or bending, particularly at welds and joints. Inspect electrical enclosures for cracks or other damage. Check that screws, bolts, pins and other fasteners are in place, secured and properly tightened. Inspect actuators for excessive wear and misalignment. Inspect power cord for damage including the plug and strain relief. Verify that cables and wires are properly retained and clear of moving parts. Verify the plug connectors for the controls, drive motors, and motor control box are fully engaged. Verify the side rails/assist bars latch securely in the raised position. Verify all casters securely lock when activated. Verify that all bed control switches operate correctly.Review of the undated facility policy titled Proper Use of Side Rails revealed, The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids . General Guidelines . 12. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used).Review of the Joerns User-Service Manual, UltraCare XT page 14 Preventative Maintenance provided by the facility revealed, Preventative Maintenance To ensure maximum life of your product, follow all warnings and cautions in the User Manual and maintain your bed with care, as outlined below. The maintenance required will be dictated by your bed's usage and care - a thorough inspection should be conducted monthly. To Maximize Service Life. 1. Joerns UltraCare(R) XT bed frames have self-leveling electronics and do not require a regular reset procedure to remain level. 2. Keep the bed clean. 3. Observe bed operation. 4. After initial week of use, check all threaded fasteners for looseness, and make sure all pins are in their normal location and fastened securely. Check monthly for loose bolts, nuts, pins and other retaining hardware. Tighten any loose hardware. 5. Make sure each inspection includes the underside of the bed frame and mattress support platform. 6. Visually inspect the bed frame and accessories for any cracking, bending, or hole enlargement. 7. Check wiring for proper connections and damage (fraying, kinking, or deterioration). 8. Check actuators for correct mounting at attachment points and ensure all related pins are mounted securely and properly to the bed frame. Actuators are not serviceable but are replaceable if required. 9. Lubricate pivot point, pins and bolts as required. 10. Properly stow pendant. Place pendant in pendant holder right side up or use hook to avoid excessive bending of cable. Avoid dropping or stretching pendant during use to maximize service life. If any discrepancies are noted during inspection, they must be corrected before continuing bed frame use.Review of the FDA guidance (https://www.fda.gov/regulatory-information/search-fda-guidance-documents/hospital-bed-system-dimensional recommendations for rail entrapment revealed, . Potential Zones of Entrapment, This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. The seven areas in the bed system where there is a potential for entrapment are: Zone 1: Within the Rail, Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support, (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Zone 3: Between the Rail and the Mattress, Zone 4: Under the Rail, at the Ends of the Rail, Zone 5: Between Split Bed Rails, Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board, Zone 7: Between the Head or Foot Board and the Mattress End. Dimensional Limits for Identified Entrapment Zones 1-4, FDA is recommending dimensional limits for zones 1 through 4 at this time because we believe the majority of the entrapments reported to FDA have occurred in these zones. We based these recommended limits upon the body parts entrapped in these individual zones identified through adverse event reports and entrapment scenarios described in the reports.During observation of R22's bed on 03/03/26 at 3:35 PM, revealed bilateral upper bed rails, in the up position; observation of R24's bed on 03/03/26 at 2:56 PM revealed bilateral upper bed rails, in the up position; observation of R40's bed on 03/03/26 at 11:58 AM revealed bilateral upper bed rails, in the up position, with an approximate eight inch gap from the mattress to the head board and approximate two inch gap from the foot of the mattress to the foot board; and observation of 41's bed on 03/03/26 at 12:20 PM revealed bilateral upper bed rails, in the up position.During an observation on 03/04/26 at 4:11 PM, the Executive Director (ED) revealed the gap at R40's head of the bed was measured by the ED to be nine inches. It was observed the gap at the foot of the bed was now approximately an inch.During an interview on 03/04/26 at 5:15 PM, the Facilities Services Director (FSD) stated, There are no inspections on the beds in the past 12 months. The FSD also noted a foam insert was placed in the bed gap for R40. During an interview on 03/05/26 at 2:39 PM, the Director of Nursing (DON) stated the facility did not have a policy on bed inspections.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure alternatives were attempted prior to the use of bed rails for 4 of 4 residents (Resident (R)22, R24, R40, and R41) reviewed for bed rails out of a total sample of 13. This failure had the potential to increase accidental entrapment or injury when an alternate assistive device may have been effective.Findings include:Review of the undated facility policy titled Proper Use of Side Rails revealed, .The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. General Guidelines . 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms or reason for using side rails. 6. Less restrictive interventions that will be incorporated in care planning. 7. Documentation will indicate if less restrictive approaches are not successful prior to considering the use of side rails. 8. The risks and benefits of side rails will be considered for each resident. 9. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks .1.Review of R22's admission Record from the electronic medical record (EMR) Profile tab revealed an admission date of 02/08/26, with diagnoses including but not limited to, artificial hip joint, muscle weakness, and periprosthetic fracture of the left hip.Review of R22's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/10/26, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicative of being cognitively intact.During an observation and interview on 03/03/26 at 3:35 PM, R22 had bilateral assist bars on the bed. When queried if the facility advised her of the risks that can be associated with the use of bed rails, explaining about the possibility of entrapment, R22 stated, they [the facility] are good about everyone telling me how to use them, but did not remember anyone telling her about entrapment. Review of R22's Side Rail Evaluation, from the EMR Assessments tab revealed an assessment dated [DATE] that showed, Side Rail Conclusions: Side rails are not indicated at this time. The Side Rail Assessment did not document any attempted alternatives to the use of bed rails. Further review of R22's EMR Assessments, Progress Notes, and Miscellaneous tabs did not reveal any risk/benefit advisements regarding side rail use.2. Review of R24's admission Record from the EMR Profile tab revealed an admission date of 02/04/26, with diagnoses including but not limited to, osteoarthritis, muscle weakness, osteoporosis with current pathological fracture, and a humeral fracture.Review of R24's admission MDS with an ARD of 02/10/26, revealed a BIMS score of 13 out of 15, indicative of being cognitively intact.During an observation and interview on 03/03/26 at 2:56 PM, R24's bed was noted to have bilateral assist bars. When queried if the facility advised her of the risks that can be associated with the use of bed rails, explaining about the possibility of entrapment, R24 stated she does use the bed rails, but the facility had not advised her of the risks/benefits of the rails. Review of R24's EMR Assessments tab revealed a Side Rail assessment dated [DATE] revealed, Side Rail Conclusions: Side rails are indicated and serve as an enabler to promote independence in bed mobility. The Side Rail Assessment did not document any attempted alternatives. Further review of R22's EMR Assessments, Progress Notes, and Miscellaneous tabs did not reveal any risk/benefit advisements regarding side rail use. 3. Review of R40's admission Record from the EMR Profile tab revealed an admission date of 02/20/26, with diagnoses including but not limited to, osteoarthritis, orthostatic hypertension, and muscle weakness.During an observation and interview on 03/03/26 at 11:58 AM, R40's bed was noted to have bilateral upper side rails. R40 stated she does use the bed rails. When asked if the facility had advised of any risks/benefits of the bed rails, R40 responded No ma'am, nobody said anything. R40 answered (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	questions during the interview and appeared to be cognitively aware.Review of R40's EMR Assessments tab revealed a Side Rail assessment dated [DATE], which revealed, Side Rail Conclusions: Side rails are indicated and serve as an enabler to promote independence in bed mobility. The Side Rail Assessment did not document any attempted alternatives. Further review of R40's EMR Assessments, Progress Notes, and Miscellaneous tabs did not reveal any risk/benefit advisements regarding side rail use. 4. Review of R41's admission Record from the EMR Profile tab revealed an admission date of 02/27/26, with diagnoses including but not limited to, polyosteoarthritis, right shoulder pain, muscle weakness, and a history of falling.During an observation and interview on 03/03/26 at 12:20 PM, R41's bed had bilateral upper assist bars that R41 stated he does use. When queried if the facility advised him of the risks that can be associated with the use of bed rails, explaining about the possibility of entrapment, R41 did not remember anyone reviewing the risks/benefits of the side rails. R41 answered questions during the interview and appeared to be cognitively aware.Review of R41's Side Rail Assessment, dated 02/27/26, revealed, Side Rail Conclusions: Side rails are indicated and serve as an enabler to promote independence in bed mobility. The Side Rail Assessment did not document any attempted alternatives to the use of bed rails. Further review of R41's EMR Assessments, Progress Notes, and Miscellaneous tabs did not reveal any risk/benefit advisements regarding side rail use.During an interview on 03/04/26 at 4:05 PM regarding documented attempted alternatives to bed rails, the Director of Nursing (DON) stated, No, we have always just had the side rails upon admission, using the Side Rail assessment. We have not attempted alternatives. [There is] No documented risk/benefit or consent.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 resident (Resident (R) 32) of 13 residents in the sample reviewed for MDS accuracy. Specifically, R32's MDS failed to identify the correct discharge location at the end of the resident's stay. This failure created a potential for lack of identification of current problems and resident needs, leading to an incomplete or ineffective plan of care. Findings include:Review of the facility's policy titled, MDS 3.0 Completion dated 10/01/24 revealed, Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan . Discharge Assessment-completed using the discharge date as the ARD. Must be completed within 14 days of the discharge date /ARD. Review of R32's admission Record located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to, fracture of the lower end of left radius and multiple fractures of pelvis without disruption of pelvic ring.Review of R32's EMR under the Progress Notes tab dated 12/26/25, revealed the resident was admitted for short-term rehab following a hospital stay for pubic fracture.Review of R32's EMR under the Progress Notes tab dated 01/29/26, revealed the resident with, complaints of dizziness, dr [doctor] notified.pt [patient] in afib [atrial fibrillation] . pt transfered [sic] to . hospital. Review of R32's Discharge Return Not Anticipated MDS with an Assessment Reference Date (ARD) of 01/29/26 and located under the MDS tab of the EMR revealed the Discharge Status was recorded to have discharged to Home/Community. R32 did not return to the facility. During an interview on 03/05/26 at 10:01 AM, the MDS Coordinator (MDSC) stated, R32 went to the hospital and did not return to the facility. Upon review of R32's Discharge MDS, the MDSC confirmed that they had mistakenly documented that the resident had gone home when they had not.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure 1 of 3 residents (Resident (R)35) reviewed for respiratory services, received oxygen as ordered by the physician. This failure placed the resident at risk of receiving insufficient oxygen to meet the assessed respiratory need.Findings include:Review of the facility's undated policy titled, Oxygen Administration stated, . Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered .Review of R35's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R35 was initially admitted on [DATE], and readmitted on [DATE], with diagnoses including but not limited to, acute respiratory failure with hypoxia.Review of R35's EMR under the Orders tab revealed a physician order dated 02/27/26 for Oxygen 3 Liters via Nasal Cannula every day and night shift for hypoxia. This physician order was discontinued on 03/02/26 and a new physician order dated 03/02/26 indicated, Oxygen 2 Liters via Nasal Cannula every day and night shift for hypoxia. During an observation on 03/03/26 at 12:16 PM, R35 was observed in bed while using the oxygen from the room concentrator. The oxygen concentrator was revealed to be set at 4.5 LPM (Liters Per Minute).During an observation on 03/04/26 at 1:55 PM, R35 was observed in bed with the room oxygen concentrator on and set at 4.5 LPM.During an observation on 03/04/26 at 4:10 PM, R35 was observed in bed with the oxygen room concentrator on and set at 4.5 LPM. Review of R35's Care Plan dated 02/26/26 and located in the EMR under the Care Plan tab revealed the resident had altered respiratory status and difficulty breathing related to acute respiratory failure and congestive heart failure. Interventions included administering medication/puffers as ordered, and oxygen settings via nasal prongs at 3 LPM as ordered. The care plan was not revised to ensure the physician order was accurate.During an interview on 03/04/26 at 4:15 PM, Certified Nursing Assistant (CNA)1 said that CNAs could replace oxygen tanks, could take resident vitals, and could inform a nurse if there was a resident concern. CNA1 said that only nurses adjusted the LPM on an oxygen concentrator.During an interview on 03/04/26 at 4:20 PM, Registered Nurse (RN)1 said residents would receive oxygen as ordered by the physician. Upon review of R35's physician orders, RN1 confirmed that the resident was ordered to be on oxygen at 2 LPM continuously. RN1 observed the resident in their room and confirmed the resident was receiving oxygen at 4.5 LPM. RN1 lowered the oxygen room concentrator down to 2 LPM. RN1 stated that R35 received medication administration from Licensed Practical Nurse (LPN)1.During an interview on 03/04/26 at 4:34 PM, LPN1 stated that R35 had a physician order for 2 LPM, but that they could turn it up to 4 LPM as needed. Upon review of R35's physician orders, LPN1 stated that she thought there was a physician order for oxygen that could be titrated to 4 LPM. LPN1 reviewed R35's physician orders since the initial admission and confirmed there had not been a titrated order for oxygen administration.During an interview on 03/05/26 at 2:19 PM, the Director of Nursing (DON) said that none of the residents at the facility were provided with physician orders to titrate oxygen. The DON stated that the physician orders were to be followed, and none of them would be titrated. If residents were supposed to be on 2 LPM, then that was what they should be on.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on record review and interview, the facility failed to ensure that 1 of 3 residents (Resident (R)24) reviewed, that signed an arbitration agreement, were provided with an explanation of the binding agreement in a form and manner that they or their representative understood. The failures to ensure residents or their representatives were properly and clearly informed of the signed binding arbitration agreement could affect the ability for residents and families to be properly informed of the potential implication of the binding agreement on decisions and choices about important aspects of residents' health, safety, and welfare. Findings include:Review of R24's Arbitration Agreement located in the electronic medical record (EMR) under the Miscellaneous tab indicated the resident and family member (FM)1 had signed and initialed the facility Arbitration Agreement on 02/04/26. Review of R24's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/10/26, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated no cognitive impairment.During an interview on 03/05/26 at 5:01 PM, R24 stated that FM1 had signed the Arbitration Agreement upon admission. During an interview on 03/05/26 at 4:46 PM, Case Manager (CM) stated that they gave the resident and/or resident representative the paperwork to fill out upon admission and would answer any questions they might have. Regarding the Arbitration Agreement, CM said they told the resident and/or resident representative to read the document carefully, and if they had any questions, CM would read the Arbitration Agreement to them. If there were additional questions regarding the information, CM would refer the individual to the Executive Director who could explain it to them. CM said that did not happen often, and that reading the Arbitration Agreement together made it easier for them to understand. CM confirmed they only read the agreement as written but did not clarify the document.During an interview on 03/05/26 at 5:14 PM, FM1 stated that they had received paperwork, but there had not been an explanation of anything regarding what they signed. FM1 said that they had received the paperwork, and when the CM came back, they just picked it up from them. FM1 said they were not aware they did not have to sign the Arbitration Agreement. FM1 confirmed it was confusing, and they were requested to sign it. FM1 said they were not aware that they were giving up their right to sue. FM1 confirmed they read the information multiple times but did not understand what they signed. During an interview on 03/05/26 at 5:39 PM, Executive Director stated that if a resident and or resident representative did not understand the admission Agreement/Arbitration Agreement they could reach out to them. The Executive Director confirmed that CM went over the information with the new admissions and would inform them they did not have to sign it and would ensure they understood it.