

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Oceanside Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Rosewood Avenue Tybee Island, GA 31328	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41196</p> <p>Based on clinical record review and staff interview it was determined the facility failed to include, in the resident's baseline plan of care, minimum standards of care to fully address the resident's immediate needs upon admission for one out of 21 sampled residents, Resident (R) #79.</p> <p>Findings include:</p> <p>Review of R#79's clinical record revealed she was admitted to the facility on [DATE], with diagnoses to include acute respiratory failure with hypoxia, dysphagia - oropharyngeal phase, cognitive communication deficit, essential hypertension, type 2 diabetes mellitus, restless legs syndrome, and insomnia.</p> <p>A review of a Nurses Note dated 2/18/25, at 5:09 a.m., revealed R#79 was on oxygen via nasal cannula at two (2) liters (L) resident stated allergic to codeine, V/S (vital signs) wnl (within normal limits), blood glucose level 127.</p> <p>A review of a Social Services Note dated 2/18/25, at 2:34 p.m., revealed R #79's code status as DNR (do not resuscitate), was on 2 L of oxygen, and utilized eyeglasses as an aid due to visual impairments.</p> <p>A review of R#79's baseline care plan (required to be developed within the first 48 hours of admission) included a single entry, which was a care area for nutritional status.</p> <p>There was no documented evidence that the facility timely identified and addressed the resident's care needs to include the use of oxygen, having an allergy to codeine, cognitive communication deficit, diagnosis of Diabetes, code status of DNR, or the use of eyeglasses.</p> <p>The resident's baseline care plan failed to identify interventions to address the resident's current needs at the time of admission.</p> <p>An interview with Licensed Practical Nurse (LPN) DD/Minimum Data Set (MDS) Coordinator, on 3/14/25, at approximately 9:48 a.m., confirmed the observation of the single entry in the care plan, and that the facility failed to ensure that the resident's baseline care plan included the minimum healthcare information.</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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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Nursing Home Administrator (NHA), on 3/14/25, at approximately 9:55 a.m., confirmed the facility failed to sufficiently address the care and management of R#79 on the resident's baseline plan of care.		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>41196</p> <p>Based on observations and record review, the facility failed to post the required nursing staffing data on a daily basis. This was observed for four (4) of four (4) days of survey.</p> <p>Findings include:</p> <p>Review of the facility's Nurse Staffing Posting Information policy and procedures, undated, stated:</p> <p>1. The Nurse Staffing Sheet will be posted on a daily basis .2. The facility will post the Nurse Staffing Sheet at the beginning of each shift.</p> <p>Upon request of the Daily Nurse Staffing Posting, the staff was unable to furnish the postings for certain dates requested.</p> <p>During an interview, on 3/12/25 at approximately 2:00 p.m., Registered Nurse #1 stated that she could not find the nurse staffing data. She stated that the job was overwhelming and she was trying to organize the files.</p> <p>During an interview, on 3/14/25 at approximately 9:30 a.m., the Administrator acknowledged that the facility had not posted the Daily Nurse Staffing consistently and that going forward the facility would post the information daily.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>41196</p> <p>Based on observation, staff interviews, review of controlled drug count records, and facility policy review, it was determined that the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs on three out of three medication carts (West Medication Cart One, [NAME] Medication Cart Two, and East Medication Cart).</p> <p>Findings include:</p> <p>Review of a facility's policy titled, Controlled Substance Administration and Accountability, undated, revealed all controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift.</p> <p>A review of a document titled Change of Shift Narcotic Log identified by Licensed Practical Nurse (LPN) AA as the change of shift controlled count sheets for [NAME] Medication Cart Two on 3/11/25, at approximately 9:49 a.m., revealed that the on-coming nurse and/or off-going nurse failed to sign the sheets during shift change on the following dates to verify completion of the task to count the controlled drugs in the respective medication cart: 1/1/25 through 1/11/25, 1/14/25, 1/20/25, 1/21/25, 1/26/25, 1/29/25, 1/30/25, and 1/31/25; 2/3/25, 2/4/25, 2/5/25, 2/12/25, 2/14/25, 2/19/25, 2/27/25, and 2/28/25; 3/1/25, 3/2/25, and 3/3/25.</p> <p>During an interview with LPN AA, on 3/11/25, at approximately 9:51 a.m., she confirmed the observation and acknowledged that licensed nurses are expected to sign the count verification at change of shift.</p> <p>A review of a document titled Change of Shift Narcotic Log identified by LPN BB as the change of shift controlled count sheets for [NAME] Medication Cart One, on 3/11/25, at approximately 10:07 a.m., revealed that the on-coming nurse and/or off-going nurse failed to sign the sheets during shift change on the following date to verify completion of the task to count the controlled drugs in the respective medication cart: 1/1/25 through 1/31/25, (the entire month, all shifts, of January 2025); 2/1/25 through 2/9/25, 2/11/25, 2/14/25, 2/15/25, 2/16/25, 2/17/25, 2/23/25, 2/25/25, and 2/27/25; 3/2/25, 3/9/25, and 3/10/25.</p> <p>An interview with LPN BB, on 3/11/25, at approximately 10:11 a.m., confirmed the observation and she acknowledged that licensed nurses are expected to sign the count verification at change of shift.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of a document titled Change of Shift Narcotic Log identified by LPN CC as the change of shift controlled count sheets for East Medication Cart, on 3/11/25, at approximately 10:20 a.m., revealed that the on-coming nurse and/or off-going nurse failed to sign the sheets during shift change on the following dates to verify completion of the task to count the controlled drugs in the respective medication cart: 1/3/25 through 1/6/25, 1/8/25, 1/10/25, 1/11/25, 1/17/25, 1/18/25, 1/19/25, 1/25/25, 1/27/25, 1/30/25, and 1/31/25; 2/1/25, 2/2/25, 2/16/25, 2/22/25, and 2/25/25; 3/1/25, 3/4/25, 3/8/25, 3/9/25, and 3/10/25.</p> <p>During an interview with LPN CC, on 3/11/25, at approximately 10:23 a.m., she confirmed the observation and acknowledged that licensed nurses are expected to sign the count verification at change of shift.</p> <p>During an interview, with the Nursing Home Administrator (NHA) on 3/13/25, at approximately 11:50 a.m., she confirmed there was no additional documentation to provide and that it was her expectation that nursing staff signed the Control Substance logs at change of shift to demonstrate that he/she had completed the count of the controlled drugs to identify any discrepancies, and that the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>41196</p> <p>Based on observation, staff interview, and facility policy, it was determined that the facility failed to adhere to acceptable storage requirements and use by dates for multi-dose diabetes medication on one of three medication carts observed, (West Cart Two. This affected Resident (R) #10, R#48, and R#70.</p> <p>Findings include:</p> <p>A review of facility policy titled Multi-Dose Vials, undated, revealed multi-dose vials would be re-labeled with a beyond use date, 28 days after the vial is opened or punctured (unless otherwise specified by the manufacturer). The beyond-use date rule would begin on the first (1st) day the multi-use vial was opened or punctured. The medication label would also include the initials of the nurse who opened the vial. The policy indicated that staff should visually inspect the vial before each use to double check the expiration date, beyond use date if previously opened, and ensure there was no visible contamination. The Unit Manager would perform random checks of opened multi-dose vials for appropriate dating.</p> <p>Observation of the [NAME] Medication Cart Two, on 3/11/25, at approximately 9:58 a.m., in the presence of Licensed Practical Nurse (LPN) AA, revealed the following opened multi-dose diabetes medications:</p> <p>One vial of Fiasp (type of insulin), opened and available for use, not dated when initially opened, and belonged to R#10.</p> <p>One vial of Lantus (type of insulin), opened and available for use, not dated when initially opened, and belonged to R#48.</p> <p>One vial of Lantus Insulin Glargine (type of insulin), opened and available for use, not dated when initially opened, and belonging to R#70.</p> <p>Interview on 3/11/25, at approximately 10:00 a.m., with LPN AA, confirmed the observation, and that the medication should have been dated when initially opened.</p> <p>Interview with the Nursing Home Administrator (NHA) on 3/13/25, at approximately 11:50 a.m., confirmed the facility failed to date multi-dose medications when opened to assure acceptable storage times.</p>		