STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425035	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J F Hawkins Nursing Home	1330 Kinard Street Newberry, SC 29108

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and review of the facility policy, the facility failed to ensure staff consistently maintained catheter drainage bags covered and positioned appropriately to maintain resident dignity for 2 of 2 residents (R22 and R51) reviewed. This deficient practice had the potential to create diminished dignity, and contamination risk. Findings include: Review of the facility's policy, Catheter Care Procedure - Urinary, last revised 12/28/23, revealed staff are expected to maintain catheter drainage to gravity without kinks or loops, keep privacy bags covering the drainage bags while in use, and uphold resident dignity. On 04/14/26 at 11:32 AM, R51 was observed ambulating in the hallway with a physical therapist, who was assisting the resident by holding an uncovered urinary catheter drainage bag filled with amber-colored urine visible to others. A second observation revealed R22 at 11:43 AM on 04/14/26 resting in bed with their catheter drainage bag uncovered and visible to all passing by. On 4/15/26, a follow-up observation again at 8:46 AM revealed R22's catheter drainage bag uncovered, while sleeping. During an observation and interview on 04/16/26 at 11:08 AM, R51 was observed again in the day room seated in a wheelchair speaking with another resident; their urinary drainage bag remained uncovered and visible in a public setting. During an interview at 4:19 PM, Licensed Practical Nurse (LPN)2 stated staff are trained to keep catheter bags covered and off the floor and explained, There was a cover last week, I am not sure what happened to it this week. On 4/16/26 at approximately 4:30 PM, the Director of Nursing (DON) viewed the placement of R22's catheter drainage bag resting on the floor. The DON noted that although the bag was covered on that date, its placement was now not appropriate, as the resident's bed was positioned low to the floor, resulting in the catheter drainage bag resting directly on the surface of the floor. The DON stated, It is not acceptable for the catheter bag to be on the floor.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy, the facility failed to ensure that a resident who required assistance with Activities of Daily Living (ADLs) received necessary care and services, specifically nail care and facial grooming, for 1 of 2 residents reviewed for ADL care (Resident (R)78). This deficient practice had the potential to affect the resident's dignity and personal hygiene.Findings include: Review of the facility policy titled Activities of Daily Living, last revised 12/28/23, revealed the following: Policy: The facility takes measures to minimize the loss of residents' functional abilities, including Activities of Daily Living (ADLs). ADLs include the ability to bathe, dress, and groom. A resident who is unable to carry out Activities of Daily Living receives the necessary services to maintain proper nutrition, grooming, and personal and oral hygiene.Review of the facility policy titled Nail Care, last revised 08/20/24, revealed the following: Policy: The purpose of this procedure is to provide guidelines for the care of a resident's nails to promote good grooming and health. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. Routine nail care, including trimming and filing, will be provided on a regular basis and as the need arises.Record review of R78's Face Sheet revealed R78 was admitted to the facility on [DATE] with diagnoses including but not limited to: aphasia following cerebral infarction; hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the right dominant side; morbid (severe) obesity due to excess calories; arthritis, left hand; and primary osteoarthritis, unspecified hand. According to the Quarterly Minimum Data Set (MDS) dated [DATE], R78 has a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicates she is cognitively intact.Record review of R78's Care Plan, last revised 02/17/26, revealed the following: is at risk for altered activity patterns/pursuits related to being nonverbal. [R78] uses a tablet to communicate. Resident has an ADL self-care performance deficit related to CVA/TIA, depression, hemiplegia, and psychoactive drug use.A review of resident progress notes dated 11/01/25 through 04/15/26 revealed no documentation of refusals of ADL care or any charting related to nail care or facial hair grooming.An initial observation and interview with R78 on 04/15/26 at 9:20 AM revealed long hairs on her chin and long nails, with some dirt underneath and a yellow, grimy appearance. The resident stated via iPad that she would like her nails trimmed and her facial hair shaved. On the iPad, she indicated that this makes her feel sad.An observation and follow-up interview with R78 on 04/15/26 at 2:39 PM revealed the same observations.A follow-up interview with R78 via iPad revealed that her fingernails have not been cut since she has been at the facility; this included her facial hair as well. When asked how often staff trim her nails and facial hair, the resident stated, never. She also stated via iPad that her hair is washed every few months. When asked if she felt her personal care needs were being met, the resident stated, sometimes, depending on who works. When asked what happens when she requests help, she stated that staff came to change her clothes and provided a bed bath that day; however, they did not address her nails. She further stated that a nurse indicated he does not feel comfortable performing nail care. The resident stated related her facial hair, she does not remember the last time it was done.An observation on 04/15/26 at 5:05 PM revealed the same observations.An observation on 04/16/26 at 1:23 PM revealed the same observations.An interview with Licensed Practical Nurse (LPN)1 and Certified Nursing Assistant (CNA)1 on 04/16/26 at 1:45 PM revealed they both provide care for R78. LPN1 works part-time, and CNA1 works full-time, five days a week, and regularly cares for R78. LPN1 stated that nurses or aides can cut nails and trim facial hair; however, for diabetic residents, nurses perform nail care. LPN1 acknowledged R78's facial hair and nails and stated she could not remember the last time her nails were cut. LPN1 stated R78 does not refuse care and is nonverbal, with communication via iPad. LPN1 further stated R78 is encouraged to participate in ADLs and that refusals would be documented on the Kardex. LPN1 stated she has observed R78's nails and facial hair; however, the resident has not requested nail care, and she has not offered it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA1 stated R78 does not refuse ADL care. CNA 1 also stated he has observed her nails and facial hair but has not offered assistance. LPN1 and CNA1 stated they would address the concern.An interview with the Director of Nursing (DON) on 04/16/26 at 2:00 PM confirmed she could not find any progress notes indicating refusals. The DON stated the resident did not participate in any activities related to manicures, based on review of the medical record. The DON further stated that progress notes related to nail care are typically documented only for residents who receive podiatry services every three months. Her expectation is for staff to offer residents assistance.

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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. F759 - Free of Significant Medication ErrorsBased on review of the facility policy, observation, interviews, and record review, the facility failed to ensure medications were administered in accordance with manufacturer instructions and professional standards for 2 of 3 residents (R39 and R100) reviewed for medication administration. The facility crushed medications labeled as delayed-release and extended-release and failed to ensure a resident rinsed their mouth after administration of an inhaled corticosteroid, resulting in significant medication errors with the potential for altered drug absorption, reduced therapeutic effect, and avoidable infection risk.Findings include:Review of the facility's policy titled, Medication Administration, dated 10/30/20 and reviewed 1/17/23, revealed medications are to be administered in accordance with manufacturer specifications and professional standards of practice, and staff are not to crush medications identified as do not crush.Review of physician orders for R39 dated 03/28/25 at 12:27 PM, included the instruction, May crush allowable meds. During an interview at 1:39 PM on 04/15/26, the Pharmacist clarified that extended-release (XR), delayed-release (DR), sustained-release (SR), and enteric-coated medications are not considered allowable for crushing under any condition.During an observation on 04/15/26 at approximately 8:30 AM, Licensed Practical Nurse (LPN)4 was observed administering medications to R39. After verifying the rights of medication administration, the nurse placed multiple medications into a pouch, including Aspirin Delayed-Release and Potassium Chloride Extended-Release (KCl-ER), crushed them together, and administered them in applesauce.On 04/15/26 at 12:36 PM, LPN3 was observed administering Breo Ellipta (fluticasone-vilanterol) to R100 without prompting or assisting the resident to rinse and spit after inhalation.During an interview on 04/16/26 at 10:50 AM, the Director of Nursing (DON) confirmed that enteric-coated, delayed-release, and extended-release medications are not to be crushed.Record review of the physician order on 04/16/26 at 3:24 PM revealed an order for R100, which indicated: Breo Ellipta 200-25 mcg, 1 puff daily; rinse mouth with water and spit after use for Chronic Obstructive Pulmonary Disease.Record review of R100's care plan on 04/16/2026 at approximately 3:33 PM revealed, behaviors related to traumatic brain injury (TBI), including hoarding items, making accusatory statements, refusing showers, and becoming belligerent when staff attempt to clean the room; however, there was no documentation addressing refusal to rinse and spit after inhaler use (initiated 9/18/23; revised 01/17/24).During a follow-up interview on 04/16/26 at 3:49 PM, the DON stated that R100 typically refuses to rinse and does not like to spit out their water after inhaler use; however, she could not verify that a refusal occurred at the time of observation and stated the refusal behavior would be addressed and reflected in the resident's care plan going forward. A subsequent review of the updated care plan on 04/16/26 at approximately 4:48 PM revealed the same behavioral concerns with the addition of documentation that the resident refuses to swish and spit after oral inhaler medication (revised 04/16/26).