STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425042	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Post Acute	661 Rutherford Rd Greenville, SC 29609

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review and interviews, the facility failed to notify Resident (R)1's physician of elevated blood pressures for 1 of 1 resident, reviewed for notification of changes.Findings Include:Review of the facility policy titled Change In a Resident's Condition or Status with a complete revision date of February 2021 states, Policy Statement: 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.). Policy Interpretation and Implementation 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): . d. significant change in the resident's physical/emotional/mental condition; . 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self - limiting); Review of R1's Face Sheet revealed that the facility admitted R1 on 12/19/25, with diagnoses including, but not limited to: Alzheimer's Disease, essential (primary) hypertension and hypothyroidism.Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 12/26/25, revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating R1 was unable to complete the interview. Further review of the Active Diagnoses Section noted R1 as having Hypertension.Review of R1's Physician Orders revealed an order for Benazepril 5 mg (milligram) tablets with instructions to give one tablet by mouth one time a day for hypertension. Hold for [systolic blood pressure] SBP less than 110.Review of R1's Blood Pressure Summary revealed the following:01/04/26 7:48 AM BP 172/10201/04/26 9:26 AM BP 172/10101/05/26 1:22 AM BP 171/119Review of R1's Nurses Notes did not revealed documentation that the physician was notified of R1's elevated blood pressures. Review of R1's Care Plan Report dated December 2025 revealed, Special Instructions: Resident is a PACE resident. Please contact PACE [Program for All-inclusive Care of the Elderly] for any medical needs [phone number].During an interview on 03/10/26 at 2:37 PM, the Unit Manager (UM) stated all of her medication orders would have come from PACE. The DON stated yes when asked if 171/119 was an elevated blood pressure. The DON then stated a call should have been placed to the on-call Medical Director (MD) with PACE. The nurse may have contacted the direct contact through PACE that works in our building.An attempted phone interview on 03/10/26 at 2:55 PM, with LPN2 was unsuccessful.During an interview on 03/10/26 at 3:21 PM, the patient liaison for the facility revealed, I do not recall receiving a call from the facility on the fourth or the fifth of January 2026 regarding R1 and an elevated blood pressure.During an interview on 03/10/26 at 6:25 PM, the weekend supervisor revealed, I was not made aware of R1's elevated blood pressure.During an interview on 03/10/26 at 6:28 PM, CNA1 revealed I notified Registered Nurse (RN)4 of the resident's elevated blood pressure right away. I am not sure what she did after that.During an interview on 03/10/26 at 6:34 PM, the DON revealed, her expectation is that the nurse on the floor should reach out to PACE. The nurse should also notify the family of the resident's change in condition. The nurse notifies PACE of the change in condition and then gets new (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders. We should monitor the elevated blood pressure and follow the new physician orders from PACE.During an interview on 03/10/26 at 6:40 PM, RN4 revealed, I do not recall this patient, but I would have reached out to the onsite physician or the on call for PACE and gotten orders to address the blood pressure. I do not know what happened, the only place that we document is in the progress notes. If there is not a note there, it would not be documented anywhere else.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and interviews, the facility failed to obtain and administer missing Lacosamide, a seizure medication, for Resident (R)2, resulting in the resident not receiving 11 doses of the medication from 1/7-1/13, for 1 of 1 resident reviewed.Findings Include: Review of the facility policy titled, Adverse Consequences and Medication Errors, with a revision date of June 2025 revealed, Policy Statement: The interdisciplinary team monitors medication usage to prevent and detect medication - related problems such as adverse drug reactions (ADRs) and side effects. Medication Errors: 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with provider's orders, manufacturer specifications, or accepted professional standards and principals of the professional(s) providing services. 2. Examples of medication errors include: a. omission- a drug is ordered but not administered;Review of R2's Face Sheet revealed he was admitted to the facility on [DATE] with diagnoses including, but not limited to, Epilepsy, paranoid schizophrenia and dementia.Review of R2's Care Plan Report revealed that no care plan was developed relating to Epilepsy, seizure risk, or seizure medications. Review of R2's Medication Administration Record (MAR) dated 01/07/26 through 01/14/26 revealed that R2 did not receive the following medications as ordered: Lacosamide oral tablet 100mg, give 1.5 tablets by mouth two times a day for Seizures. R2 missed 11 doses of the medication.During an interview on 03/10/26 at 04:37 PM, Licensed Practical Nurse (LPN) 3 started, If I scratched out the progress note about the Lacosamide not being given, that means that I administered it. If I am waiting for a medication, I keep a running list and then I call the pharmacy for a status update.During an interview on 03/10/26 at 05:07 PM, the Staff Development Coordinator stated, we have a protocol when there is a missing medication. The nurses are to call the pharmacy and document that call. They are to notify the Medical Doctor (MD)for alternatives, and they can also check the Omnicell if the medication is not a narcotic.During an interview on 03/10/26 at 05:45 PM the Director of Nursing (DON) stated you are unable to speak with the Nurse Practitioner (NP) due to her being with her son that had surgery today.During a phone interview on 03/10/26 at 06:55 PM, R2's Primary Care Physician (PCP) revealed that she has no memory of being notified in any way regarding R2 missing any doses of Lacosamide 100mg. The PCP stated that typically the NP is notified first regarding any medication issues. If there is a medication that is missing or a prescription is needed, the NP should work with pharmacy to resolve it. If the NP is having an issue, I should be notified so that I can step in for an alternative solution if the medication is going to be delayed. Other options include ordering another medication or medication from the Pyxis. The missing medication should have been communicated immediately by phone, encrypted message, or verbal face to face not by a note left in a book.During an interview on 03/10/26 at 06:34 PM the DON revealed that when residents are admitted to the facility, the nurse on the floor should send all the residents' prescriptions to the pharmacy. If there is no prescription for a medication, the nurse should reach out to onsite/on call to get a new prescription. That is very simple. The on call can call the Omnicare Pharmacy and e fax a new prescription to the pharmacy and the pharmacy can send it out stat[immediately]. All the nurses have been educated on that. Typically, the nurses reach out to me or the unit managers to get a new prescription from NP, MD or whoever is on call. I was not aware that there was no prescription for the Lacosamide.