STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425102	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POINSETT REHABILITATION AND HEALTHCARE CENTER	8 NORTH TEXAS AVENUE GREENVILLE, SC 29611

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide an environment free of potential abuse for four out of seven sampled residents (Resident #5, Resident #17, Resident #19, and Resident #23) reviewed for resident to resident altercations. Specifically, staff failed to maintain 1:1 observation of Resident #5 which led to resident to resident altercations with no injuries. This failure also had the potential of Resident #5 to be abused by Resident #17, Resident #19, and Resident #23 in response to Resident #5's abusive behaviors. Findings include: Review of a facility intake report, initiated 6/05/20, shows Resident #5 has been involved in nine resident to resident altercations. Review of Resident #5's face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #5's quarterly MDS with an ARD of 07/21/20, indicated the resident's Brief Interview of Mental Status (BIMS) score is 99 which indicates the resident was unable to complete the interview. Review of this MDS revealed the following behaviors: 1. behaviors toward other residents, staff and self: 1 to 3 days during the observation period. He/she exhibited refusal of care 1 to 3 days during the observation period. Review of the Electronic Medical Record (EMR) revealed a behavioral care plan for Resident #5 that showed multiple medication adjustments after each incident, multiple room changes, staff to introduce resident to other residents in his new hall and observe for signs of adjustment difficulties, and 1:1 observation on all shifts initiated as a nursing intervention on 12/31/19. Review of policy, One to One Procedure and Responsibilities, effective date November 2019, revealed the following: . 3. Remain at bedside, next to wheelchair or stationary chair at all times to include while the resident is sleeping (do not sit outside) . 6. The resident assigned is to be within arm's reach at all times. Please be sure the sight line to the resident is unobstructed .8. Engage with the resident via ambulation, propulsion of wheelchair, reading, attending activities, listening to music, conversation, board games ect. Keep the resident occupied but not over stimulated . Review of dhec (Department of Health and Environmental Control)5-day Report, dated 5/01/20, details Resident #17 was reported sitting in front of the emergency exit and Resident #5 was approaching the door. Resident #17 told Resident #5 to go the other way. Then Resident #5 hit Resident #17. Resident #17 called for help and staff immediately responded separating the residents. A small scratch on Resident #17's right arm was noted. Review of the facility investigation revealed the 1:1 sitter was talking with a staff member and watching Resident #5. Sitter was counseled and educated on responsibilities for 1:1 to remain within arms-length of the resident to be able to intervene. Review of dhec 5-day Report, dated 5/26/20, details Certified Nursing Assistant ((CNA) scheduled as a sitter for Resident #5 had gone on break and returned to the floor and heard Resident #19 call out. Resident #19 was pointing at Resident #5 as if he/she were bothering Resident #19. No witnesses and no injuries observed. As a result of this incident, Resident #5 was moved to a private room and staff were in-serviced on the 1:1 policy and the need to cover for sitters during breaks. Review of the dhec 5-day Report, dated 6/10/20, details staff member heard Resident #23 call out Come get him. Staff observed Resident #5 sitting on Resident #23's bed drinking from his/her water pitcher. Resident #5 was removed from the room and Resident #23 reported he/she was hit on left side of the jaw. The facility investigation found the assigned sitter for Resident #5 was late, the previous sitter left without relief, and the floor nurse did not reassign a sitter. Staff was in serviced on 1:1 responsibilities and staff involved were counseled. During an interview on 08/12/20 at 10:23 AM, Licensed Practical Nurse (LPN) #1 said he/she was not advised that the sitter was going to be late and no one was in the room. LPN#1 reported I took care of the sitter immediately (assigned a staff member as a sitter). Reported she/he always makes sure to look in on every sitter at the first of the shift since that time. During an interview on 08/12/20 at 10:30 AM, CNA #1 stated he/she sits for Resident #5. Resident #5 likes to walk and will walk all day. Likes to be in the sunshine, so we walk outside frequently. Resident #5 does get in bad moods and you have to stay very close to so he/she does not grab another resident. During an interview on 08/12/20 at 12:30 PM, CNA #2 stated, (Resident #5's name) does not like to be re-directed. I try to talk calmly to him. During an interview on 08/12/20 at 8:30 AM, CNA #5 and sitter #2, both employees stated that they have been present when the resident has grabbed other residents. They are maintaining the 1:1 supervision. During an interview with the Director of Nursing (DON) on 08/12/20 at 3:00 PM, the DON stated that administrative staff verify that a sitter is scheduled every shift. She/he said the nursing staff is instructed to verify the sitter is present at the beginning of every shift and document 1:1 every shift. The DON stated that there have been no incidents since 06/06/20 after Resident #5 was moved to a private room, medications were adjusted, and staff have maintained 1:1 observation.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to fully implement their 1:1 observation policy for one of seven sampled residents (Resident #5) reviewed for resident to resident altercations. Specifically, staff failed to fully implement their 1:1 observation policy for Resident #5 which led to resident to resident altercations with no injuries. This failure also had the potential of Resident #5 to be abused by Resident #17, Resident #19, and Resident #23 in response to Resident #5's abusive behaviors. Findings include: Review of a facility intake report initiated 6/05/20, revealed Resident #5 has been involved nine resident to resident altercations. Review of Resident #5's face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #5's quarterly MDS with an ARD of 07/21/20, indicated the resident's Brief Interview of Mental Status (BIMS) score is 99 which indicates the resident was unable to complete the interview. Review of this MDS revealed the following behaviors: 1. behaviors toward other residents, staff and self: 1 to 3 days during the observation period. He/she exhibited refusal of care 1 to 3 days during the observation period. Review of the Electronic Medical Record (EMR) revealed a behavioral care plan for Resident #5 that showed multiple medication adjustments after each incident, multiple room changes, staff to introduce resident to other residents in his new hall and observe for signs of adjustment difficulties, and 1:1 observation on all shifts initiated as a nursing intervention on 12/31/19. Review of Department of Health and Environmental Control (dhec) 5-day Report, dated 5/01/20, details Resident #17 reported sitting in front of the emergency exit and Resident #5 was approaching the door. Resident #17 told Resident #5 to go the other way. Then Resident #5 hit Resident #17. Resident #17 called for help and staff immediately responded separating the residents. The 1:1 sitter was talking with a staff member and watching Resident #5. Responsibility #6 of 1:1 policy The resident assigned is to be within arm's reach at all times. Please be sure the sight line to the resident is unobstructed. Sitter was counseled and educated on responsibilities for 1:1. Review of dhec 5-day Report, dated 5/26/20, details CNA(sitter) for Resident #5 had gone on break after telling the nursing staff she/he was leaving. The CNA returned to floor and heard Resident #19 call out. Resident #19 was pointing at Resident #5 as if he/she were bothering Resident #19. No witnesses and no injuries observed. Responsibility #4 of 1:1 policy DO NOT LEAVE your assigned resident at

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) any time during your shift without getting someone to cover your assignment. Staff were in-serviced on the 1:1 policy and the need to cover for sitters during breaks. Review of the dhec 5- day Report, dated 6/10/20, details staff member heard Resident #23 call out Come get him. Staff observed Resident #5 sitting on Resident #23's bed drinking from his/her water pitcher. Resident #5 was removed from the room and Resident #23 reported he/she was hit on left side of the jaw. Investigation found assigned sitter for Resident #5 was late, the previous sitter left without relief and the floor nurse did not reassign a sitter. Responsibility #5 of 1:1 policy- You cannot leave your assigned resident until your relief arrives and report is provided. Staff was in serviced on 1:1 responsibilities and staff involved were counseled. Review of policy One to One Procedure and Responsibilities, effective date November 2019, revealed the following: 3. Remain at bedside, next to wheelchair or stationary chair at all times to include while the resident is sleeping (do not sit outside). 4. DO NOT LEAVE your assigned resident at any time during your shift without getting someone to cover your assignment. 5. You cannot leave your assigned resident until your relief arrives and report is provided 6. The resident assigned is to be within arm's reach at all times. Please be sure the sight line to the resident is unobstructed. 8. Engage with the resident via ambulation, propulsion of wheelchair, reading, attending activities, listening to music, conversation, board games ect Keep the resident occupied but not over stimulated. During an interview with the Director of Nursing (DON) on 08/12/20 at 3:00 PM, the DON stated that the administrative staff verify that a sitter is scheduled every shift. She/he said the nursing staff is instructed to verify the sitter is present at the first of every shift and document 1:1 every shift. The DON stated there have been no incidents since 06/06/20 since the resident is in private room, medications have been adjusted, and 1:1 observation has been maintained per the 1:1 observation policy.
F 0732 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Post nurse staffing information every day.** Based on observation and interview, the facility failed to ensure the daily staffing was posted for the residents to view. This deficient practice had the potential to affect the residents from being able to view the staffing available for care. Findings include: During observation on 08/11/20 at 9:10 AM, review of the daily staffing sheet that hung on the outside of the Director of Nurses (DON) office revealed a date of 08/04/20, seven days ago. During an interview on 08/11/20 at 9:15 AM, the DON was asked to look at the staffing sheet. The DON reviewed the sheet and stated, That's wrong. That should not be there. During an interview on 08/11/20 at 10:00 AM, the Administrator was asked about the week-old date on the staffing sheet. The Administrator stated, It should not have been hanging with a week-old date . During the same interview, the Administrator was asked for the policy for the staffing sheet. The Administrator stated there was no policy.