STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425047	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Achieve Rehabilitation and Nursing Center	611 East Hampton Street Anderson, SC 29624

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on review of facility policy, observation, record review and interview, the facility failed to ensure Resident (R)1 was free from misappropriation of a narcotic medication for 1 of 4 residents reviewed for misappropriation. Findings include: Review of the facility policy dated 11/26/24, titled, Abuse, Neglect and Exploitation revealed under the policy, Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a residents belongings or money without the residents consent. Review of R1's Facesheet revealed she was admitted to the facility on [DATE], with diagnoses that include, but not limited to: polyneuropathy, paraplegia, and anxiety. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/10/25, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R1 was cognitively intact. Review of R1's Medication Monitoring/Control Record revealed, Percocet 10/325 milligrams (mg) take one by mouth twice daily. The date received was 01/23/25, and amount received was 30 tablets. Two of the Percocet were signed off as administered by Licensed Practical Nurse (LPN)1 on 01/22/25, the first entry time was 9:10 AM, and the second entry time was 9:00 PM. The remaining amount of Percocet was 28 tablets. Further review of the Medication Monitoring/Control Record dated 01/23/25, recorded Percocet was also signed off as administered by LPN1 at 9:15 AM, and by LPN2 at 8:35 PM. Review of R1's Medication Administration Record (MAR) dated 01/22/25, revealed Percocet was signed as administered by LPN1 on 01/21-23/25 at 9:00 AM. Review of the MAR on 01/21/25 and 01/22/25, revealed Percocet was signed as given by LPN2 at 9:00 PM. Additionally, the MAR revealed at 9:00 PM on 01/21/25 and 01/22/25, was coded with a 2. The chart codes for 2 revealed Drug Refused. Review of a Pharmacy Packing Slip Proof of Delivery revealed R1's Percocet was delivered to the facility on [DATE] at 1:06 AM. (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of an undated statement from LPN1 revealed R1 had zero tablets left on 01/21/25. Her medication came in on 01/22/25. It also stated she could not understand why LPN2 didn't understand, but the count was correct. Review of a Disciplinary Action Form dated 01/29/25, revealed LPN1 was terminated due to failure to follow Medication Administration Policy. During an interview on 03/05/25 at 1:30 PM, the Administrator stated she had to investigate this and stated she relied on nursing because she didn't understand the nursing aspect of nurses passing medication and had to keep asking questions. The Administrator stated what LPN1 said didn't make sense because her story changed a few times, she originally reported to the Nurse Practitioner (NP) that she made a medication error and gave R1's medications to another resident. LPN1 told me that as well, then she said it was the other resident that she accidentally gave the medication to. The Administrator further stated, I terminated her because her story kept changing. I don't think it was a medication error. She confirmed 2 Percocet were missing and could not be accounted for. During an interview on 03/05/25 at 2:01 PM, LPN2 stated, When I came on shift, I asked [LPN1] if [R1's] medication Percocet had come in. She said yes. I looked at the narcotic sheet. I pointed out to [LPN1] that two of the medications were signed as given on 01/22/25 and I asked her why. LPN1 said she made a med error. Her story changed several times and then said it was a different nurse. I said we need to speak to the Director of Nurses (DON). She then said she made a medication error and had to call the NP. So she called her. After, the conversation, I called my DON. She told me LPN1 called the NP and said she made a med error. The NP had already called the DON, supposedly about a med error. Looking at the narcotic sheets, she confirmed the last time the Percocet was given was dated 01/20/25 x2 that day. She confirmed the Percocet ran out. She said, We've been told in the past that we cannot document 8 - Medication Not Available. So, I didn't, that's why I coded the 2, which I should not have coded it that way. An attempted phone interview on 03/05/25 at 2:03 PM, with LPN1 was unsuccessful. During an interview on 03/05/25 at 2:33 PM, R1 stated, I take Percocet twice a day, 9 PM and 9 PM. R1 further stated, I remember being out of my Percocet in January, it was for a couple days. I told the nurses I was in pain. They gave me Tylenol. Tylenol only takes away a headache, it doesn't relieve my pain, I have nerve damage on my right side, back and front.