Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425042	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Post Acute	661 Rutherford Rd Greenville, SC 29609

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, and review of facility policy, the facility failed to allow immediate family or other relatives the right to visit at any time for one (Resident (R) 122), reviewed for visitation of 31 sample residents. This had the potential for the resident to experience a decreased quality of life. Findings include: Review of the facility's policy titled Visitation with a revision date of 08/22 revealed, Our facility permits residents to receive visitors subject to the resident's wishes and the protection of the rights of other residents in the facility. Policy Interpretation and Implementation: Residents are permitted to have visitors of their choosing at the time of their choosing. The facility provides 24-hour access to individuals visiting with the consent of the resident. Review of R122's admission Record located under the Profile tab in the electronic medical record (EMR), indicated that R122 was admitted to the facility on [DATE]. Review of R122's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/09/25 and located under the MDS tab in the EMR revealed R122 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated she was cognitively intact. During an interview on 04/22/25 at 11:09 AM with R122, she stated that she did not like the fact that her parents have to leave at a certain time and she wanted them to be able to stay in the room and visit. She stated, My friends have been asked to leave, and my parents. During an on 04/22/25, at 11:09 AM with Family Member (FM)2 stated that the visitation hours are difficult because they want us to leave by 7:00 PM. FM2 stated, I work during the day, so when I get off and get here, I don't have much time. They have moved us to the common room, and we were able to stay until 9:00 PM once. My husband likes to eat breakfast with her and spend some time during the day, because she gets a little anxious when we are not here. So, we try to be here for her, but the visitation hours make it difficult. (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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/23/25 and 04/24/25, there were signs posted throughout the facility that revealed, Visitation Hours are currently 8:00 AM - 7:00 PM for patients in semi-private rooms. Residents have the option of visiting with their guest(s) in a public sitting area from 7:00 PM until 9:00 PM. All visitors must exit the building by 9:00 PM unless specific orders have been given/approved by MD [physician] or Hospice. Each unit is responsible for enforcing this policy!! During an interview on 04/23/25 at 6:33 PM with the Social Service Director (SSD), the SSD stated that visitation is from 8:00 AM - 7:00 PM, in a shared room, visitors can stay until 9:00 PM at night. If someone needs to set up a time outside those hours, they will need to speak with the Administrator. The signs that explain the visitation hours are posted throughout the facility. During an interview on 04/23/25 at 7:06 PM with FM3 revealed that they could stay in the room with R122 until 9:00 PM. FM3 stated, I would also come early in the morning so I could eat breakfast with her. R122 is experiencing anxiety about the visitation times because she is used to my wife and me being there with her. During an interview on 04/24/25 at 8:31 AM with the Director of Nursing (DON), the DON stated, R122 was very young, and the family is very protective. They are always in her room, from 5:30 AM till late at night. The dad is always in the room, and the roommate feels that she cannot get proper activities of daily living (ADLs) care with the dad in the room. We explained to the dad that he has to stay in the lobby until 8:00 AM so the roommate can get morning care. During an interview on 04/24/25 at 5:10 PM with the Administrator, the Administrator revealed We always want to make sure that it is a safe environment, and residents are protected. In referring to the signs that are posted in the facility about visitation, the Administrator did not reply.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure that an allegation of staff to resident verbal abuse for one (Resident (R) 89) reviewed for abuse was reported to the state agency (SA) within two hours of knowledge of the alleged verbal abuse. The failure to timely report allegations of abuse put the resident at risk for further abuse. Findings include: Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating with a revision date 04/21, indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) . If resident abuse (staff to resident and/or resident to resident), neglect, exploitation, misappropriation of resident's property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator . All allegations of staff-to-resident abuse must be reported immediately, but no later than 2 hours. Review of R89's admission Record located under the Profile tab in the electronic medical record (EMR), indicated that R89 was admitted to the facility on [DATE]. Review of R89's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/25 and located under the MDS tab in the EMR revealed R89 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was moderately impaired in cognition. During an interview on 04/22/25 at 11:35 AM, R89 reported that Certified Nursing Assistant (CNA)4 called his mother an [expletive]. R89 said he informed his son, Family Member (FM)1 about these issues, who then discussed the situation with the Administrator. R89 was unable to remember when the alleged verbal abuse occurred. Review of R88's (R89's roommate) annual MDS with an ARD of 03/29/25, revealed that R88 had a BIMS score of 15 out of 15, which indicated the resident had intact cognition. During an interview on 04/22/25, at 11:35 AM, R88 reported an incident involving CNA4 and R89. According to R88, R89 used an offensive term to describe her (CNA4), and in response, CNA4 directed the same inappropriate language about R89's mother. During an interview on 04/23/25, at 10:14 AM, FM1 indicated that he had met two weeks ago with the Administrator to discuss several concerning incidents involving R89. FM1 stated, We discussed a staff member using abusive language to describe his grandmother, and his father being left unattended in the shower room for 40 minutes. Review of the facility provided Long-term Care (LTC) Reportable Event did not list any report for R89 identifying any incident of abuse and/or neglect being reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/25, at 2:28 PM, the Administrator confirmed that R89's son had previously discussed an incident where the resident was left unattended in the shower room for over 40 minutes. This concern was forwarded to the Director of Nursing (DON) for investigation. The Administrator recalled that the son's primary complaints focused on his father being placed in isolation and encountering a nurse with poor communication skills. Regarding the alleged verbal abuse from CNA4 to R89 about his mother, the Administrator stated he had no prior knowledge of this situation. During an interview on 04/23/25, at 3:17 PM, the DON acknowledged that R89's son had expressed concern about his father being left in the shower room for over 45 minutes. The DON stated she reviewed security camera footage but found no evidence of this occurrence, and when questioned, the CNAs denied the incident. When asked about the reported incident involving abusive language from CNA4 towards R89's mother, the DON claimed no prior knowledge until the Administrator inquired about it earlier today. During an interview on 04/24/25 at 5:10 PM with the Administrator, the Administrator confirmed he was made aware yesterday (04/23/25) of the allegation made by R89 regarding CNA4 using abusive language about R89's mother. The Administrator confirmed he did not report the allegation to the SA on 04/23/25 when he became aware, nor has he reported as of 04/24/25.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure that an allegation of staff to resident verbal abuse for one (Resident (R)89) reviewed for abuse out of a total of 31 sampled, was thoroughly investigated. The failure to thoroughly investigate allegations of abuse had the potential for further abuse to the resident. Findings Include: Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revision date 04/21, indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to . verbal abuse. Identifying barriers such as fear of retaliation or causing trouble for someone and implementing interventions to remove barriers and promote a culture of transparency and reporting, investigating, and reporting any allegations within the timeframes required by federal requirements, and protecting residents from any further harm during investigations. Review of R89's admission Record located under the Profile tab in the electronic medical record (EMR), indicated that R89 was admitted to the facility on [DATE]. Review of R89's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/25 and located under the MDS tab in the EMR revealed R89 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was moderately impaired in cognition. During an interview on 04/22/25 at 11:35 AM, R89 reported that Certified Nursing Assistant (CNA) 4 called his mother an expletive. The resident expressed concerns to this surveyor about CNA4's abusive words and mentioned that while CNA4 had previously been reassigned to a different hall, she has since returned to working in his area. The resident informed his son, Family Member (FM)1 about these issues, who then discussed the situation with the Administrator. R89 was not able to remember when this allegation of verbal abuse occurred. Review of R88's annual MDS with an ARD of 03/29/25 located under the MDS tab in the EMR, revealed that R88 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 04/22/25, at 11:35 AM, R88 reported an incident involving CNA4 and R89. According to R88, R89 used an offensive term to describe CNA4 and in response, CNA4 directed the same inappropriate language toward R89's mother. During an interview on 04/23/25, at 10:14 AM, FM1 indicated that he had met two weeks ago with the Administrator to discuss several concerning incidents involving R89. We discussed a staff member using abusive language to describe his grandmother, and his father being left unattended in the shower room for 40 minutes. FM1stated that while the Administrator promised to investigate these incidents and provide follow-up information, no communication has been received in the two weeks since the meeting. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/25, at 2:28 PM, the Administrator confirmed that Resident 89's son had previously discussed an incident where the resident was allegedly left unattended in the shower room for over 40 minutes. This concern was forwarded to the Director of Nursing (DON) for investigation. The Administrator recalled that the son's primary complaints focused on his father being placed in isolation and encountering a nurse with poor communication skills. Upon inquiry about the facility's documentation procedures, the Administrator acknowledged that this family-reported concern was not documented as a formal grievance in the facility's recorded formal grievance log, and had no documentation of the investigation. Regarding the reported incident where CNA4 allegedly made inappropriate comments about Resident 89's mother, the Administrator stated he had no prior knowledge of this situation. During an interview on 04/24/25 at 8:05 AM with the Administrator, the Administrator indicated that the investigation was still ongoing. Messages were left for CNA4, but calls have not been returned. During an interview on 04/24/25 at 8:31 AM with the DON, the DON stated that she and a Unit Manager took R89 to a private place and talked on 04/23/25. R89 indicated that a couple of weeks ago, a black CNA with braids was nasty and had a bad attitude, called his momma an expletive, kicked the door, and bumped his chair. He said that he had seen her a couple of weeks ago, she had braids, but he did not know her name. The DON further indicated on 04/15/25 when FM1 came and talked with me and the Administrator, all he discussed was moving R89 around and being left in the shower for 40 minutes, however in reviewing the video this did not occur.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a written transfer notice that contained all required information was provided to three of three residents and/or their representative (Resident (R) 87, R113, and R83) reviewed for facility initiated emergent hospital transfer out of 31 sample residents. This failure has the potential to affect the resident and their Resident Representative (RR) by not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired. Findings include: Review of the facility's policy titled Transfer or Discharge, Emergency, dated December 2016, revealed .(4) should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: .(d) prepare a transfer form to send with the resident. 1. Review of the admission Record located under the Profile tab of the electronic medical record (EMR) revealed (R)87 admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease, major depressive disorder, muscle weakness, bipolar disorder, and fibromyalgia. Review of the significant change Minimum Data Set (MDS) located under the MDS tab of the EMR with and Assessment Reference Date (ARD) of 02/01/25 revealed R87 had a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating she was cognitively intact. Review of the Nurse's Note dated 01/26/25, located under the Progress Notes tab in the EMR revealed Resident returned to facility from weekend LOA [leave of absence]. Resident reports falling last night while at the Best Western with her male friend. Resident reports severe pain in L[eft] shoulder and ROM [range of motion] is restricted. Reports pain at 9/10. Body assessment completed. Bruising to chin, L[eft] breast, and R[ight] elbow. Dried blood under nose. [The] Resident reports she hit her mouth on the L[eft] side. Multiple teeth [were]chipped. [The] Resident reports missing some teeth before fall. Third eye NP notified of change in condition. New orders for pain control. L[eft] shoulder x-ray ordered. DON [Director of Nursing] notified. [The] Resident is [her] own RR, aware of new orders. Resident [is] lying in bed at this time with call light in reach. Review of the EMR did not reveal evidence that a written transfer/discharge notice was provided to R87 on 01/26/25. 2.Review of the admission Record located under the Profile tab in the EMR revealed R113 admitted on [DATE] with diagnoses of cystitis, unspecified without hematuria, muscle weakness, dependence on renal dialysis, acute on chronic diastolic heart failure, and essential hypertension. Review of the Medicare 5-day MDS located under the MDS tab in the EMR revealed R113 had a BIMS of 15 of 15 indicating he was cognitively intact. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse's Note dated 03/15/25, located under the Progress Notes tab in the EMR revealed [The] nurse was completing [the] pre-dialysis assessment. Pt [patient] presented with low bp [blood pressure] high hr [heart rate] [and] low-grade fever with c/o [complaints of] pain to RLE [right lower extremity]. On call [was] contacted. [The] nurse [was] concerned [the patient] pt would not be [able to] receive dialysis r/t [related to] fever and complications with low bp. ON call advised for pt to be sent to hospital for HLC. [The] nurse initiated EMS [emergency medical services] and [the] pt was transported via stretcher to [the hospital]. Review of the EMR did not reveal evidence that the resident received a transfer/discharge notice on 03/15/25. During an interview on 04/23/25 at 3:20 PM, Licensed Practical Nurse (LPN)2 stated she was not aware of a transfer/discharge form that should be given to the resident and their representative explaining why the resident was being sent to the hospital. During an interview on 04/23/25 at 3:22 PM, LPN3 stated a transfer discharge form should be sent with the residents but, she did not know if this facility provided them to the residents and their representatives upon discharge. During an interview on 04/23/25 at 3:33 PM, R87 stated the EMS personnel received all paperwork when she was transferred. She stated the staff verbally told her why she was being sent to the hospital on [DATE], and she did not receive a written transfer/discharge notice. During an interview on 04/23/25 at 4:15 PM, the Director of Nursing (DON) stated she was not aware the residents and their representative were supposed to receive a written copy of the transfer/discharge notice explaining why they were being sent out of the facility. She stated residents and families were verbally notified of why they were being transferred to the hospital. During an interview on 04/23/25 at 4:24 PM, R113 stated he did not receive a written transfer/discharge notice when he was sent to the hospital. 3. Review of the admission Record located under the Profile tab of the EMR revealed R83 was admitted on [DATE] with diagnoses of anoxic brain damage, respiratory failure, congestive heart failure, and tracheostomy. Review of the admission MDS with an ARD of 03/04/25 located under the MDS tab of the EMR revealed R83 had memory issues and severely impaired cognition. Review of the Nurse Progress Note dated 03/29/25, located in the EMR under the Progress Note tab in the EMR revealed R83 had shortness of breath, and the staff transferred the resident to the Emergency Department (ED). Although R83's Family Member was notified of her transfer to the hospital via telephone, there was no documentation that a written notice for R83's transfer to the hospital with the reason for her hospitalization was sent to the family. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse Progress Note dated 04/16/25, located in the EMR under the Progress Note tab of the EMR revealed R83 had a copious amount of respiratory secretions seeping out from pts HME (heat moisture exchanger). Nurse initiated care HME discarded, inner cannula changed and commenced suctioning. Nurse noticed consistency to be frothy and green with a foul order. Nurse then placed aerosol mask per respiratory order. Nurse started to prepare medications and bolus feed in that amount of time nurse noticed aerosol mask full of respiratory secretions. Nurse had to suction pt several times within the hour, she notified the medical staff, and R83 was transferred to the ED. Although R83's Family Member was notified of her transfer to the hospital via telephone, there was no documentation that a written notice for R83's transfer to the hospital with the reason for her hospitalization was sent to the family. During an interview with the Social Worker Director on 04/23/25 at 3:43 PM, she was asked for documentation to show that R83's family received written notification upon a R83's transfer/discharge to the hospital on [DATE] and 04/16/25 and the reason for the transfer/discharge. She stated the facility did not provide written notices to R83's family for the above discharges from the facility. The Social Worker Director said the staff notified family members by telephone about resident transfers to the hospital and did not send written notices to the family members/representatives regarding the date and reasons for their transfers/discharges to the hospital. During an interview on 04/25/25 at 10:20 AM, Unit Manager (UM)3 said at one time, the Ums sent written notification of the reason for a resident's discharge to a resident's family/representative. She said she had not sent written notices related to R83's hospital admissions and said the DON had assumed this task.

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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** Based on record review, interview, review of maintenance documentation, and review of facility policy, the facility failed to ensure one siderail was securely attached to the bed for one Resident (R)33) of one resident reviewed for side rails, which resulted in a fall, which required hospitalization out of a sample of 31 residents. After the fall, R33 developed a hematoma and pain to the right leg. This had the potential for other residents to have side rail safety issues that had the potential for residents to fall or sustain injuries. Findings include: Review of the facility's policy titled, Bed Safety and Bed Rails Program, revised in August 2022, revealed: Maintenance staff routinely inspect all bed and related equipment to identify risks and problems including potential entrapment risks. Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications. Review of the admission Record located under the Profile tab of the electronic medical record (EMR) revealed R33 was admitted on [DATE] with diagnoses of congestive heart failure, chronic kidney disease, acute and chronic respiratory failure, and morbid obesity. Review of the Bed Rail and Entrapment Risk Observation/Assessment dated 09/24/24 and 12/24/24, located under the Evaluation tab of the EMR revealed R33 used a side rail on the left and right upper bed rail to enhanced mobility related to her balance and generalized weakness or frailty. The bed rail enhances R33's freedom of movement, moving from a lying to a sitting position, and turning and repositioning. Review of the quarterly Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 12/23/24 located under the MDS tab of the EMR revealed R33 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating she was cognitively intact, and was dependent and/or required maximal staff assist for positioning, transfer, and activities of daily living. Review of the Care Plan dated 01/09/25 located in the EMR under the Care Plan tab of the EMR revealed R33 was at risk for injury related to use of siderail/bedrail and required a ¼ siderail on both sides of the bed as an enabler related to promoting bed mobility and positioning. Interventions included: Inspect residents' skin for potential complications or injury related to bedrail/siderail use. Review of R33's weight dated 03/10/25 located in the EMR under the Wts/VS tab of the EMR documented R33's weight was 465.8 pounds. During an interview on 04/22/25 at 11:18 AM, R33 stated the Certified Nursing (CNA) was providing care, she as she began to turn on her left side holding the left grab bar (side rail) with her right hand, the grab bar came apart from the bed frame, and she fell to the floor. She said she sustained a bruise on her right hip, which was painful. R33 said the grab bar was replaced shortly after she fell. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse's Note dated 03/13/25 under the Progress Note tab of the EMR documented the CNA called the nurse to room and the resident was observed lying on stomach between bed and air conditioner. The CNA stated when the resident rolled over on left side for CNA to perform perineal care, Resident grabbed bedrail and bedrail broke, and resident rolled out of bed. Review of the Witness Statement provided by the Director of Nurses (DON) dated 03/13/25, documented CNA went to help R33 with rolling to the side to remove her dress. As soon as she rolled to the side, CNA heard something break and the resident rolled out of bed onto the floor. R33's leg hit the air conditioner unit causing the bruise on her upper right leg. During an interview on 04/24/25 at 10:31 AM, CNA3 said on 03/13/25, she was removing R33's shirt to provide personal care. She said R33 held the left side rail with her right hand and when turning toward the left side of the bed, the side rail came off the bed, R33 rolled to the floor, and her right leg hit the air conditioner. CNA3 said prior to the incident, R33 had no issues with their side rails. Review of the Nurse Practitioner (NP) Progress Note dated 03/13/25 located under the Progress Note tab in the EMR documented R33's left side rail broke or became loose, and the resident rolled on the floor. R33 had no changes in her mental status and denied injury or pain. Review of the Nurse's Note dated 03/14/25 located under the Progress Note in the EMR documented R33 had slight bruising to the right thigh and no complaints of pain. Review of the NP Progress Note dated 03/14/25 located under the Progress Note tab in the EMR documented R33 had right leg pain and left foot pain. The Progress Note documented R33 had right anterior lateral thigh pain , decreased range of motion, and swelling. There was no decreased range of motion, swelling or pain on palpation to the left foot. The plan was to obtain X-rays of the right hip femur and knee to rule out any acute fractures or dislocations. Review of the evening shift Nurse's Note dated 03/14/25 documented, Resident could not receive an Xray to her right lower extremity due to her weight exceeding 400 pounds. Resident must be sent out for Xray. Review of the Nurse's Note, dated 03/15/25 documented R33 had right leg pain and was at the hospital for an Xray. During an interview on 04/24/25 at 2:21 PM, the NP said R33 had comorbidities and anemia. The NP said on 03/14/25, she assessed R33 and her bruising had increased and she had pain. She said R33 received anticoagulant medication and was at risk for bleeding. The NP said she was concerned about a fracture and/or a hematoma (a localized collection of blood outside of blood vessels, typically caused by an injury or trauma, can appear as a bruise or lump), and ordered x-rays at the facility. The NP said the swelling in R33's right thigh was soft and not hard. The NP said the staff notified her after 5:00 PM that due to her weight, the Xray could not be completed at the facility. She stated she told the staff to transfer R33 to the hospital for the Xray. The NP said the hospital completed Xrays and a Cat Scan, which confirmed hematoma, R33 returned to the facility on [DATE]. The NP said she was R33's fall was due to the pins not being placed back in the side rail. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Greenville Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 661 Rutherford Rd Greenville, SC 29609	

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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	Review of the hospital Discharge Summary dated 03/18/25 revealed R33 sustained a fall from her bed at the facility. The Discharge Summary documented R33's right hip, right femur, and right knee x-rays revealed no fractures. The Discharge Summary documented R33 was transferred back to the facility on [DATE]. Review of the facility provided document titled Work History Report dated 02/07/24 documented the Assistant Maintenance Director inspected all residents' bed mattresses/beds, and bed rails and no issues were identified. Review of the User-Service Manual that included information about the side rail used on R33's bed, provided by the DON revealed Visually inspect the bed and accessories for broken welds or creaks and check for loose hardware on a monthly basis .lubricate pivot point, pins, and bolts as required. During an interview on 04/23/25 at 9:49 AM, the Maintenance Assistant said beds, mattresses, and bed rails are assessed for each resident every month. The Maintenance Assistant said on 02/07/25, she assessed R33's bed, mattress, and side rails. She stated there were two pins on each side rail that were secure and there was no safety issues observed. She stated the March 2025 bed/mattress/side rail audit for safety had not yet been completed. The Maintenance Assistant said on 03/13/25 after the incident, she assessed R33's bed, which was a bariatric bed and was to have a ¼ side rail on each side of the upper bed. She stated the left side rail was on the floor, the two pins that held the siderail to the bed frame were not located, which had caused the side rail to become unattached from the bed. During further interview on 04/23/25 at 7:02 PM, the Maintenance Director said prior to 03/13/25, all residents' beds/mattresses/side rails were checked each month and there were never any issues. He said the Maintenance Director told him the pins that secured R33's bed to the bed frame were not in place at the time of her fall. The Maintenance Director said R33 was very heavy and he believed the force of her pushing or holding onto the left side rail and having no pins in that side rail to stabilize the side rail caused the saddle of the side rail (part of side rail that resident would hold) to bend, and the side rail became unattached to the bed, which caused her fall. He said 03/13/25, he corrected the side rail issue on R33's bed before R33 was transferred back to her bed. He confirmed that having no pins to secure the left side rail to the bed frame was a safety risk for R33. During an interview on 04/24/25 at 10:15 AM, with UM3 and on 04/24/25 at 12:49 PM with UM2, both stated that the UMs are responsible for doing weekly checks on resident's side rails, which includes assessing the correct side rail is on the bed and there are no safety issues. They said they shake and pull on the side rails to ensure they are not loose and are secure and sturdy. UM3 said on 03/12/25, she assessed R33's bed and side rails and the side rails were not loose and appeared safe and secure. UM2 and UM3 said they do not assess whether a side rails' pins are in place. During an interview on 04/23/25 at 10:05 AM, the DON, the Administrator, the Maintenance Director, and the Maintenance Assistant, the DON was asked about R33's fall. The DON said the Maintenance Director told her the bedrail became loose, R33 fell out of bed. The Maintenance Director said he told the DON the pins holding the side rail to the bed were not placed in the side rail, the side rail became loose, and R33 fell. The DON said she was not aware there were issues with missing pins on the side rail of R33's bed and the missing pins were the cause of R33's fall.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and facility policy review, the facility failed to ensure that menus were followed in regard to serving sizes. This had the potential to affect 120 of 124 residents who consumed meals from the facility's kitchen and placed them at nutritional risk. The facility identified four resident who were nothing by mouth (NPO). Findings include: Review of policy titled Diet Accuracy with a revision date 2/23, revealed Tray cards are to be used on the tray line for service and checked prior to leaving the kitchen for accuracy. Proper portions are to be served according to menu extensions. During an observations on 04/24/25 at 11:30 AM of the serving line in the kitchen revealed the menu being served was, honey glazed turkey with poultry gravy, mashed potatoes, roasted brussels sprouts, cornbread square, margarine, and pumpkin cheesecake bar. Resident's meal tickets indicated they were to get anywhere from two ounces (oz) to six oz of turkey. While watching the serving line, some slices of turkey were large and some were small; there was no consistency to the size of the turkey slices and the turkey was not weighed to ensure the appropriate amount of turkey was served. Close to the end of the serving line, the turkey that residents were receiving was broken pieces of turkey that were being scooped out and placed on trays. During an interview on 04/24/25 at 12:50 PM with the Dietary Manager (DM), the DM revealed that the meat slicer was broken and the turkey had to be cut by hand, so some of the slices were different sizes. The DM revealed for the portion sizes, six oz was two slices of turkey, four oz was 1 ½ slices of turkey, and three oz was one slice of turkey. When questioned about not knowing the amount of turkey the residents were getting, the DM did not reply. During an interview on 04/24/25 at 2:03 PM with the Registered Dietician (RD) revealed she did not know that the meat slicer was out of commission, and said there should be a way to measure portion sizes. Food is a big thing and is effective for the quality of life.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and test tray sample, the facility failed to provide food that was palatable and at the proper temperature. This had the potential to affect 120 of 124 residents who consumed food from the kitchen and for them to be at nutritional risk. The facility identified four residents who were nothing by mouth. (NPO). Findings include: 1.Review of R89's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/25 and located under the MDS tab in the electronic medical record (EMR) revealed R89 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was moderately impaired in cognition. During an interview on 04/22/25 at 11:15 AM with R89, R89 indicated that the food was served cold. 2. Review of R88's annual MDS with an ARD of 03/29/25 located under the MDS tab in the EMR, revealed that R88 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 04/22/25 at 11:35 AM with R88 indicated that the food was usually served cold, and the bread was always soaked in whatever vegetable that was on the plate. During a test tray sample on 04/24/25 at 1:16 PM, the Dietary Manager (DM) took the temperatures of the test tray. The mechanical turkey was at 94.5 degrees Fahrenheit (F). The DM and the surveyor tasted the mechanical chicken, the DM agreed that the chicken was cold. The DM indicated that the plate warmers were broken, and the pellet warmer was broken as well. During an interview on 04/24/25 at 3:03 PM with the Registered Dietitian (RD), revealed the RD was not aware that the plate warmers were not functioning. When putting food on a cold plate, the food is going to get cold. Food is a big thing, and it is effective for the quality of life.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure that facility's Binding Arbitration Agreement (BAA) was explained to residents in a manner that they understood for three out of three (Residents (R)68, R117, and R276) out of a total sample of 31 residents. The facility further failed to ensure the BAA informed residents and/or representative they had the right to rescind the agreement within 30 days. This failure placed the 122 residents at risk of signing an agreement they did not understand. Findings include: Review of the facility policy titled Binding Arbitration Agreements dated November 2023 revealed, Residents (or representatives) are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements . 1. Residents (or their representatives) have the right to make informed decisions about important aspects of their health, welfare, and safety . 5. The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement, including that the resident may be giving up his or her right to have a dispute decided in a court proceeding (i.e., litigation). 6. The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a form and manner that he or she understands, taking into consideration the resident's (or representative's) language, literacy and stated preference for learning . a. A signature alone is not sufficient acknowledgement of understanding. Review of the facility's Arbitration Agreement revealed, 12.0 BINDING ON PARTIES AND OTHERS 12.1 The Parties intend that this Agreement shall benefit and bind the Facility and its owners, directors, administrators, employees, and agents and shall benefit and bind the Resident (as defined in 2.2) and the Resident's spouse, children, next of kin, heirs, administrator, executor, power of attorney, guardian, legal representative, responsible party, trustee, successors, assigns, and agents, all to the fullest extent allowable by law . 16.0 ACKNOWLEDGMENT OF UNDERSTANDING 16.1 BY SIGNING BELOW, THE RESIDENT CONFIRMS THAT: (1) The Resident has read this Agreement or had it read to him/her; (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(2) The Agreement has been explained to the Resident in a form and manner the Resident understands, including in a language the Resident understands, and the Resident has had an opportunity to ask questions of a Facility representative and receive answers to any questions about the terms and conditions of this Agreement. 1.Review of R68's Face Sheet located under the Profile tab of the Electronic Medical Record (EMR) revealed R68 was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of cognitive communication deficit. Review of the Brief Interview for Mental Status (BIMS) dated 01/16/25 performed by the facility located under the Evaluations tab of the EMR revealed a BIMS score of nine out of 15, which indicated R68 had moderate cognitive impairment. The EMR indicated that R68 signed a BAA with no representative on 01/16/25. 2.Review of R117's Face Sheet located under the Profile tab of the EMR revealed R117 was admitted to the facility on [DATE]. Review of the BIMS dated 12/30/25 performed by the facility located under the Evaluations tab of the EMR revealed no score and indicated R117 had severe cognitive impairment. R117 signed a BAA with no representative on 12/30/24. 3.Review of R276's Face Sheet located under the Profile tab of the EMR revealed R276 was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of cognitive communication deficit. Review of R276's admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/06/25 revealed R276 had a BIMS score of 10 out of 15, which indicated R276 had moderate cognitive impairment. R276 signed a BAA with no representative on 12/09/24. During an interview on 04/24/25 at 1:57 PM, the Director of Admissions (DA) stated Arbitration is if for any reason residents or their family want to take legal action against the facility, there is a choice to meet within the cooperation and not have to pay legal fees out of their own pocket. We can come to an agreement. When asked how she determined the residents signing the agreement by themselves had the capacity to understand the complex legal terms in the arbitration agreement, the DA stated she would first see what their BIMS was. If they did not have the capacity, she would reach out to the representative. The DA stated with a BIMS of 12 or lower, she would consider a resident incapable of understanding the facility's arbitration agreement. When asked if she explained to residents that they have a right to a neutral arbitrator, the DA stated either party can choose the arbitrator, and either party can demand arbitration. When asked if she explained to residents that they have the option to rescind the agreement after signing, the DA did not know the number of days the BAA provided for the residents to rescind the agreement. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked if R68 was cognitively capable of understanding the BAA with a BIMS score of nine at admission, the DA stated R68 seemed to understand everything and signed it all after it was explained. DA further explained that when R68 was initially admitted , she signed the agreement on 01/16/25. The resident subsequently went to the hospital, and when she returned, she was no longer cognitively able to sign, so her responsible party which was her brother signed it. The DA stated, we have them sign the BAA more than once, that is what corporate wants. The DA further stated that R68 had a BIMS of nine at her initial admission and was only moderately impaired and understood everything. When asked how R68 could understand when the DA herself could not understand and explain the contents of the BAA, the DA had no response. During an interview on 04/24/25 at 5:00 PM with the Administrator, the Administrator stated the BAA was only for a duration of five years. When asked if this was reflected in the BAA that residents signed, the Administrator stated the time limitation was in the facility's Arbitration policy. When asked what his expectations were regarding the BAA process, the Administrator stated he would look into the arbitration agreement. During an interview 04/24/25 at 5:05 PM, R276 stated he did not recall signing a BAA, or anyone explaining what a BAA was, and did not know what this was. R276 stated he signed many documents at admission and did not remember what he signed. R68 was not available for interview. During an interview with R117 on 04/24/25 at 5:11 PM, the resident was neither able to verbalize nor demonstrate understanding of signing a BAA. The resident responded with unintelligible words.