

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Senior Care of Marion		STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S Highway 501 Marion, SC 29571	
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 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on review of the facility policy, record review and interview, the facility failed to ensure Resident (R)1 was free from verbal abuse, for 1 of 1 resident reviewed for verbal abuse. Specifically, Licensed Practical Nurse (LPN)1, used curse words directed at R1 when R1 refused to take her medications. Findings include: Review of the facility policy titled Abuse, Neglect and Exploitation documented. It is the policy of this facility to provide protection for the, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Under definitions: the definition of abuse, means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instance of abuse of all residents, irrespective of their age, ability to comprehend, or disability. Physical abuse includes, but not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Mistreatment means inappropriate treatment or exploitation of a resident. Review of R1's Face Sheet revealed the facility admitted R1 with diagnoses including, but not limited to, anxiety, major depressive disorder, schizophrenia and tremors. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/07/26, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R1 was cognitively intact. Review of the facility's investigation revealed a documented statement dated 10/08/25 revealed, Certified Nursing Assistant (CNA)1 was in the adjoining restroom to R1's room and overheard the altercation. CNA1's statement revealed that the nurse brought the medication into R1's room on 10/04/25 and R1 was not ready to take the medication and wanted the nurse to leave it in the room. The nurse informed the resident that she could not leave it, so the nurse tried to get it back. So Licensed Practical Nurse (LPN)1 held R1's arm while trying to get the medication cup from her other hand. CNA1 reported bad words being said to R1. CNA1 asked the nurse to leave R1 alone so she could calm down. The altercation was reported to the unit manager at this time. During an attempted interview with LPN1 on 01/28/26 at 2:12 PM, was unsuccessful due to the number being discontinued. During an interview on 01/28/26 at 2:16 PM, CNA1 stated she was in the shared restroom with a roommate and she heard R1 and the nurse arguing back and forth. CNA1 stated the resident was holding the cup of medication in her hand and the nurse was holding her other arm and trying to get the cup of medications from the resident. CNA1 stated, I did not hear the nurse call the resident a b**** but I heard</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: 425416	Facility ID: 425416 If continuation sheet Page 1 of 3

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F 0600 Level of Harm - Actual harm Residents Affected - Few	the word c*** a few times. During an interview on 01/28/26 at 4:20 PM, R1 stated she remembered the incident very well. She went on to say that the nurse brought medications in her room in a cup. It was early, so I asked her what medications she was going to give me. The nurse started yelling for me to just take them and I told her I wanted to know what medicines they were. The nurse started to take the medication cup out of my hand. She kept calling me a big fat c*** and kept saying it over and over. I was really scared because she came in the next day. I did not want her taking care of me again. I don't want anyone else to have to be scared and treated like I was treated. During an interview on 01/28/26 at 1:16 PM, the Administrator stated they had to let the nurse go because the nurse said bad words to the resident. During an interview on 01/28/26 at 3:00 PM, the Director of Nursing stated the nurse was fired, because she stated she did call the resident a b****.		

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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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on review of facility policy, record review and interview, the facility failed to report an allegation of verbal abuse within the 2 hour reporting timeframe for an altercation between Resident (R)1 and Licensed Practical Nurse (LPN)1 for 1 of 3 residents reviewed for abuse. Findings include:Review of the facility policy titled Abuse, Neglect, and Exploitation documents under Section VII. Reporting/Reponse of Abuse, Neglect and Exploitation, When abuse, neglect or exploitation is suspected: 1. Immediately report all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified time frames; 2. Assure that reporters are free from retaliation or reprisal; 3. Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service.Review of R1's Face Sheet revealed the facility admitted R1 with diagnoses including, but not limited to, anxiety, major depressive disorder, schizophrenia and tremors.Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 01/07/26, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R1 had intact cognition. Review of the facility's investigation revealed a statement written by Certified Nursing Assistant (CNA)1 dated 10/08/25, in which CNA1 was in the adjoining restroom to R1's room and overheard the altercation. CNA1 stated that the nurse brought the medication into R1's room on 10/04/25 and R1 was not ready to take the medication and wanted the nurse to leave it in the room. The nurse informed the resident that she could not leave it, so the nurse tried to get it back so Licensed Practical Nurse (LPN)1 held R1's arm while trying to get the medication cup from her other hand. CNA1 reported bad words being said to R1. CNA1 asked the nurse to leave R1 alone so she could calm down. The altercation was reported to the Unit Manager at this time.During an interview on 01/28/26 at 1:16 PM, the Administrator stated they had to let the nurse go. The night it happened the charge nurse did not let us know it happened. The nurse should have been walked out of the facility but the nurse supervisor did not.During an interview on 01/28/26 at 3:00 PM, the Director of Nursing stated the nurse was fired, because the nurse stated she did call the resident a b****. The resident reported the incident after she returned from the hospital and not at the time it happened.</p>		