

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Nhc Healthcare - Greenwood		STREET ADDRESS, CITY, STATE, ZIP CODE 437 East Cambridge Street Greenwood, SC 29646	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**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 informed consent was obtained from the resident prior to the use of a psychotropic medication for one of five residents (Resident (R) 42) reviewed for unnecessary medications out of 20 sampled residents. This placed the resident at risk of not being informed of the possible side effects of the medication.</p> <p>Findings included:</p> <p>Review of a March 2024 facility policy titled, Patient Care Policies revealed, .Patients have the right to make provisions for guiding decisions on their behalf .</p> <p>Review of R42's Face Sheet located in the resident's electronic medical record (EMR) under the Face Sheet tab revealed R42 was admitted to the facility on [DATE] with diagnoses that included depression with anxiety disorder.</p> <p>Review of R42's quarterly Minimum Data Set (MDS) located in the RAI-Resident Assessment Instrument tab of the EMR with an Assessment Reference Date (ARD) of 03/23/25 revealed R42 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R42 was cognitively intact. The MDS also indicated R42 was administered antianxiety and antidepressant medications daily during the seven-day observation period.</p> <p>Review of R42's Physician Order, dated 04/02/25 and located in the Orders tab of the EMR revealed, Klonopin [a long-acting benzodiazepine used to anxiety disorders] 0.5 mgs [milligrams] every 12 hours.</p> <p>Review of R42's Nursing Progress Note, dated 04/21/25 located in the resident's EMR under the Progress Notes tab and completed by Registered Nurse (RN) revealed, Psychotropic Medication Informed Consent: Name of psychotropic medication: .Klonopin .Initiation .Informed in advance of the benefits, risks, and alternative for the medication including any black box warning for antipsychotic medications. Black Box Warning: Elderly patients with dementia-related psychosis and treated with antipsychotics have an increased risk of death: Yes Prior to initiating or increasing the above listed medication/s, informed consent was provided by: Patient Representative [name withheld].</p> <p>During an interview on 04/30/25 at 2:00 PM, RN2 was asked why the representative gave verbal consent for the psychotropic medication instead of R42. RN2 stated, I know her representative who knows her medications, so I called him. RN2 was asked since the facility had assessed her to be intact cognitively, why was R42 not consulted. RN2 stated, We just always call the representative.</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
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/30/25 at 2:48 PM, the Assistant Director of Nursing (ADON) was asked why RN2 did not consult and obtain consent from R42 since she was assessed to be intact cognitively. The ADON stated, She should have obtained consent from the resident.</p>

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and review of the facility's policy, the facility failed to ensure two of two residents (Residents (R) 40 and R289) were afforded the right to participate in their care planning process. This failure placed the residents at risk of not being aware of the goals and outcomes of their care and for their care plan not to be person centered.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Patient Care Plans, dated November 2023 revealed, .The center will ensure an interdisciplinary and comprehensive approach to the development of the patient's care plan of care. Patient's goals for care and preferences will be determined and used to develop their plan of care. The services outlined in the comprehensive care plan meet professional standards of quality .Patient/patient representative participation will continue to be documented via the care conference section of the EHR [electronic health record] .</p> <p>1. Review of R40's Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R40 was admitted to the facility on [DATE] with diagnoses that included a stroke with left-sided paralysis and diabetes.</p> <p>Review of R40's quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 04/03/25 revealed that R40 had a Brief Interview of Mental Status (BIMS) score of 11 out of 15 which indicated she was moderately cognitively impaired.</p> <p>During an interview on 04/29/25 at 11:46 AM, R40 was asked if she attended her care conferences at least quarterly. R40 stated, I don't know if there are care plan conferences.</p> <p>Review of R40's 02/25/25 quarterly Care Conference located in the Care Plan tab of the EMR revealed that R40's representative attended the meeting; however, there was no documentation on the Care Conference note to show that R40 was invited or had declined to attend.</p> <p>Review of R40's Social Service notes, located in the Progress Notes' tab of the EMR did not show any documentation that R40 had been invited or had declined to attend the Care Conference on 02/25/25.</p> <p>During an interview on 05/01/25 at 1:49 PM, the Patient and Family Services Coordinator (PFSC) stated, When she was admitted to the facility, the patient and the family are invited to attend the Care Conference however, over time, some patients are more confused than others and if they can be involved in the plan of care, they would come to participate in the Care Conference. The PFSC was asked if there should be documentation to show that the resident was invited or had declined to attend. The PFSC stated, Yes.</p> <p>2. Review of R289's Face Sheet located in the Face Sheet tab of the EMR revealed R289 was admitted to the facility on [DATE] with diagnoses that included diabetes.</p> <p>Review of R289's admission MDS located in the MDS tab of the EMR with an ARD of 04/16/25 revealed, R289 had a BIMS score of 15 out of 15 which indicated R289 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 04/10/25 admission Care Conference located in the Care Plan tab of the EMR revealed no documentation that R289 or his representative had attended the Care Conference. The 04/04/25 Baseline Care Plan provided by the Director of Nursing (DON) showed that it had been mailed to the resident representative. There was no documentation in the Progress Notes to show an invitation was mailed and accepted by the resident representative or if the resident had been invited and had declined to attend.</p> <p>During an interview on 05/01/25 at 9:30 AM, the DON stated, My expectation is that the residents are to be invited to their Care Conferences even if they have an inability to consent to healthcare decision. It doesn't matter if they participate, answer questions, or just listen.</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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to report an allegation of physical abuse to the State Survey Agency (SSA) within two hours for an incident between residents (Resident (R)115 and R5).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation dated 09/14/17 indicated .Any partner having either direct or indirect knowledge of any event that might constitute abuse.must report the event immediately, but not later than 2 hours after forming the suspicion.It is the policy of this facility that 'abuse' allegations.are reported per Federal and State law.</p> <p>Review of a document provided by the facility titled Section 100_Definitions and References. 101. Definitions indicated . Physical Abuse. The act of intentionally inflicting or allowing to be inflicted physical injury on a resident by an act or failure to act. Physical abuse does</p> <p>not include altercations or acts of assault between residents.</p> <p>Review of R115's Face Sheet found in R115's electronic medical record (EMR) under the Resident tab indicated the resident was admitted to the facility on [DATE].</p> <p>Review of R115's nursing Progress Note, dated 01/19/25 and located under the Resident tab of the EMR revealed Registered Nurse (RN)1 documented that several Certified Nursing Assistants (CNAs) reported R115 walked out of her room, approached R5, and hit R5 in the head. RN1 documented she reported the resident-to-resident incident to RN3.</p> <p>Review of R5's Face Sheet found in R5's EMR under the Resident tab indicated the resident was admitted to the facility on [DATE].</p> <p>Review of R5's nursing Progress Notes, dated 01/19/25 and located in the resident's EMR under the Resident tab indicated RN1 documented several CNAs reported R5 was sitting by the fish tank when R115 walked out of her room, approached R5, and hit R5 in the head.</p> <p>During an interview on 04/30/25 at 11:36 AM, RN1 stated after it was reported to her that R115 hit R5 in the head, she reported this to RN3.</p> <p>During an interview on 04/30/25 at 12:10 PM, RN3 stated confirmed RN1 reported the resident-to-resident incident which involved R115 and R5 to her.</p> <p>During an interview on 04/30/25 at 12:19 PM, RN3 stated she reported the resident-to-resident incident which involved R115 and R5 to the Administrator, who was the abuse coordinator.</p> <p>During an interview on 04/30/25 at 3:06 PM, the Administrator confirmed he did not report the resident-to-resident incident to the SSA.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure supervision while toileting for one of four residents (Residents (R) 112) reviewed for falls out of 30 sampled residents. This failure caused harm to R112 when he sustained a right hip fracture from a fall off the toilet. This failure placed residents at risk of further injury and a diminished quality of life.</p> <p>Findings include:</p> <p>Review of R112's Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R112 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, a history of falling, and osteoporosis of the right knee.</p> <p>Review of R112's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 01/29/25 and located in the MDS tab of the EMR revealed R112 had a Brief Interview for Mental Status (BIMS) score of five out of 15 which indicated R112 was severely cognitively impaired. The MDS also indicated the resident required substantial assistance for toileting, and was able to self-propel his wheelchair.</p> <p>Review of R112's Fall Care Plan edited on 04/29/25 and located in the Care Plan tab of the EMR revealed, Fall Risk r/t [related to] History of Falling/Chronic Gait Instability/Alzheimer's/ Dementia with Agitation. RECENT FALL WITH RIGHT FEMUR [HIP BONE] FRACTURE. Interventions include but are not limited to:</p> <p>a. Encourage Res [resident] to call for assistance with ADLs [activities of daily living] and transfers. Dated 01/08/25.</p> <p>b. Staff to monitor for Restlessness, Dated 04/01/25.</p> <p>Review of R112's Nursing Progress Note, dated 02/12/25 and located in the Progress Notes tab of the EMR, completed by Licensed Practical Nurse (LPN) 2 revealed, .CNA [Certified Nurse Assistant] found resident in the bathroom floor. Resident complained of pain on his right leg. Residednt (sic) was unable to move right leg. Neuro checks and ROM [range of motion] completed, and no changes noted besides resistance in right leg. Nurse notified NP [nurse practitioner] on call and was instructed to send resident to [hospital name withheld] for evaluation .</p> <p>Review of R112's Nursing Progress Note, dated 02/17/25 and located in the Progress Notes tab of the EMR by Registered Nurse (RN) 2 revealed, .readmitted from [hospital name withheld] has touchdown weight bearing status on RLE [right lower leg] large amount of serous [a watery fluid] noted on 3 dressings on s/p [status post] surgical sites on RLE. Has 4 staples intact on s/p surgical sites above right knee on lateral side of RLE, 20 staples noted in s/p surgical site on right thigh, and 11 staples on s/p surgical site on right hip .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's 02/17/25 5-day Investigation Report to the State Agency [SA] revealed, .Certified Nursing Assistant communicated to the Resident that she was assisting another resident and would assist him to the restroom immediately after. Resident has poor safety awareness and refused to wait. When the CNA checked on the resident he was noted in the restroom and was seen with poor body posture on the commode (leaning forward). The CNA gave verbal cues to the resident to sit straighter for safety though the resident refused to comply. The nurse was called to assist. She gave the same verbal cues, and the resident would not comply. The CNA took his dinner tray out of the room and when she returned, she saw the resident coming off the commode due to his poor posture. The CNA stated she tried to intervene to lessen the fall but was unable to act fast enough. Resident voiced he thought his leg was broken. Resident was assessed for injuries. NP and family made aware. Orders were received to send Resident to the ED [emergency department] for evaluation .</p> <p>An attempted interview with LPN2 was made on 04/30/25 at 11:44 AM. A voice mail was left for a return call regarding R112's fall. No return call was received by the end of the survey.</p> <p>During an interview on 04/30/25 at 1:11 PM, the Director of Rehabilitation stated, R112 was on our caseload at the time of the fall. He was a high-risk for falls prior to the fracture and was unaware of his limitation. He was able to self-propel in his room and in the hallway and could stand and transfer, but it was ugly and not very good. The Director of Rehabilitation was asked if R112 was told to stay right there and not move till I get back would he remember the command. The Director of Rehabilitation stated, No, he wouldn't.</p> <p>During an interview on 04/30/25 at 3:08 PM, CNA2 stated, It was supper time, he had eaten [his meal] and I was picking up his tray, but he was already in the bathroom. I told him to use the call light and to let us know, but I had his tray in my hand. I told him to sit back as he was leaning forward. The nurse heard me tell him to sit back and she walked in and told him to sit back also. He did sit back but, as I had the meal tray in my hand, I left the room and went to put the tray back into the cart. CNA2 was asked if both herself and the nurse left the room with the resident on the toilet. CNA2 stated, Yes, we left together. CNA2 further stated, When I came back, he was already on the floor. CNA2 was asked about R112's ADL [activities of daily living] status prior to the fall. CNA2 stated, He could move around in the wheelchair. I would tell him to use the call light when he needed to go to the bathroom anytime, and we would come to help him. He was able to transfer but we still liked to help him. CNA2 was asked since R112 had been assessed by the facility to be severely impaired in cognition, so do you think he would remember to use the call light. CNA2 stated, I would say yes. He could ring the call light and ask to go to the bathroom or to pass him the urinal, but it was not consistent. CNA2 was asked if she had asked R112 why he fell. CNA2 stated, He did not give me an explanation as to why he fell.</p> <p>During an interview on 05/01/25 at 10:35 AM, LPN1 was asked if R112 had the ability to consistently know when and how to use the call light. LPN1 stated, No ma'am, not consistently. Before the fall he would occasionally push the call light, but it was not consistent. LPN1 was asked if R112 required staff supervision when using the toilet. LPN1 stated, Yes, he does, at least on my shift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/01/25 at 11:00 AM, the Director of Nursing (DON) was asked about why the staff left him unattended before he fell. The DON stated, Yes, I questioned that also. A lot of times, his condition would fluctuate, and he was able to transfer himself before the fall. We have trained staff that if a resident is unsafe, they are not to leave them unattended. The DON further stated, I don't think he was left on purpose, I think he was okay at that time versus needing one on one supervision.</p> <p>A policy was requested but was not received prior to the exit.</p>		