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	01/11/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013 Based on observation, record review, interview, and facility policy review, the facility failed to provide care and services in a manner that maintained and promoted dignity which included ensuring the privacy curtain was pulled closed, for 1 of 1 resident, (Resident (R)123), reviewed for resident rights. This failure placed residents at risk for diminished self-worth, self-esteem, and feelings of embarrassment. Findings include: Review of the facility's policy titled, Resident Rights, dated 2024, documented, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity . Maintain resident privacy. Review of R123's Admission Record located under the Profile tab in the electronic medical record (EMR) documented, R123 was admitted to the facility on [DATE], with diagnoses including but not limited to: Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/25/24, revealed R123 had a Brief Interview for Mental Status (BIMS) of 99 out of 15 which indicated R123 was severely cognitively impaired, was incontinent of bowel and bladder functions, and was dependent on one staff for personal care and dressing. During an observation on 01/08/25 at 10:19 AM, a staff member stated a resident was receiving personal care. The curtain between R123 and her roommate's bed was not pulled. The roommate was sitting in her wheelchair and R123 was lying in her bed, which was visible to the roommate. R123 was wearing a shirt and a brief. Certified Nursing Assistant (CNA)3 was providing incontinent care to R123. CNA3 proceeded to remove R123's brief, exposing the lower half of her body, provided incontinence care, placed a clean brief on R123, and finished dressing her with the privacy curtain still not pulled. During an interview on 01/08/25 at 10:25 AM, CNA3 stated she usually worked the second shift, was behind in her assignment, R123 needed to be washed, dressed, and out of bed, she was distracted, and forgot to pull the privacy curtain. CNA3 stated the roommate, who was alert and oriented, was able to observe her care to R123. (continued on next page)

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

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	01/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/10/25 at 10:02 AM, Licensed Practical Nurse (LPN) 3 stated the staff were to ensure a resident's privacy with clothing/blanket and pull the privacy curtains whenever providing personal care to a resident. During an interview on 01/09/25 at 1:16 PM, the Director of Nurses (DON) stated all staff were educated regarding the facility's dignity policy during orientation and as needed. She stated when staff were assisting residents, they were to ensure a resident's body parts were not exposed to others and privacy curtains were to be pulled to ensure residents' dignity.

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	01/11/2025

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on interview, record review, and review of facility policy, the facility failed to accurately document Resident (R)110's wishes to be a full code; and failed to periodically review code statuses for R110, for 1 of 36 sampled residents reviewed for code status. This failure placed the resident at risk of not receiving life saving measures. On [DATE] at 8:56 PM, the Administrator was notified that the failure to accurately reflect a residents code status in the medical record, in accordance with the resident's wishes, constituted Immediate Jeopardy at F578. On [DATE] at 8:56 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of [DATE]. The IJ was related to 42 CFR 483. 10 - Resident Rights. On [DATE] at 6:39 PM, the facility provided an acceptable plan for removal of the IJ. The survey team validated the IJ was removed on [DATE] at 1:00 PM, following the facility's implementation of the plan for removal of the IJ. The facility remained out of compliance at F578 at a lower scope and severity of D. Findings include: Review of the facility policy titled, Residents' Rights Regarding Treatment and Advance Directives, with a copyright date of 2024, documented it was the facility policy to support and facilitate a resident's right to formulate an advanced directive. Decisions regarding advanced directives and treatment will be periodically reviewed as part of the comprehensive care planning process. Any decisions will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. Review of the Admission record located under the Profile tab of the EMR revealed R110 was admitted to the facility on [DATE]. Review of R110's quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of [DATE], identified R110 as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated he was cognitively intact and capable of making his own decisions. Review of R110's electronic medical record (EMR) revealed his code status on the dashboard of the EMR was marked as a Do Not Resuscitate (DNR). Review of R110's Physician Orders located in the Orders tab of the EMR, revealed an order for DNR with an order start date of [DATE]. (continued on next page)

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	01/11/2025

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a document titled [Facility Name] located in the Documents tab of the EMR, documented, Please indicate your choice by checking the appropriate statement the choices were Full Code or Do Not Resuscitate. The resident check marked Full Code and next to the words full code it revealed I request that if (Resident's Name) has sudden failure of a vital function that emergency medical measure be used to restore the function. The form was signed by the resident and a facility representative with signature dates of [DATE]. Review of R110's Plan of Care located in the Care Plan tab of the EMR, revealed R110 had a Focus area of Advanced Directives which revealed he was a DNR with an initiation date of [DATE] and a revision date of [DATE]. During an interview on [DATE] at 5:37 PM, Licensed Practical Nurse (LPN)7 was asked what she would do if R110 was found without vital signs. LPN7 stated she would check the EMR for his code status. LPN7 checked the EMR and stated he was a DNR and therefore she would not start cardiopulmonary resuscitation (CPR). During an interview on [DATE] at 5:38 PM, LPN3 was asked what she would do if R110 was found without vital signs. LPN3 stated she would check the EMR for his code status. She checked the EMR and stated he was a DNR and therefore she would not start CPR. During an interview on [DATE] at 5:41 PM, R110 stated he wanted to be resuscitated and he stated he wanted to be Full Code and he wanted to be resuscitated. When asked, he also stated he would want to be sent to the hospital if needed. During an interview on [DATE] at 2:52 PM, the Administrator stated this resident had the order in place since [DATE] and confirmed it had been incorrect since [DATE]. On [DATE] at 6:39 PM, the facility provided an acceptable plan for removal, which included the following: 1. Immediately upon notification resident #110 Code Status medical record was updated to reflect their Advance Directive Form. 2. All residents have the potential to be affected by this alleged deficient practice. 3. On admissions all residents will be listed as full code unless documented is provided. The Interdisciplinary team will review advance directives quarterly and annually. All new admissions will be reviewed daily x 4 weeks, then weekly x4 weeks, then x1 month thereafter, in effort to ensure substantial compliance. Random audits will be reviewed daily x 4 weeks, then weekly x 4 weeks, then 1 month thereafter. 4. Director of Nursing (DON)/Designee conducted a facility-wide assessment to determine if any other residents were affected by this alleged deficient practice. Any identified concerns were immediately corrected. The DON/Designee reeducated all licensed practical nurses and registered nurses to review code status order entry on the third shift. Any staff not currently working will be educated prior to the start of next shift. (continued on next page)

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	01/11/2025

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All Licensed Nursing staff were educated by the Director of Nursing/Designee on [DATE], the outcome of the Immediate Jeopardy ensuring that Residents have the right to formulate advanced directives. Any staff not currently working will be educated prior to the start of the next shift until all staff have been educated. 5. DON/Designee will complete random audits using a Advance Directive audit tool for all new admissions. Random audits to be conducted daily x4 weeks, then weekly x4 weeks, then x1 month thereafter, in effort to ensure substantial compliance. Any negative findings will be corrected immediately, and this will be discussed at the Facility monthly Facility Quality Assessment and Performance Improvement (QAPI) meeting. Plan of removal date: [DATE], 9:00 am.

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	01/11/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26190 Based on record review and interview, the facility failed to provide the Advanced Beneficiary Notice of Non-Coverage (ABN) and the Notice of Medicare Non-Coverage (NOMNC) to 1 of 2 residents (Resident (R)136) reviewed for Beneficiary Notification of 36 sample residents. This failure had the possibility to negatively impact residents due to them not being aware that they no longer had coverage for their stay under Medicare Part A. Findings include: Review of R136's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R136 was admitted to the facility on [DATE], with diagnoses including but not limited to: other neurological conditions, urinary tract infection, diabetes, and depression. Review of R136's five-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 08/28/24, located under the Resident Assessment Instrument (RAI) tab, indicated R136 was set up assist for oral hygiene; supervision for showering; dependent for lower body dressing; partial/moderate assistance for upper body dressing, transfers, and bed mobility. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R136 was cognitively intact. Review of the SNF (Skilled Nursing Facility) Beneficiary Notification Review forms that were provided to the facility for completion, indicated R136's forms were incomplete and the ABN and NOMNC had not been provided to R136 when Medicare Part A Services ended on 12/22/24. During an interview on 01/11/25 at 11:20 AM, the Administrator confirmed that the beneficiary notices had not been provided to R136. The Administrator explained that the Social Service Director may not have understood the necessity of the forms being completed and notification made to the residents since they had so few residents that were covered by Medicare Part A.

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	01/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on observation, interviews, and facility policy review, the facility failed to ensure a clean, comfortable, homelike environment related to the rooms and common areas not being maintained in clean conditions for 3 of 4 units (100 unit, 200 unit, and 300 unit). Failure to maintain a clean homelike environment has the potential to result in resident dissatisfaction with their living conditions and increased depression. Findings include: Review of the facility's policy titled, Cycle Cleaning with a copyright date of 2024, revealed it was the facility policy to identify the functional areas in the facility that require cleaning and to use the cleaning schedules to maintain regularly scheduled environmental service tasks and it was the responsibility of the Environmental Services Manager to ensure cleaning was maintained. 1. During intermittent observations conducted over four days of the survey (01/08/25 through 01/11/25) the bottom portions of the walls on the 300 unit were soiled with scuffs up and down the length of the corridors and there was a dark brown build up on the floor along the baseboards; there was heavy dirt build up on the floor around the door frames to the kitchen and the employee lounge. 2. During an observation on 01/08/25 at 3:14 PM, and on 01/10/25 at 10:05 AM, there was a water stained and drooping ceiling tile in the corridor leading to the shower room across from room [ROOM NUMBER]. The stain was brown and appeared to be from a leaking pipe or leaking roof. 3. During an observation on 01/08/25 at 12:43 PM, and on 01/10/25 at 10:05 AM, resident room [ROOM NUMBER] had dirt built up along the walls, vents, and under the closets. The top of the baseboard type heater had a build up of dust and debris. 4. During an observation on 01/08/25 at 12:34 PM, and on 01/10/25 at 10:09 AM, the bathroom off of room [ROOM NUMBER] had a buildup of dirt along the walls and behind the toilet. 5. During an observation on 01/08/25 at 11:11 AM, and on 01/10/25 at 10:12 AM, the floor in front of the refrigerator located behind the nursing station on the 200 unit had a heavy build up of black dirt in front of it. 6. During an observation on 01/08/25 at 11:17 AM, and on 01/10/25 at 10:12 AM, the floor under and on the side of the ice maker and in front of the refrigerator on the 100 unit had a build-up of dirt. The wall to the side of the refrigerator was soiled with what appeared to be dried spilled residue. During observation and interview on 01/10/25 from 9:50 AM through 10:15 AM, the units were toured with the Maintenance Director and the Housekeeping Supervisor (HS). They verified each of the above observations. The HS verified the areas described above were soiled and in need of cleaning and stated it would be his expectation that the areas be clean and well maintained.

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	01/11/2025

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 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** 15013 26190 Based on record review, interview and facility policy review, the facility failed to provide appropriate Activities of Daily Living (ADLs) for residents to maintain adequate personnel hygiene for 2 of 2 residents (Resident (R)145 and R115) reviewed for ADLs of 36 sample residents. Findings include: Review of the facility's undated policy titled, Activities of Daily Living (ADLs) documented, .Care and services will be provided for the following activities of daily living: 1. Bathing . Policy Explanation and Compliance Guidelines .2. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain .personal .hygiene . Review of the facility's undated policy titled, Resident Showers documented, Policy: It is the practice of this facility to assist residents with bathing to maintain proper hygiene .Policy Explanation and Compliance Guidelines: 1. Residents will be provided showers as per request or as per facility schedule protocols . Review of the facility's policy titled, Nail Care, dated 2023, documented Routine cleaning and inspection of nails will be provided during Activities of Daily Living (ADL) care on an ongoing basis. Routine nail care to include trimming and filing will be provided on a regular schedule .Nail care will be provided between scheduled occasions as the need arises. The resident's care will identify: the frequency of nail care to be provided, the person responsible for providing nail care .Nails should be kept smooth to avoid skin injury. Only licensed nurse shall trim or file fingernails of residents with diabetes. 1. Review of R145's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R145 was admitted to the facility on [DATE], with diagnoses including but not limited to: hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, heart failure, chronic obstructive pulmonary disease, bipolar disorder, and major depressive disorder. Review of R145's five-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 12/09/24, located under the Resident Assessment Instrument (RAI) tab indicated R145 was set up assist with eating; dependent for lower body dressing; substantial/maximum assist for upper body dressing and showering/bathing; and partial/moderate assist for bed mobility. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R145 was cognitively intact. Review of Unit 1's Shower Sheet binder, provided by the facility, indicated R145, since her admission on 12/02/24, received a shower/bath on the following dates: 12/13/24 and 12/30/24. Review of the shower schedule that was posted in the binder revealed room [ROOM NUMBER] (R145's room) was to receive a shower on Monday/Wednesday/Friday during the second shift. (continued on next page)

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	01/11/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 4:00 PM, R145 stated she had not been receiving a bath/shower on a regular basis. R145 said since her admission to the facility she had gone 13 days without a shower, then received a shower only to go another 11 days without a shower. During an interview on 01/09/25 at 2:10 PM, Certified Nursing Assistant (CNA)7 stated there should be a shower sheet in the binder for every bath/shower completed. During an interview on 01/09/25 at 2:20 PM, Occupational Therapy Assistant (OTA)1 confirmed they assisted with showers for some of the residents. OTA1 explained their showers were part of the resident's therapy session and they did set up for the resident, but the resident did the rest. OTA1 reviewed the Occupational Therapy (OT) notes in their computer system and located additional showers for R145 on the following dates: 12/04/24, 12/13/24, 12/19/24, and 01/09/25. OTA1 stated R145 had complained to her, previously, about not getting enough showers/baths. During an interview on 01/09/25 at 3:30 PM, a request was made with the Administrator to provide any additional completed shower sheets for R145. No additional shower sheets were located. During an interview on 01/10/25 at 9:55 AM, CNA8 and CNA12 stated the shower sheets were to be filled out for every bath/shower that was completed for a resident and placed in the shower sheet binder located at the nurse's station. CNA8 confirmed that the OTA assisted with resident's bathing/showering as part of their therapy session. During an interview on 01/10/25 at 11:00 AM, the Director of Nursing (DON) stated showers were supposed to be consistently three times a week for all residents. The DON stated shower sheets were to be filled out when the resident's shower was given. The DON said she felt there were times when the CNAs were not completing the shower sheets but were providing the showers for residents. During an interview on 01/11/25 at 11:10 AM, Registered Nurse (RN)1 stated R145 had not brought it to her attention that she was missing showers. 2. Review of R115's Face Sheet located under the Profile tab in the EMR documented R115 was admitted to the facility on [DATE], with diagnoses including but not limited to: type two diabetes mellitus and the history of a stroke with hemiparesis. Review of the quarterly MDS located under the MDS tab in the EMR with an ARD of 10/10/24, documented R115 had a BIMS of 99 out of 15, which indicated R115 was severely cognitively impaired, required maximum assistance from the staff for personal care and personal hygiene that included nail care, and had no rejection of care. Review of the Care Plan, dated 11/06/23 and located under the Care Plan tab in the EMR related to Activities of Daily Living (ADL)/self-care performance deficit revealed dependent one assist for personal hygiene and bathing. Observations on 01/08/25 at 10:45 AM, 01/09/25 at 3:08 PM, and 01/10/25 at 10:15 AM, revealed R115 had long fingernails, black material under all of her fingernails, an offensive odor from her left contracted hand, and needed hand and nail care. (continued on next page)

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	01/11/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/11/25 at 10:15 AM, Certified Nursing Assistant (CNA)9 stated R115 was confused, cooperative with care, and the staff provided her personal care and nail care during personal care and as needed. She stated the nurses trimmed R115's nails and she was only allowed to clean the nails. CNA9 stated sometimes there were not enough staff to provide nail care to residents. CNA9 stated although she provided range of motion (ROM) exercises to R115, R115 had three fingers on her left hand that did not open and close all the way, and she did not provide ROM to the left hand. She stated she washed R115's left hand carefully as best she could and had not noticed any odors. During an interview on 01/10/25 at 10:20 AM, Licensed Practical Nurse (LPN)3 stated R115 was compliant with care and the licensed staff trimmed her fingernails as she had diabetes mellitus, and the CNAs cleaned her nails. LPN3 stated it was the responsibility of the CNAs to wash R115's left hand and report any issues. During an interview on 01/10/25 at 10:25 AM, LPN3 assessed R115's fingernails and left hand. She confirmed R115's left hand had an odor and stated her nails were long, dirty, and her hand and nails needed cleaning and trimming. During an interview on 01/10/25 at 9:39 AM, the Director of Nursing Service (DON) stated the CNAs provided fingernail care to residents during their shower, during a full bed bath, and as needed. She stated R115's left hand was to be cleaned and dried during personal care, and issues such as an odor to the hand were to be reported to the nurse.

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	01/11/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on facility policy review, observations, interviews, and record review, the facility failed to provide a consistent activities program for residents on the secure/dementia care unit for 1 of 4 residents (Resident (R)116) and failed to provide activities of choice for 1 of 1 resident (R75) reviewed for activities of 36 sample residents. The failure to provide an activities program in a behavioral health unit can exacerbate behaviors due to boredom and negatively impact their psychosocial well-being. Findings include: Review of the facility's policy titled, Activities and dated as implemented on 12/01/24, documented, Policy: It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored and individual and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interactions within the community. Definitions: Activities refer to any endeavor, other than routine ADLs (activities of daily living), in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health .9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. These include, but are not limited to, considerations for: Residents who exhibit unusual amounts of energy or walking without purpose, Residents who engage in behaviors not conducive with a therapeutic home. Residents who exhibit behaviors that require a less stimulating environment to discontinue behaviors not welcomed by other residents sharing a social space. Residents who go through others' belongings. Residents who have withdrawn from previous activity interest/customary routines and spend time alone in room/bed most of the day. Residents who excessively seek attention from staff and/or peers, Residents who lack awareness of personal safety, Residents who have delusional and hallucinatory behavior that is stressful to themselves . 1. Review of R116's undated Face Sheet found in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE], with diagnoses including but not limited to: paranoid schizophrenia, history of a traumatic brain injury (TBI) with intellectual disabilities and aggressive behaviors, as well as psychosis with auditory hallucinations. Review of R116's EMR revealed, a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/24, located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated R116 was severely cognitively impaired. During an observation on 01/09/25 at 3:30 PM and on 01/11/25 at 12:45 PM, R116 was observed to be independently ambulatory with the use of a wheelchair. R116 could stand and ambulate short distances in his room without devices. R116 was rarely found in his room during the survey. He spent much of his time in the dayroom of the secure unit, or in front of the nurse's station engaging with staff and other residents. (continued on next page)

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	01/11/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R116's Care Plan located in the Care Plan tab of the EMR and dated as implemented on 11/23/23, revealed quarterly reviews and revised interventions updated prn (as needed). The care plan included R116's behaviors of wandering, walking without assistance, placing himself on the floor intentionally, physical aggression towards staff, other residents and self when delusional and/or hallucinating. The interventions included .Present just one thought, idea, question or command at a time; Cue, reorient and supervise as needed; Observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity; Distract resident from wandering or aggressive behaviors by offering pleasant diversions, structured activities, food, conversation, television, books; and intervene as necessary to protect the rights and safety of others . During an interview on 01/09/25 at 10:00 AM, Licensed Practical Nurse (LPN)1 and Certified Nursing Assistant (CNA)1 stated, We are supposed to have activities, but it hasn't happened in a while. There was a COVID outbreak last month and the activity person for back here (secure unit) has been out for knee surgery. When asked who was covering for the activity person, both staff members confirmed no-one was providing organized activities for the cognitively impaired residents on the secure unit and hadn't for several weeks . During an interview on 01/10/25 at 9:30 AM, The Regional Director of Clinical Services (RDCS) stated she was unaware that no-one was providing activities on the dementia unit and stated she would make sure that was addressed. She confirmed the facility policy was not followed if organized activities were not being provided on the secure unit. During an interview on 01/10/25 at 2:30 PM, Registered Nurse (RN)2 stated she was the secure unit manager. RN2 was asked about activities for the residents, and she confirmed, .the activity person assigned back here has been out for medical, so my staff has to do it . When advised that no activities, except supervised smoking, had been observed on the unit during the survey, RN2 stated, .well we are supposed to do it if there's time . During a phone interview on 01/11/25 at 11:30 AM, the Activity Director (AD) stated she was now fully staffed and had an activity person for each unit. When asked about the secure unit she stated that the specific staff member had been out on medical leave, but someone else was covering for her. When advised no activities had been observed during the four on-site days, the AD stated she would take care of it when she returned the following week. 2. Review of R75's activity note, dated 10/06/23 and timed 3:55 PM, located under the Progress Notes tab of the EMR, revealed the resident was nonverbal and spoke with her son to obtain information. According to the note, R75 liked to watch crime shows. Review of the plan of care under the Care Plan tab of the EMR, revealed she had an activity plan of care (POC) with a last reviewed date of 01/07/25, revealed she was non-verbal and once liked watching crime shows and horror movies. The interventions included continuing one-on-one visits at least twice a week and encouraging her to get up and go to the day room to watch television. The diagnosis listed on the POC included but was not limited to muscle weakness, vascular dementia with psychotic disturbance, aphasia, hemiplegia, and hemiparesis following a cerebral infarction, and cognitive communication deficit. (continued on next page)

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	01/11/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the annual MDS with an ARD of 10/09/24, and located under the MDS tab of the EMR revealed she had a BIMS score of 99 out of 15 which revealed the resident was severely cognitively impaired. Under the activity portion of the MDS it was marked that it was somewhat important for her to listen to music she liked and to do her favorite activities. The MDS identified her as being dependent on staff for transfers, dressing, and locomotion in the wheelchair. Review of a handwritten progress note, provided by the facility, dated 12/31/24, and signed by the AD revealed the resident was no longer being set up in the day room and she was placed on one-on-ones on Monday, Wednesday, and Friday. The note revealed activities would listen to music and enjoy snacks with her. During observations on 01/08/25 at 2:34 PM and 3:22 PM, 01/09/25 at 12:08 PM, 12:26 PM, 2:58 PM, 3:29 PM, and 5:21 PM; on 01/10/25 at 8:03 AM, 9:29 AM, and 12:24 PM; and 01/11/25 at 10:35 AM; R75 was observed laying in her bed on her back either sleeping or awake. The curtain was pulled in front of her bed, and she did not have a television or radio playing during the observations. During an interview on 01/11/25 at 10:41 AM, Certified Nursing Assistant (CNA)11 stated she had cared for the resident for the past year. She stated the resident was kept in her room and liked to stay in bed. She stated when they got her up and took her to the dining room to watch television (TV) she screamed out baby baby. She stated the resident liked to watch television and she used to watch her roommate's TV however the roommate moved out a while back. She stated other than activity visiting her about twice a week the resident was not engaged in any activities. She verified the resident did not have access to a radio or TV in her room. During an interview on 01/11/25 at 10:50 AM, LPN9 stated R75 did not like to leave her room. She stated she liked to watch TV, and she used to watch her roommates' TV, and the roommate would get upset because she would have it on when she did not want it on, and she spoke to the son about getting earphones for her. She stated her roommate moved sometime before Thanksgiving and the resident had no access to a TV since. She stated if R75 had a TV or radio it would give her more stimulation. During an interview via telephone on 01/11/25 at 12:45 PM, LPN10 was asked about R75's activities and she stated the resident liked staying in her room. She stated when they got her up, she screamed or verbalized. She stated R75 liked to watch TV, and they would put her in a geriatric chair to watch TV, but she tended to scream when they took her out to the dining room where the TV was located. She stated she used to watch her roommates' TV, but her roommate moved out a month or two ago and she has not had a TV since then. She stated the resident could benefit from having a TV in her room. During a telephone interview on 01/11/25 at 11:29 AM, the AD stated R75 was just added to the one-on-one list on 12/31/24 but she has not been started on one-on-ones yet because they had covid in the building and were not fully staffed. She stated R75 screamed when she was put in the geriatric chair and taken to the dining room where the television was located. She stated R75 liked to watch television and listen to music. She stated she used to watch her roommate's television however the roommate moved some time ago and she has not had access to a television since she moved. She stated they did have a radio on the unit for all the residents to share, however she was not sure where the radio was. She stated the resident would benefit from having a television and radio in her room since she preferred to stay in her room, and she enjoyed watching television. 30067

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	01/11/2025

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 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** 30067 Based on observations, interviews, and record review, the facility failed to follow physician's orders for compression wrap for 1 of 1 resident (Resident (R)33) reviewed for edema of 36 sample residents. This failure had the potential to negatively affect R33's diagnosed undated circulatory deficits. Findings include: Review of R33's undated Face Sheet found in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE], with diagnoses including but not limited to: dementia with behaviors, anxiety disorder, and Alzheimer's disease. Review of R33's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/24, located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R33 was moderately cognitively impaired. During observations on 01/09/25 at 3:30 PM and on 01/11/25 at 12:45 PM, R33 had notable edema (condition where excess fluid accumulates in the body's tissues, causing swelling) to her feet and legs. R33 rarely sat to elevate her legs, so the edema worsened during the day as she stood and waited for her ride home every day. There were no observations of R33 wearing the compression hose as ordered. Review of R33's Order Summary Report and found under the Orders tab of the EMR, revealed a physician's order, dated 11/16/24 at 7:00 AM, Please have supply person order: Tubular compression wraps: Tubular compression size G to BLE (bilateral lower extremities) and size J to thighs. To be applied daily for chronic lymphedema BLE. May be removed at bedtime to give rest. Review of R33's Medication Administration Record (MAR) and her Treatment Administration Record (TAR) found in the EMR under Orders, then Reports tabs from 11/15/24 through 01/11/25, revealed no entries related to the application or removal of the compression wraps. Review of the EMR progress notes in the Progress Notes tab, revealed on 11/24/24, Medication Administration Note: Please have supply person order tubular compression wraps: Tubular compression size G to BLE and J to thighs to be applied daily for chronic lymphedema BLE. May be removed at bedtime to rest. This note was repeated on 12/07/24; on 12/29/24; on 01/04/25; and again on 01/05/25. During an interview on 01/10/25 at 9:30 AM, the Regional Director of Clinical Services (RDCS) stated she entered the multiple Administrative Notes, . because the contracted DME (Durable Medical Equipment) provider had not filled the order. She confirmed that seven weeks was excessive, and the facility needed another way to ensure the physician's orders got implemented timely. During an interview on 01/11/25 at 10:30 AM, the Director of Nursing (DON) stated it was absolutely her expectation that treatment orders were processed and carried out timely. She stated this delay in treatment was unacceptable and she would correct immediately.

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	01/11/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013 Based on observation, interview, record review, and facility policy review, the facility failed to ensure that residents who were dependent on staff for restorative nursing received range of motion, a carrot to the left hand, and/or a wedge to the leg for positioning, as ordered by the Physician for 2 of 3 residents (Resident (R)115 and R71) reviewed for restorative services of 36 sample residents. This failure has the potential for other residents to be at risk for decreased range of motion, worsening of their contracture, and/or increased edema. Findings include: Review of the facility's policy titled, Restorative Nursing Programs, dated 2023, documented, It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level .Restorative aides will implement the plan for a designated length of time, performing the activities and documenting on the Restorative Aide Documentation Form .The Restorative Nurse, or designated licensed nurse will provide oversight of the restorative aide activities, review the documentation at least weekly, and evaluate the effectiveness of the plan. 1. Review of R115's Face Sheet, located under the Admissions tab in the electronic medical record (EMR) documented R115 was admitted to the facility on [DATE], with diagnoses including but not limited to: type two diabetes mellitus and history of a stroke with hemiparesis. Review of R115's Physician Orders located under the Orders tab in the EMR, dated 04/14/24, revealed, Resident may participate in Restorative Nursing Programs 5 times a week for ROM upper and lower extremities. Review of R115's Physician Orders located under the Orders tab of the EMR, dated 05/24/24, revealed, Resident may participate in Restorative Nursing Program as per MD [Medical Doctor] order: Place carrot to left hand five times a week, place wedge to left leg five days per week for positioning. Review of R115's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 10/10/24, revealed a Brief Interview for Mental Status (BIMS) of 99 out of 15 which indicated R115 was severely cognitively impaired, had a functional limitation of range of motion on the upper and lower body on one side, required maximum assistance on the staff for personal care, and had no rejection of care. During observations on 01/08/25 at 10:46 AM, 01/09/25 at 3:06 PM, and 01/10/25 at 10:15 AM, revealed R115 had no wedge to her left leg and no carrot in her left hand. During an interview on 01/11/25 at 10:15 AM, Certified Nursing Assistant (CNA)9 stated R115 was confused, cooperative with care, and the staff provided her with personal care. CNA9 stated although she provided range of motion (ROM) exercises to R115, R115 had three fingers on her left hand that did not open and close all the way, and she did not provide ROM to the left hand. (continued on next page)

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	01/11/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/10/25 at 10:25 AM, Licensed Practical Nurse (LPN)3 stated she was not aware R115 was to have a carrot placed in her left hand. She stated she was not sure R115 used a wedge on her left leg for positioning and said she had not observed a wedge in her bed. During an interview on 01/10/25 at 11:37 AM, the Restorative Aide (RA)1 stated she met with the Rehabilitation Director weekly, and they discussed the restorative program for each resident. She said she was educated on any changes in the resident's restorative program and any new residents added to the restorative program. RA1 stated that for the past several months, she worked as a CNA, had a CNA assignment, did not meet with the Rehabilitation Director, and did not provide restorative services to residents on the restorative program. RA1 stated she was assigned to work as a RA on 01/09/25 and 01/10/25. She stated she provided range of motion exercises to R115's upper and lower body. RA1 stated she was not aware R115 was to have a carrot in her left hand and there was no wedge in R115's room. RA1 stated she told the Rehabilitation Director about the missing wedge. During an interview on 01/10/25 at 12:01 PM, the Therapy Director stated for the past several months she had not met with RA1 to discuss the residents on the restorative program as RA1 was assigned to work as a CNA on the nursing units. The Therapy Director stated the CNAs were expected to provide ROM during personal care. She stated she was not aware that R115 needed a carrot and wedge. The Therapy Director said although R115's orders were for five days a week; they should have been for seven days a week. During an interview on 01/11/25 at 3:30 PM, the Regional Director of Clinical Services (RDCS) confirmed there were no RA notes in the clinical record for R115 from 11/01/25 to 01/10/25. During an interview on 01/10/25 at 9:39 AM, the Director of Nurses (DON) stated although restorative nursing had not been provided by the RA for several months, the CNAs could provide ROM during care, could place carrots etc. and use wedges or positioning devices as ordered. She stated she was not aware R115 did not have a wedge and carrot available for use. The DON stated R115 did not receive her restorative program from 11/01/24 to 01/09/25. 2. Review of R71's Face Sheet, located in the EMR under the Admissions tab documented R71 was admitted to the facility on [DATE], with diagnoses including but not limited to: history of a stroke with hemiparesis (partial weakness on one side of the body) and hemiplegia (paralysis on one side of the body). Review of the Physician Orders located in R71's EMR under the Orders tab, dated 01/06/25, revealed Restorative Nursing for left hand brace. To be worn six hours per day. Review of the quarterly MDS located under the MDS tab in the EMR with an ARD of 08/22/24, documented R71 had a BIMS of 15 out of 15 which indicated R71 had intact cognition, functional limitation of range of motion on the upper and lower body on one side, was dependent on staff for personal care, and had no rejection of care. During an observation and interview on 01/08/25 at 11:21 AM, R71 stated he had not seen any rehabilitation staff in several days and no one had applied the splint to his left hand in several days. Although R71 had a left-hand splint in his room, it was not observed on his left hand. (continued on next page)

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	01/11/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/10/25 at 10:05 AM, R71 stated no one applied the left-hand splint to his left hand yesterday or today and there was no left-hand splint observed on his left hand. Review of the Adaptive Rehab In-Service /Staff Meeting Acknowledgement and Attendance Record, dated 01/30/24, revealed R71 was to use a splint on his left hand six hours per day. The record revealed that four staff on R71's unit had received education, including one nurse. The record revealed that RA1 was not listed on the form. During an interview on 01/10/25 at 11:37 AM, RA1 stated she worked as a CNA on the nursing unit and not as an RA for several months. She stated that on 01/06/25 to 01/08/25, she worked as a CNA and not a RA. RA1 stated that on 01/09/25 and 01/10/25, although she was assigned to work as a RA, she was not educated that R71 was on restorative program that included a left hand splint, and therefore did not apply the splint on 01/09/25 and 01/10/25. RA1 stated R71 had not had the left-hand splint placed between 01/06/25 and 01/11/25. During an interview on 01/10/25 at 12:01 PM, the Therapy Director stated she had not met with the RA for several months. The Therapy Director stated R71 was on occupational therapy from 11/08/24 to 01/02/25, (Thursday). She stated the splint was to be worn seven days a week for six hours. She stated she notified the DON prior to 01/02/25 that R71's occupational therapy ended, and they needed a physician order for the splint to be done by the RA. The Therapy Director stated she was not aware the order for R71's splint was not obtained until 01/06/25. She stated the orders for restorative nursing were usually obtained as soon as she emailed or gave them to the DON. She stated on 01/03/25, the staff on R71's unit, which included the nurse and CNAs assigned to the unit that day were educated about the splint and the splint was applied to R71's left hand. She stated her staff did not apply the splint to R71 after 01/03/25 as it was not the responsibility of nursing to apply the splint. She stated after the education was completed; the nurses were to continue the education with the other staff. The Therapy Director stated RA1 was not usually assigned to R71's floor and would have been educated by the nurse when RA1 was assigned to work as a RA again and not assigned as a CNA on a unit. During an interview on 01/11/25 at 3:30 PM, the RDCS confirmed there were no RA notes in the clinical record for R71 from 01/04/25 to 01/11/25. During an interview on 01/10/25 at 9:24 AM, the Director of Nurses (DON) stated R71 completed his occupational therapy and when notified on 01/05/25 or 01/06/25, she obtained an order for a restorative splint program for R71. She confirmed the RA had not worked as an RA for several months. When asked who was responsible for placing the splint on R71, she stated if RA1 was not assigned to work as an RA, the DON stated the nurse would assume the responsibility. The DON stated R71 had not had the left-hand splint applied from 01/06/25 to 01/11/25.

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	01/11/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013 Based on observation, interview, record review, and facility policy review, the facility failed to maintain acceptable nutritional parameters by not monitoring weights, implementing interventions, and monitoring meal intake for 1 of 2 residents (Residents (R)123) reviewed for nutrition of 36 sample residents. This had the potential to cause further weight loss without a root cause analysis and/or additional interventions put in place. Findings include: Review of the facility's policy titled, Weight Monitoring, dated 01/25, revealed, The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes .Developing and consistently implementing pertinent approaches and monitoring the effectiveness of interventions and revising them as necessary. A weight monitoring schedule will be developed upon admission for all residents .Residents with weight loss-monitor weekly .The physician should be informed of a significant change in weight and may order nutritional interventions. The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss. Meal consumption information should be recorded . Review of R123's Face Sheet, located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE], with diagnoses including but not limited to: heart failure, renal insufficiency, diabetes mellitus, major depression, and anemia. Review of R123's Comprehensive Care Plan located in the EMR under the Care Plan tab, revealed the resident had a Nutrition Care Plan, dated 08/29/24, related to risk for malnutrition related to Alzheimer's disease, depression, and history of dysphagia. The goal was R123 to have no significant weight change and show no signs/symptoms of malnutrition. The Care Plan interventions included: monitor/record/report to MD (Medical Doctor) as needed (prn) signs of malnutrition, significant weight loss: three pounds in one week, greater than five percent in one month, greater than 7.5% in three months, greater than ten percent in six months, and Registered Dietician (RD) to evaluate and make diet change recommendations prn. Review of R123's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/23/24, located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 99 out of 15 which indicated R123's cognition was severely impaired. The MDS indicated R123 received a regular diet and was assisted with meals. Review of R123's quarterly MDS with an ARD of 11/25/24 located in the MDS tab of the EMR, revealed R123 was dependent on staff for eating. Review of R123's Physician's order located in the EMR under the Orders tab, dated 08/23/24, documented: Boost (oral supplement) twice per day (bid) and a regular diet. (continued on next page)

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	01/11/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R123's Physician Progress Note located in the EMR under the Document tab, dated 09/24/24, revealed R123 had Alzheimer's disease with early onset, the staff reported R123 did well when assisted with meals, R123 was at risk for malnutrition due to dementia, and the RD was to be consulted as needed (prn) to assist with supplements/nutrition. Review of R123's weights located in the EMR under the Weights and Vital tab, revealed the following: -08/21/24 - 115.0 lbs. (Pounds) -08/27/24 - 117.8 lbs. -09/03/24 - 118.2 lbs. -10/09/24 - 117.4 lbs. -11/05/24 - 100.2 lbs. -01/10/25 - 92.5 lbs. Review of the quarterly Nutrition Evaluation located in the EMR under the Documents tab, dated 11/26/24, revealed R123 consumed 75% to 100% of her meals, her height was 64 inches, and her weight was 100.2 pounds, which was a significant weight loss of 14.9 % in three months. No significant weight loss/gain during the past 6 months. No supplements currently ordered. Pt [patient] with diagnosis of unspecified dysphagia however difficulty swallowing/chewing not currently noted .No nutrition concerns .Goals: no significant weight changes in the next 3 months . continue diet as currently ordered; week weights . Review of the Physician Orders located in the EMR under the Orders tab, dated 12/27/24 revealed: Regular diet, mechanical soft-ground meat texture, thin liquid consistency. Review of the Food and Fluid Intake provided by the Regional Director of Clinical Services (RDCS), dated 11/26/24 to 1/10/25, revealed: there was no documentation related to R123's meal and snack intake on 11/27/24, 11/28/24, 12/01/24, 12/02/24, 12/04/24, 12/06/24, 12/07/24, 12/09/24, 12/09/24, and 12/11/24 to 01/10/25. R123's meal intake on 01/11/25 revealed the resident consumed 75 % and her snack intake documented NA (not applicable). During an observation on 01/08/25 at 11:45 AM, R123 was out of bed in the dining room. A staff member sat next to R123 and fed her lunch. R123 consumed approximately 50 % of her meal and drank her milk and juice. During an observation on 01/11/25 at 12:00 PM, R123 was out of bed in the dining room. A staff member sat next to R123 and fed her lunch. She had an extra dessert on her tray. R123 ate approximately 50% of her meal and half of the extra dessert. When it finished, the Certified Nursing Assistant (CNA) offered Boost (nutritional supplement) to R123 but R123 refused to drink it. (continued on next page)

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	01/11/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 2:45 PM, CNA3 stated the staff fed R123. She stated in the last few months, R123 had increased sleepiness and sometimes ate very poorly. CNA3 stated some days, R123 ate 25 percent, and other days ate 50 percent. She stated her best meal was at lunchtime. CNA3 stated the staff transferred her back to bed after dinner for a nap. CNA3 stated R123 liked Boost and on the days when R123 was more awake, they gave her Boost with a snack. CNA3 stated R123 usually drank 50 to 75 percent of the Boost. During an interview on 01/09/25 at 1:16 PM, the Director of Nurses (DON) stated R123's Alzheimer's disease had progressed over the past several months and she had further decline after having Covid-19 in December 2024. She stated if a resident had a significant weight loss/gain since last month, the staff were to reweigh the resident. The DON stated if there was still a discrepancy, the weight was to be reported to her and the Physician, and the nurse was to initiate weekly weights. The DON stated she was not aware of R123's significant weight loss in November 2024, there was no evidence in the clinical record that the physician was notified, a reweigh was not obtained, weekly weights were not initiated, there were no progress notes related to the weight loss, and she did not discuss weight concerns with the team at morning meetings. The DON said the Registered Dietician evaluated residents at the facility twice per week and also worked from home a few days. She stated weight summary reports could be printed to review 30-60-90-180-day weights. The DON stated that when a resident lost a significant amount of weight, the RD evaluated the resident during their next visit. She stated although R123's weight loss was documented on 11/05/24, the RD did not evaluate R123 until 11/26/24 when her quarterly assessment was due. The DON stated the RD's evaluation had conflicting information related to R123's weight loss. She stated although the RD documented R123 had a 14.9% weight loss in six months, R123 was admitted on [DATE] and the weight loss was in three months, which was greater than 14.9%. The DON stated the RD's intervention was for weekly weights, continuing the current plan, and follow up as needed. The DON stated the RD did not notify her of R123's significant weight loss and lack of weekly weight monitoring. During an interview on 01/10/25 at 10:02 AM, Licensed Practical Nurse (LPN)3 stated R123 had significant cognitive impairment, she was at risk for weight loss, received supplements, and the staff fed the resident her meals. LPN3 stated she was not aware of R123's weight loss. LPN3 stated the CNAs reweighed residents with weight discrepancies and were to notify her of any weight loss or gain. LPN3 stated residents with significant weight loss were weighed weekly. LPN3 stated she had not discussed R123's weight loss with the Physician, Director of Nurses, or the Registered Dietician as she was not aware of her weight loss. She stated the Restorative Aide (RA) entered weights in the EMR and stated she was not aware R123's weights were not in the EMR. LPN3 stated R123 had a fair appetite and was not on hospice. LPN3 stated R123 had a fair appetite, received supplements, and the staff frequently encouraged and gave her snacks and fluids. She stated some days R123 was sleepy and had a decreased appetite. During an interview on 01/10/25 at 10:10 AM, Licensed Practical Nurse (LPN)3 stated R123 had end stage Alzheimer's disease and had a decline in her physical and mental status. LPN3 stated the staff fed R123 and said her appetite was fair. She stated R123 liked Boost, and the staff offered and assisted her to drink Boost as she was able. LPN3 stated some days, R123 was very sleepy, and the staff had a difficult time feeding her. LPN3 stated R123 liked Boost, and no choking. LPN3 stated the nurses and CNAs offered supplements and snacks during each encounter with R123. (continued on next page)

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	01/11/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/10/25 at 11:37 AM, RA1 stated she entered residents' weights in the EMR, and she or the CNAs notified the nurse of weight discrepancies. RA1 stated she had been assigned to work as a CNA on the units and had not entered resident weights into the EMR. She stated said she was assigned to work as a RA on 01/09/25 and 01/10/25 and entered any weights obtained by the CNAs into the EMR. During an interview on 01/11/25 at 10:15 AM, CNA9 stated she fed R123 her meals and snacks. She stated R123 was confused, and her appetite was fair to poor. CNA9 stated she entered the resident's meal percentages in the EMR. She stated she was not aware of R123 being on weekly weights. CNA9 stated she encouraged R123 to eat at meals and frequently offered fluids and snacks to her between meals. During an interview on 01/10/25 at 3:15 PM, the DON stated R123's weight was 92.5 pounds, which was a 21.3 percent weight loss in three months. The DON stated the Physician was called and only new interventions were initiated. The DON stated although R123 had expected weight loss from her advanced Alzheimer's disease and Covid-19, the facility did not investigate R123's weight loss, obtain weekly weight, notify her and the Physician, and did not put appropriate interventions in place to reduce any further weight loss.

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	01/11/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013 Based on observation, record review, interview and facility policy review, the facility failed to ensure residents received oxygen via nasal cannula, according to the physician's order, and that oxygen supplies were stored appropriately when not in use for 2 of 2 residents (Resident (R)400 and R87) reviewed for oxygen administration of 36 sample residents. Additionally, the facility failed to ensure 1 of 1 resident (R71) had physician orders for oxygen administration of 36 sample residents. This failure had the potential for the residents to receive increased oxygen causing hyperoxia (cells, tissues and organs are exposed to an excess supply of oxygen). Findings include: Review of the facility's policy titled, Oxygen Administration, initiated 12/04/24 and revised 01/01/25, revealed, Oxygen is administered under orders of a physician, except in case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system. b. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment setting for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen. 5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: a. Follow manufacturer recommendations for the frequency of cleaning equipment filters. b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. c. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. Use only sterile water for humidification. d. If applicable, change nebulizer tubing and delivery devices every 72 hours or per facility policy and as needed if they become soiled or contaminated. e. Keep delivery devices covered in plastic bag when not in use. 1. Review of R400's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to: chronic respiratory failure with hypoxia Review of R400's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/24, and located in the resident's EMR under the MDS tab, revealed R400 was in a persistent vegetative state/no discernible consciousness. Review of R400's Care Plan, dated 10/30/24 and located in the EMR under the Care Plan tab, revealed, The resident has chronic respiratory failure with hypoxia. Interventions in place were to administer oxygen, dated 01/08/25 02:25 PM. Review of the physician orders dated 12/04/24 and located under the Orders tab of the EMR revealed O2 via trach collar at eight liters per minute (LPM) via tracheostomy collar continuously. (continued on next page)

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	01/11/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 01/08/24 at 3:00 PM, 01/09/24 at 11:15 AM, and 01/10/24 at 9:34 AM, the resident was lying in bed using a tracheostomy collar and the oxygen concentrator was set at six LPM. During an observation and interview on 01/11/24 at 12:30 PM, Licensed Practical Nurse (LPN)5 stated R400 should be on eight LPM. She looked at R400's oxygen concentrator and stated it was set at 6 LPM. She then tried to adjust the rate, and the concentrator level would not rise to 8 LPM. During an interview on 01/11/24 at 12:50 PM, the Director of Nurses (DON) stated she would expect staff to follow physician orders for oxygen administration and administer the correct LPM. 2. Review of R87's undated Admission Record located under the Profile tab of the EMR, revealed R87 was admitted to the facility on [DATE], with diagnoses including but not limited to: chronic obstructive pulmonary disease (COPD) and congestive heart failure. Review of R87's quarterly MDS with an ARD of 12/18/24, located in the EMR under the MDS tab, revealed R87 had a BIMS score of 15 out of 15, which indicated R87 was cognitively intact. Review of R87's Care Plan, dated 01/08/24, located in the EMR under the Care Plan tab, revealed oxygen settings O2 via Nasal cannula at 2 LPM as needed. Review of R87's physician orders, dated 09/01/23 and located under the Order tab of the EMR, revealed O2 via nasal cannula collar at 2 liters per minute (LPM). During observations on 01/08/24 at 1:26 PM and on 01/09/24 at 9:35 AM, the oxygen concentrator was set at 2.5 LPM. And on 01/10/24 at 11:45 AM the resident was lying in bed using a nasal cannula and the oxygen concentrator was set at 3 LPM. There was no date on the oxygen tubing or humidifier bottle on any observation. The concentrator was crusted with white stains. During an observation and interview on 01/11/24 at 12:30 PM, LPN4 stated R87 should be on two LPM. She looked at R87's oxygen concentrator and stated it was set at three LPM. She stated she should have checked it. During an interview on 01/11/24 at 12:50 PM, the Director of Nurses (DON) stated she would expect staff to follow physician orders for oxygen administration and administer the correct LPM. 3. Review of R71's Face Sheet located under the Admissions tab in the EMR documented R71 was admitted to the facility on [DATE], with diagnoses including but not limited to: history of a stroke with hemiparesis (partial weakness on one side of the body) and hemiplegia (paralysis on one side of the body), history of Covid-19, anxiety, stroke, and cardiac pacemaker. Review of the quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 08/22/24 revealed R71 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R71 had intact cognition and did not use oxygen. Review of R71's Care Plan located under the Care Plan tab in the EMR, dated 11/22/24, revealed no care plan for oxygen. (continued on next page)

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	01/11/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R71's December 2024 and January 2025 Physician Orders located under the Orders tab in the EMR, revealed no order for R71 to receive oxygen, no orders to change the oxygen tubing, and no orders for oxygen monitoring. Review of R71's December 2024 and January 2025 Treatment Administration Record (TAR) located under the Orders tab in the EMR, revealed no order for R71 to receive oxygen, no orders to change the oxygen tubing, and no orders for oxygen monitoring. During an interview on 01/08/25 at 11:21 AM, R71 stated he has used oxygen for many years and has used oxygen since his admission to the facility. He stated he did not know his current oxygen rate. Observations on 01/08/25 at 10:56 AM and 5:00 PM, 01/09/25 at 4:35 PM and 8:00 PM, and 01/10/25 at 10:02 AM revealed R71 was using oxygen via a nasal canula at 2.5 liters per minute (lpm). The oxygen unit was dusty and soiled with a dried brown material and the filter was full of gray lint. The oxygen tubing was dated and clean. During an interview on 01/10/25 at 10:02 AM, Licensed Practical Nurse (LPN)3 stated R71 has received oxygen since he was admitted to the facility. She stated all residents receiving oxygen were to have a physician order for oxygen. LPN3 confirmed that R71 did not have an order for oxygen, and she stated she would call the physician for oxygen orders. LPN3 stated R71's oxygen unit was dirty and not sanitary, and the unit and filter needed to be cleaned. During an interview on 01/10/24 at 9:25 AM, the Director of Nurses (DON) stated all residents receiving oxygen were to have a physician order for oxygen that included the method of administration, the oxygen rate and whether the oxygen was continuous or as needed (prn), monitoring for oxygen, and weekly changing of oxygen equipment. She stated oxygen information was to be recorded on the TAR and in the care plan. The DON stated the night nurse was to clean oxygen machines weekly and as needed and were to clean the filters every night. The DON confirmed there was no physician order for oxygen, care plan, or information for R71's oxygen use in the clinical record. 26190

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	01/11/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03115 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure the menu was followed for 2 of 2 residents, who wish to remain anonymous, of 36 sample residents. Failure to follow the menu had the potential to result in weight loss, resident dissatisfaction, and resident hunger with the potential to affect 151 of 157 residents consuming food in the facility. Findings include: Review of the facility's policy titled, Menus and Adequate Nutrition with a revised date of 01/01/25, revealed menus must be posted in the kitchen and in an area accessible to all residents at least one week in advance. The policy stated the menus will be followed as posted. Review of the menu titled, 2022-23 F/W [Fall/Winter] Menus .Week: 2 revealed the facility was supposed to serve the residents on regular diets, low concentrated sweets diets, and liberal renal diets three ounces of buttered corn and two hushpuppies along with their lunch meal. Residents on the mechanical soft diet were supposed to receive four ounces of seasoned carrots and a dinner roll. Residents on puree diets were to receive two ounces of puree bread with the noon meal on 01/10/25. During an interview on 01/08/25 at 11:49 AM, a resident wishing to remain confidential, stated the food was not appetizing, she did not get the food on the menu or what she requested, and the food was often cold. During an interview on 01/08/25 at 12:47 PM, a resident wishing to remain confidential, stated the menu was not followed and the food was not hot about 75% of the time. During an observation and interview on 01/10/25 at 11:36 AM, [NAME] 2 placed the serving utensils in the food items on the steam table. She placed a 3-ounce scoop in the corn, a 3-ounce scoop in the lima beans, and a 3-ounce scoop in the puree lima beans. She did not have carrots on the steam table and when queried about why she gave the mechanical soft and purees lima bean and not carrots she stated she just decided to make the change without any additional explanation. At 11:59 AM, she began serving the noon meal using the above scoops. On 01/10/25 at 12:14 PM after she completed serving the unit 300 cart and the first cart to unit 400, the Dietary Manager (DM) was asked to check the scoop sizes. He verified the scoop in the corn, lima beans, and puree lima beans were 3-ounce scoops and should have been a 4-ounce scoop. After he was asked about the scoop sizes, he switched the 3-ounce scoop into the corn with a 4-ounce scoop and left the 3-ounce scoop in the lima beans. During the meal service, no rolls or hushpuppies were observed on the tray line and were not on the residents' trays. During an interview on 01/10/25 at 12:24 PM, [NAME] 2 was asked if she was supposed to serve bread with the meal and she stated she was supposed to give the residents two hushpuppies or a roll and she stated she forgot to prepare the hushpuppies and rolls and stated she did not give them to any of the residents.

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	01/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03115 Based on observation, interviews, and facility policy review, the facility failed to ensure sanitizer was at a strength to sanitize the counters; ensure pans, utensils, equipment, and food preparation counters were clean and sanitized; ensure food was labeled and dated and disposed of by the use by date; ensure food was refrigerated after opening in accordance with the manufacturer's instructions; ensure hand washing between touching soiled objects and returning to serving; and ensure the outside of food and spice containers were clean with the potential to affect 151 of 157 census residents consuming food out of 1 of 1 kitchen. Failure to store, prepare, and distribute under sanitary conditions had the potential to result in cross contamination of food and food borne illness. Findings include: Review of the facility's policy titled, Use and Storage of Food Brought in by Family or visitors with a revised date of 01/01/25, revealed food placed in the resident refrigerators must by labeled and dated and consumed within three days and any foods older than three days would be discarded. Review of the facility's policy titled, Handwashing Guidelines for Dietary Employees with a copyright date of 2024, revealed employees must wash their hands after touching anything unsanitary. Review of the facility's policy titled, Sanitation Inspection with a copyright date of 2024, revealed all areas of the kitchen would be kept clean and sanitary. Review of the facility's policy titled, Date Marking for Food Safety with an implementation date of 12/13/24, revealed refrigerated ready to eat food shall be held at a temperature of 41 degrees or less for a maximum of seven days; food shall be clearly marked with the date the food should be consumed or discarded; and food should not exceed the manufacturer's use-by date or four days which ever is earliest. Review of the facility's policy titled, Food Safety Requirements with an implementation date of 12/01/24, revealed food will be stored, prepared, and distributed and served in accordance with professional standards for food service safety. The policy stated food should be stored in a manner that helps prevent deterioration or contamination of the food, including the growth of microorganisms. Staff should wash hands between contact with soiled objects and food. The policy stated all equipment used in the handling of food should be cleaned and sanitized and handled in a manner to prevent contamination. 1. During an observation of the kitchen on 01/08/25 with the Dietary Manager (DM) from 10:08 AM through 10:54 AM the following food service equipment/areas were observed to be soiled and in need of cleaning: a) The shelf under the coffee pot and the shelf under the sheet pan racks were covered with aluminum foil. The foil was visibly soiled with dust and what appeared to be dried food residue. (continued on next page)

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	01/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b) A Robo coupe food processor and a five-gallon container of Clear Canola Salad Oil were stored on a soiled shelf below a food preparation counter located next to the food storage room. The outside of the oil container was visibly soiled with what appeared to be spilled oil; the food processor was soiled with what appeared to be dust and food crumbs; and the shelf was soiled with oil and what appeared to be food crumbs. The DM stated they did not use the food processor anymore and verified the observation. c) The bottom of two drawers containing food utensils was visibly rusty and soiled with food particles. The drawer contained two food scoops that had visibly dried food on them. The DM verified the observation and verified the utensils were not properly cleaned prior to being placed in the drawer. 2. During an observation of the kitchen and interview on 01/08/25 at 10:24 AM, the red containers of sanitizing solution with a wiping cloth in it tested at zero (0) parts per million (ppm). [NAME] (C)1 stated she was using it to clean off the food preparation counters. The Registered Dietitian (RD) assisted with obtaining the sanitizer level of the solution and verified it was zero ppm. During an observation and interview on 01/10/25 at 10:54 AM, two red containers of sanitizing solution located under the food preparation counter located across from the 3-compartment sink were tested by the DM. They both tested to be zero parts per million. [NAME] 3 stated they were using it to clean the counter. One of the containers had a cloth in it. [NAME] 3 stated he thought he put the sanitizer in the container at 9:15 AM that morning. The DM stated the solution should be good for at least four hours. Review of the manufacturer's instructions located on the Oasis 146 Multi-Quat Sanitizer revealed the sanitizer should be 150 to 400 ppm to sanitize food contact surfaces. 3. During an observation on 01/08/25 at 10:29 AM, the dry food storage room located off the main kitchen was inspected with the DM and the RD. The storage room contained the following items: a) Two open unsealed boxes of kosher salt were not dated to indicate when they were opened and one of the boxes was visibly soiled on the outside of the box with what appeared to be an oily substance. The DM stated the boxes should have had an open date and should have been sealed closed once they were opened. b) Sixteen (16) 16-ounce containers of spices that had been opened and partially used revealed the outside of each of the containers were visibly soiled with what appeared to be dried food substance and five of the containers felt greasy to the touch. c) Two-16 ounce open and partially used containers of paprika had a use by date of 07/12/23. The containers were not labeled with the date they were opened and one of the containers had the lid open exposing it to potential cross contamination. (continued on next page)

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	01/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d) Two-one gallon open and partially used containers of Kens Home Style Ranch dressing revealed the outside of both containers was heavily soiled with spilled salad dressing and the date of 12/05/24 was marked on the containers with a black marker. The DM stated the 12/05/24 date was the date the containers were opened and placed in the food storage room. The manufacturer's instructions stated to keep refrigerated after opening. The RD and DM verified the salad dressing should have been refrigerated after it was opened, and the outside of the container should have been cleaned prior to storing it. e) One - one gallon opened partially used container of Kikkoman Teriyaki sauce had an open date of 01/18/24 marked on it with a black marker. The manufacturer's instructions on the label stated refrigerate after opening. f) A 16-ounce box of Peace Mining Belgian Waffle mix had an opened date of 12/28/24. The box was open to the air and not sealed shut. 4. During an observation of the 300-unit and interview on 01/08/25 at 10:54 AM, the resident food storage refrigerator located behind the nursing station on the 300 unit was inspected with the RD. The refrigerator did not have a thermometer in it therefore it was not possible to determine if it was maintained at a safe temperature level. The refrigerator contained three-two (2) ounce bags of sliced apples with expiration dates of 12/29/24; an undated/unlabeled plastic grocery store bag containing bread and chips; and an undated unlabeled pizza box. 5. During an observation of the 200-unit and interview on 01/08/25 at 10:56 AM, the resident food storage freezer and refrigerator located behind the nursing station on the 200 unit was inspected with the RD. The refrigerator contained an undated bag with three restaurant style food containers and a quart of open tomato juice. The tomato juice was one quarter full; did not have an open date; and had an expiration date of 12/21/24. The refrigerator also contained 18 four-ounce cartons of Mighty Shake nutritional supplements. The shakes were completely thawed. The containers were not dated to indicate the date they were thawed. The manufacturer's instructions on the outside of the containers stated to use within 14 days of thawing. 6. During an observation of the 400-unit and interview on 01/08/25 at 11:10 AM, the resident food storage freezer and refrigerator located behind the nursing station on the 400-unit was inspected with the RD. The refrigerator contained one four-ounce carton of Mighty Shake nutritional supplement. The shake was completely thawed. The container was not dated to indicate the date they were thawed. The manufacturer's instructions on the outside of the container stated to use within 14 days of thawing. 7. During an observation of the 100-unit and interview on 01/08/25 at 11:10 AM, the resident food storage freezer and refrigerator located behind the nursing station on the 100 unit was inspected with the RD. The refrigerator contained 24 completely thawed Mighty Shakes with no thaw dates on the containers; an open 32-ounce jar of apple sauce with an open date of 11/25/24; and an undated unlabeled KFC bag containing chicken. 8. During an observation of the kitchen and interview on 01/10/25 at 11:10 AM there was a tray with cups of ice sitting on top of a three-shelf chart. The DM stated they were prepared for the noon meal. The shelves of the cart were soiled with dried residue and the bottom shelf had a black build up. He verified the cart should have been cleaned and sanitized prior to use. (continued on next page)

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	01/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. During an observation of the kitchen and interview on 01/10/25 at 11:12 AM, the large metal cart next to the three-compartment sink and across from the dishwasher had Clean steam table pans stacked together on it. Four of the six pans checked where stacked together wet and soiled with a white wet residue resembling food. The DM verified this and stated the pans on the rack should have been clean and allowed to dry prior to stacking them. 10. During an observation of the kitchen and interview on 01/10/25 at 12:11 PM, [NAME] 1 took a plate to the soiled end of the dishwasher and rinsed the plate off using the water sprayer with her gloved hands. She placed the plate on the counter at the soiled end of the dishwasher and then returned to the steam table and continued serving the noon meal touching the plates and the utensils without changing her gloves. On 01/10/25 at 12:14 PM the DM stated he would have expected [NAME] 1 to remove her soiled gloves and put on clean gloves after touching the soiled sprayer and prior to returning to serving. 11. During an observation of the 400-unit and interview on 01/10/25 at 12:24 PM the closed metal food cart containing residents' noon meal trays arrived at the 400 unit. The 400-unit cart containing the resident's meal trays was visibly soiled on the rungs and on the bottom were the rungs attached to the cart. The black substance was sticky to the touch. The DM verified the cart contained the meal trays that the kitchen had just prepared and that it was not clean prior to the staff placing the residents' trays in it. He stated he would have expected the carts to be cleaned and sanitized between meals. He stated they use the carts to deliver the trays to the unit and then the soiled trays are placed back in the cart after the residents are finished eating.

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	01/11/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on record review and interviews, the facility failed to ensure the medical record accurately and completely reflected the physician's orders for 1 resident (Resident (R) 44) reviewed for medical records of 36 sample residents. Failure to accurately and completely document physician's orders had the potential in this resident not receiving needed care. Findings include: Review of R44's physician's Encounter note, dated 01/02/25 and timed 12:00 AM and located in the progress notes tab of the electronic medical record (EMR) revealed the physician wrote the resident was admitted to the hospital on 12/27/24, for altered mental status and was readmitted to the facility on [DATE], with the same physician's orders as she was on at the time she was discharged to the hospital on 12/27/24. Review of the orders, January 2025, located under the Orders tab of the EMR, revealed the nurse failed to enter the residents' previous orders for a renal, no concentrated sweets diet regular texture, thin liquids consistency, large protein portions; a foley catheter 16 French with 10 ml bulb; for acute charting for hemodialysis catheter site and to monitor drainage, bleeding and edema; providing a bagged lunch to take to hemodialysis Monday, Wednesday, and Friday; and for a fluid restriction 1200 ml/day with nursing providing 300ml/day, dietary providing 660ml/day. As a result, the January orders and the January medication administration record were absent to these orders. During an interview on 01/11/25 at 11:08 AM, the Director of Nursing (DON) verified the resident still had a foley catheter; was still receiving dialysis; was still on a fluid restriction and was still on renal, no concentrated sweets with thin liquids and large protein portions. She stated that because the resident was out of the facility at the hospital for 24 hours, she was considered a new admission, and the nurse should have input the orders into the computer and she herself checked the orders the following day and she missed that these orders had not been entered. She verified the orders were not entered into the January physician's orders resulting in the January orders not being complete and accurate. During an interview on 01/11/25 at 1:00 PM, the Regional Director of Clinical Services stated they did not have a policy specific to medical records and entering physician's orders. She provided a document titled General Nursing Admission Checklist and stated it was what the nurse's followed when admitting or re-admitting a resident to the facility. The form had a line labeled Med Orders entered correctly with an area to mark yes or no and enter a date.

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	01/11/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on observations, record review, interviews, and facility policy review, the facility failed to maintain all electrical outlets in safe operating conditions for 4 of 4 resident rooms and 7 of 7 residents (Resident (R)68, R39, R54, R15, R82, R11, and R7) reviewed of 36 sample residents. Failure to ensure residents had functioning outlets in their rooms resulted in the residents not being able to watch their televisions, charge their devices, or run their refrigerators. Failure to ensure the outlet covers are not in disrepair exposing the wires had the potential to result in shock of a resident or employee. Findings include: Review of the facility's policy titled, Electrical Safety implementation date of 01/01/25, revealed it was the facility policy for the Maintenance Director (MD) or designee to inspect and test electrical components. The policy stated hazards or other conditions that could develop into a hazard must be reported to a supervisor or MD as soon as practical. 1. During observations on 01/08/25 at 12:43 PM and 3:16 PM, on 01/09/25 at 12:12 PM, and on 01/10/25 at 10:02 PM, the outlet cover over R68's bed was observed to be broken with a fourth of the cover missing exposing the outlet. During an interview on 01/10/25 at 10:02 AM, the MD verified the outlet cover was broken. 2. During an observation and interview on 01/08/25 at 5:47 PM, R39's family member (FM)1 was interviewed. During the interview it was noted the cords to the tube feeding pump and the electric bed were strung across the room. FM1 stated that it was the only outlet that worked in the room. She stated that because the other outlets did not work R39 was not able to have his television (TV), or his refrigerator plugged in. She stated the outlets had been messed up about a month or more. She stated they used to watch TV together in the room but now they go to the lounge to watch TV. She stated the room next door also had outlet problems and at times they would have an extension cord plugged into an outlet in the hall for the room. The bed and the tube feeding pump were also observed plugged into the outlet over the TV on 01/09/25 at 12:05 PM and at 5:00 PM. During an interview on 01/09/25 at 3:31 PM, the Ombudsman stated there was a concern in the facility related to the electric outlets not working in some of the residents' rooms. During an interview on 01/10/25 at 9:39 AM, the MD was interviewed about the outlets. He stated he was just notified on Monday 01/06/25 of the outlets not working and he checked all the rooms and found the outlets did not work in three rooms. He stated an electrician came in on 01/07/25 and verified the outlets did not work. He provided a letter titled Accu-Mechanical which revealed the technician came to the facility on [DATE] and was trying to find the cause of the electrical problem. According to the letter they were preparing an estimate to update the wires and the receptacles. Review of the Daily Census report, dated 01/08/25, revealed R39, R54, R15, R82, R11, and R7 resided in the three rooms with the non-functioning outlets. (continued on next page)

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	01/11/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/10/25 at 10:05 AM, R54 was sitting in the dining room watching TV. She stated none of the outlets in her room have worked for over a month. She stated as a result she had to watch TV and charge her phone in the dining room. She stated if the outlets worked, she would watch TV in her room. She stated she had informed several employees of the outlets not working but did not provide any specific employee names. Review of R54's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 10/02/24 and located in the MDS tab of the electronic medical record (EMR) identified her as having a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating she was cognitively intact. During an interview on 01/11/25 at 10:50 AM, Licensed Practical Nurse (LPN)9 stated the electrical outlets in the affected rooms had not functioned for at least a couple of weeks. She stated when it first occurred it involved the rooms, the hallway, and the dietary department. She stated they got the power working in the hallway and the dietary department, however the outlets in three of the rooms continued to not work. She stated, she called the MD and left a message on his cell phone about the issue a couple of weeks ago. During an interview on 01/11/25 at 11:02 AM, R15 stated the outlets in her room have not functioned for the past three to four weeks. She stated she liked to watch TV and if they did work, she would watch TV in her room at times. Review of R15's quarterly MDS located in the MDS tab of the EMR with an ARD of 08/14/24, identified her as having a BIMS score of 15 out of 15 indicating she was cognitively intact. During a telephone interview on 01/11/25 at 12:45 PM, LPN10 was asked if she was aware of any electrical outlets that did not work. She stated she was, and she stated the problem had started about a month ago and when asked if it was reported she stated it had been and stated R45 had told numerous staff members about it.

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	01/11/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 15013 Based on observation and interview, the facility failed to ensure the laundry room equipment was clean, which included two large washing machines, six dryers, one fan, the windowsill, items lying directly on the floor or in a plastic bag on the floor, and a dusty laundry chute for 1 of 1 laundry room. Findings include: Observations on 01/09/25 at 11:57 AM, in the laundry room revealed the following: 1. The designated dirty area revealed: -The two large washing machines, which were next to each other had white dried material, gray grime, and dust on the outside of the machines. -There was a fan that was positioned directly on the floor, which was caked with dust and grime. -There was a blue bin directly on the floor that had dust and black material inside the bin and a glove. -There was one large plastic bag that was partially ripped with pillows partially in the bags, and the bag was lying directly on the floor. There were three pillows not in plastic bags, two were lying directly on the floor. -There were a few paper towels and two gloves lying on the floor. -There were six blankets that were stacked on top of each other and the bottom blanket was lying directly on the floor. -The outside of the laundry dispenser that contained the detergents was located on the wall near the drain and was caked with dust and grime. -There was a large plastic bag filled with clean wash cloths lying directly on the floor in the dirty laundry room. 2. The designated clean area revealed: -The six dryers had a moderate amount of dust on the top of the dryers. -There was a silver cart in the clean area of the laundry room that had a microwave and coffee pot on top of the cart, coffee and coffee filters and other items on the second shelf of the cart. --The top and second shelf on the cart were very dusty. -The refrigerator and hot water heater were very dusty. (continued on next page)

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	01/11/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The one windowsill in the laundry room was caked with dust. 3. The laundry chute that was located in another area and was filled with a large amount of dust with dust strings hanging from the inside of the chute. During an interview on 01/09/25 at 11:57 AM, Laundry Aide (LA)1 confirmed the above findings. LA1 stated there was not enough space between the two washing machines to clean the machines properly. She stated the staff cleaned the outside of the washing machines and dryers when they had time. LA1 stated none of them were tall and they could not reach on top of the machines where a lot of dust accumulated and could not reach the upper sides of the machines. She stated the laundry staff were responsible for keeping the cart clean and stated she did not know when the cart was last cleaned. LA1 stated the other two fans that were mounted on the walls were cleaned by maintenance and he had not cleaned the fan on the floor. She stated the blankets that were lying on the floor were used by the ambulance staff when transporting residents to the facility; they cleaned the blankets, and the ambulance staff periodically picked them up. LA1 stated the staff were not able to clean the laundry dispenser machine because they could not get adequate access to the area due to the area around the drain had partially deteriorated and it was not safe to step on. LA1 stated the bag of clean wash cloths was an emergency supply for the upcoming storm in case of electrical issues. LA1 stated clean items, such as the washcloths and ambulance blankets, were not to be stored in the dirty laundry area. She stated the last time there was a deep cleaning in the laundry was the summer of 2024, which included the laundry chute. LA1 stated the laundry room was dusty, dirty, and needed to be deep cleaned. During an interview on 01/09/25 at 12:32 PM, the Housekeeping Supervisor (HS) stated there was no set schedule for the cleaning of the laundry room. He stated three weeks ago that one of the laundry staff told him the laundry chute needed to be cleaned. The Housekeeping Supervisor stated he had observed the laundry chute and confirmed it needed to be cleaned with compressed air. He stated the laundry chute was to be checked weekly and cleaned monthly. The HS stated he did not know when the laundry chute had been last cleaned. He stated nothing was to be stored directly on the floor and the clean blankets used by the ambulance staff and the washcloths were to be kept in the clean part of the laundry room. The HS stated fans, carts, dryers, washing machines, and other equipment were to be kept clean. He stated the area around the drain needed to be safe for staff to step on to replace the cleaning agents in the dispenser.