STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425016	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linley Park Post Acute	208 James Street Anderson, SC 29625

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31846 Based on facility policy, record reviews and interviews, the facility failed to ensure the physician and the responsible party for Resident (R)68 were notified related to refusal of insulin on multiple occasions for 1 of 1 reviewed for notification. Review of the facility's policy titled, Change in a Resident's Condition or Status, states: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g.,changes in level of care, billing/payments, resident rights, etc.). The, Policy Interpretation and Implementation, states: 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): c. Adverse reaction to medication; d. Significant change in the resident's physical/emotional/mental condition; e. Need to alter the resident's medical treatment significantly; f. Refusal of treatment or medications two (2) or more consecutive times. The findings include: The facility admitted R68 on 06/03/2024 with diagnoses including, but not limited to, cerebrovascular accident, dysphagia, aphasia, lack of coordination, diabetes mellitus type 2 and cerebral edema. During an interview on 07/14/2024 at 12:50 PM with the responsible party for R68, she stated that R68 refuses insulin and no one lets her know. She stated, He will die without that insulin. She also stated that she was R68's Power of Attorney because he could not make any decisions for himself. Review of the medical record for R68 on 07/15/2024 at 11:35 AM revealed a Medication Administration Record (MAR) for June 2024 the findings are as follows: (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 5, 2024 R68 refused the scheduled dose of Glargine 40 units of insulin at 06:00 PM and Humalog 5 units at 06:00 PM, He additionally refused the blood sugar check and if any needed insulin via sliding scale at 06:00 PM. On June 14, 2024 R68 refused Glargine 40 units of insulin at 06:00 PM. On June 29, and June 30, 2024 R68 refused Glargine 40 units of insulin at 06:00 AM. Further review of the medical record for R68 revealed a MAR for July 2024 the findings are as follows: On July 3, 2024 R68 refused the scheduled dose of Glargine 40 units of insulin at 06:00 AM. On July 6, 2024 and July 12, R68 refused Lispro 5 units scheduled for 12:00 Noon. On July 12, 2024 R68 refused Glargine 40 units of scheduled insulin at 09:00 AM. On July 12, 2024 R68 refused the blood sugar check and any needed insulin via sliding scale at 12:00 Noon and at 06:00 PM. On July 13, 2024 R68 refused Lispro 5 units scheduled for 06:00 AM. No documentation could be found in the medical record for R68 to ensure the physician and the responsible party were notified of the refusal of insulin or blood sugar checks. During an interview on 07/16/2024 at 07:20 AM the Director of Nursing (DON) stated she would expect the nurse that encountered the refusal to notify the physician and the responsible party. During an interview on 07/16/2024 at 07:35 AM with the Licensed Practical Nurse, (LPN)5, Assistant Director of Nursing, it was brought to her attention that she had documented a refusal of insulin for R68 on 07/06/2024 and there was no documentation that LPN5 had notified the physician nor the responsible party. LPN5 reviewed her documentation and confirmed that she had not notified the physician nor the resident's responsible party. During an interview on 07/16/2024 at 08:22 AM with LPN1, she stated that anytime a resident refuses an medication we should notify the physician and the responsible party.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 31846 Based on the guidance for administering insulin via an Insulin Pen, observations and interviews, the facility failed to ensure a medication administration error rate of less than 5 percent for 4 out 25 opportunities for error. The medication administration error rate was 16 percent. Review of the guidance titled, Insulin Administration Using an Insulin Pen, states: How to Use. 7. Wipe the tip of the pen where the needle will attach with an alcohol swab or a cotton ball moistened with alcohol. 8. Remove the protective pull tab from the needle and screw it onto the pen until snug (but not too tight). 9. Remove both the plastic outer cap and inner needle cap. 10. Look at the dose window and turn the dosage knob to 2 units. 11. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. This will prime the needle and remove any air from the needle. Repeat this step if needed until a drop appears. 12. Dial the number of units ordered. The findings include: An observation during med pass on 07/15/2024 at 08:40 AM, revealed Licensed Practical Nurse (LPN)3 held the insulin pen horizontally and did not remove the cap from the needle and dialed up 2 units and pressed the injection button, she did not confirm that the insulin was seen at the tip of the needle. LPN3 confirmed that the insulin pen was primed incorrectly. She then stated that she should have held the pen upright to ensure the air was removed and that the resident would receive the correct dose of insulin. During an observation during med pass on 07/15/2024 at 09:05 AM, LPN3 was to administer Flonase. LPN3 failed to shake the Flonase prior to administration. During an interview on 07/15/2024 at 09:11 AM with LPN3, she confirmed that she had not shaken the Flonase, and that the resident shook it and administered it to herself. The resident did not shake the Flonase prior to putting it in the edge of her nostril and with her thumb on the bottom of the bottle and her first 2 fingers on the sprayer, she administered the medication. LPN3 could not confirm that the resident received the Flonase. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/15/2024 at 09:30 AM, LPN1 was to administer insulin via an insulin pen. The pen was new, she applied the needle and did not attempt to prime the insulin pen. LPN1 stated at 09:40 AM that she knew to prime the pen, but did not. She could not confirm that the resident received the correct dose of insulin. During an observation on 07/16/2024 at 07:50 AM, LPN4 was to administer insulin via an insulin pen. She cleaned the rubber seal with an alcohol prep and then applied the needle. She dialed up the 2 units for priming, and held the insulin pen horizontally and pressed the injection button, she did not confirm that insulin had escaped the needle. When asked, LPN4 stated that to prime the pens you should hold the pen vertical and not horizontal and observe for insulin escaping the needle when you push the injection button. She could not confirm that the resident received the correct dose of insulin. During interviews on 07/15/2024 and 07/16/2024, with the Director of Nursing (DON), the nurse check off sheets for demonstration, related to administering insulin via a flex pen were requested but not provided.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 31846 Based on review of the facility policies observations, record reviews and interviews the facility failed to ensure Resident (R)125 was free of significant medication errors when he received a blood pressure medication outside the ordered parameter. R125 received the blood pressure medication multiple times in error for 1 of 5 residents reviewed for unnecessary medications. The facility further failed to ensure insulin via a flex pen was administered correctly by nurses for 3 out of 3 residents observed during medication administration. Review of the facility policy titled, Administering Medications. states, Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 8. If a dosage is believed to be inappropriate or excessive for a resident, a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, and right time and right method (route) of administration before giving the medication. 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. Review of guidance titled, Insulin Administration Using an Insulin Pen, states: How to Use. 7. Wipe the tip of the pen where the needle will attach with an alcohol swab or a cotton ball moistened with alcohol. 8. Remove the protective pull tab from the needle and screw it onto the pen until snug (but not too tight). 9. Remove both the plastic outer cap and inner needle cap. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Look at the dose window and turn the dosage knob to 2 units. 11. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. This will prime the needle and remove any air from the needle. Repeat this step if needed until a drop appears. 12. Dial the number of units ordered. The findings include: An observation during med pass on 07/15/2024 at 08:40 AM, revealed Licensed Practical Nurse (LPN)3 held the insulin pen horizontally and not remove the cap from the needle and dialed up 2 units and pressed the injection button, she did not confirm that the insulin was seen at the tip of the needle. LPN3 confirmed that the insulin pen was primed incorrectly. She then stated that she should have held the pen upright to ensure the air was removed and that the resident would receive the correct dose of insulin. During an observation on 07/15/2024 at 09:30 AM, LPN1 was to administer insulin via an insulin pen. The pen was new, she applied the needle and did not attempt to prime the insulin pen. LPN1 stated at 09:40 AM that she knew to prime the pen, but did not. She could not confirm that the resident received the correct dose of insulin. During an observation on 07/16/2024 at 07:50 AM, LPN4, cleaned the rubber seal with an alcohol prep and then applied the needle. She dialed up the 2 units for priming, and held the insulin pen horizontally and pressed the injection button, she did not confirm that insulin had escaped the needle. When asked, she stated that to prime the pens you should hold the pen vertical and not horizontal and observe for insulin escaping the needle when you push the injection button. She could not confirm that the resident received the correct dose of insulin. During an interview on 07/15/2024 and 07/16/2024 with the Director of Nursing (DON), the nurse check off sheets for demonstration, related to administering insulin via a flex pen were requested but not provided. The facility admitted R125 on 06/25/2024 with diagnoses including, but not limited to, anxiety, depression and mood disorder and hypotension. Review on 07/15/2024 at 3:09 PM of the Medication Administration Record (MAR) for R125 dated June 2024 revealed a physician's order for Midodrine HCl Oral Tablet 5 milligrams. Give 1 tablet by mouth three times a day for hypotension. If SBP (systolic blood pressure) is greater than 120 DO NOT GIVE medication. The Midodrine was given on 06/27/2024 at 09:00 AM for a blood pressure of 125/60. The Midodrine was given on 06/28/2024 at 09:00 AM for a blood pressure of 135/70. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It was also given on 06/28/2024 at 12:00 Noon for a blood pressure of 135/70 and at 05:00 PM for a blood pressure of 133/79. The Midodrine was given on 06/29/2024 at 09:00 AM for a blood pressure of 133/79. At 12:00 Noon on 06/29/2024 the medication was given for a blood pressure of 134/78 and again at 5:00 PM for a blood pressure of 134/78. The Midodrine was given on 06/30/2024 at 09:00 AM for a blood sugar of 127/69. Review of the MAR for R125 on 07/15/2024 at 03:15 PM revealed a blood pressure on 07/04/2024 of 126/78 at 05:00 PM and R125 received the 5 milligrams of the blood pressure medication. The Midodrine 5 milligrams was given on 07/05/2024 at 09:00 AM for a blood pressure of 131/64. On 07/07/2024 at 09:00 AM the Midodrine was given for a blood pressure of 122/58, it was given on 07/07/2024 at 12 noon for a blood pressure of 131/71 and again at 05:00 PM for a blood pressure of 131/71. On 07/09/2024, R125 received the Midodrine for a blood pressure of 124/70 at 09:00 AM and again at 05:00 PM for a blood pressure of 130/68. On 07/11/2024 at 09:00 AM R125 received Midodrine for a blood pressure of 154/76, and at 12 noon for a blood pressure of 154/74 and again on 07/11/2024 at 05:00 PM R125 received the medication again for a blood pressure of 148/72. On 07/12/2024 R125 received Midodrine 5 milligrams at 09:00 AM for a blood pressure of 136/77 and again at 12 noon for a blood pressure of 136/77 and again at 05:00 PM for a blood pressure of 136/77. R125 should not have received the Midodrine for the days listed, due to the blood pressure falling outside the parameters of the systolic blood pressure remaining higher than 120, with orders not to give if greater than 120. During an interview on 07/15/2024 at 12:45 PM with LPN1, this surveyor brought to her attention the days she gave the medication Midodrine and the blood systolic blood pressure was greater that 120 and there is a order to which states, DO NOT GIVE according to the parameters per the physician's orders. LPN1 verbalized that she sees the parameters and agreed that she should not have given the Midodrine. During an interview on 07/15/2024 at 12:55 PM with LPN2, Unit Manager, this surveyor brought it to her attention that it is documented by her that she gave R125 the Midodrine, even though the blood pressure was out of the parameters and the phsyician's order to give the medication. She verbalized that she gave the medication. During an interview on 01:00 PM with LPN3, it was brought to her attention that she too had given the Midodrine to R125 even though the blood pressure was outside the parameters to give the medications. She looked at the documentation and stated she did not give the medication, but the Unit Manager showed her that she too had given the Midodrine and should have held if for a systolic blood pressure greater than 120.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on the facility policy, observations and interviews the facility failed to ensure outdated medications and biologicals were removed from storage with other medications and biologicals in use for residents in 3 of 4 medication carts and 2 of 2 treatment carts. Review of the facility policy titled, Storage of Medications, states, The facility stores all drugs and biologicals in a safe, secure and orderly manner. The Policy Interpretation and Implementation, states: 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. The findings include: An observation on [DATE] at 07:10 AM of the Hall B2 medication cart revealed 1 bottle of UTI-Stat Cranberry, Lot #B-23092 was expired on [DATE]. The expired bottle of UTI-Stat was verified by Licensed Practical Nurse (LPN)1 and removed from the medication cart. Review on [DATE] at 10:14 AM of the Hall B Treatment Cart revealed the following: 1 Bottle of Cleansing Body Lotion, Manufactured by Medline-Remedy, 8 fluid ounces, 236 milliliters with Lot #16H1221 was expired on ,d+[DATE]. 1 Skintegrity - Hydrogel Impregnated Gauze, Manufactured by Medline, 4 x 4 square, 2 pack with Lot #000192 was expired on ,d+[DATE]. 1 Hydrogel - Simpurity 4 x 5 wound dressing, with Lot #18090905, Mfg. [DATE] was expired on [DATE]. The expired biologicals were confirmed by LPN8 and removed from the cart. Review [DATE] at 10:30 AM of Medication Cart Hall B1 revealed the following: 1 Aspart Flex Pen Lot #FZF9J11- in use with no open date and no expiration date. 1 Lantus Flex Pen Lot #4F9583A - in use with no open date and no expiration date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 Lispro Flex Pen - Lilly - Lot #D707064A - in use with no open date and no expiration date. 1 Box Goodsense - Hemorrhoidal Suppositories Lot #2G5585, 10 Suppositories expired. 1 Bottle of Guardian Fiber Powder Lot #4037575, expired [DATE]. The above medications were confirmed by LPN9, and removed from the medication cart. Review on [DATE] at 11:06 AM of Medication Cart Hall A 1 revealed the following: 1 box of Evencare Controls for glucometers, Manufactured by Medline with Lot #108211221031203 was expired on [DATE]. The box the control solution was confirmed by LPN7 and removed from storage. Review on [DATE] at 11:20 AM of Hall A Treatment Cart revealed the following: 1 Foam Dressing 2 x 2, Item #B-NM5050F, Lot #18111105 was expired on [DATE]. 1 Can of Safe-N-Simple Odor Eliminator - Clear Lubricant with Lot #191004, expired on [DATE]. 1 Bottle of Adapt Stoma Powder with Lot #8K012, expired on ,d+[DATE]. 2 Suture Removal Trays, Manufactured by Medline with Lot #(10)21CB0461, expired on [DATE]. 14 Medihoney - Hydrogel dressings 2.4 x 2.4 (6cm x 6cm) with Lot#043620, expired on ,d+[DATE]. 4 Medihoney - Hydrogel dressings 4.3 x 4.3 (11cm x 11cm) with Lot #042820, expired on ,d+[DATE]. 2 Simpurity - Hydrogel wound dressings 4 x 5 with Lot #18090905, expired on [DATE]. 1 Tender Wet Active dressing, 2.2 (5.5 cm) round, with Lot #,d+[DATE], expired on ,d+[DATE]. The expired biologicals were confirmed by LPN8, and removed from the treatment cart.