

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Pruitthealth- Walterboro		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Witsell Street Walterboro, SC 29488	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42424</p> <p>Based on interview and record review, the facility failed to appropriately notify Resident (R)1's Resident Representative or Physician after a change in condition for 1 of 3 reviewed for notification of changes.</p> <p>Findings include:</p> <p>An interview with the Administrator on 10/03/24 at approximately 12:15 PM revealed that the facility does not currently have a policy related to notification of changes, but relies on the Situation-Background-Assessment-Recommendation (SBAR) system for staff to notify changes to the Physician and their Resident Representative, if appropriate.</p> <p>Record review revealed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to; moderate intellectual disabilities, vaginitis and vulvovaginitis in diseases, Urinary Tract Infection (UTI), and hematuria. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/11/24, revealed R1 has the Brief Interview of Mental Status (BIMS) score of 6 out of 15, which indicates a severe cognitive impairment.</p> <p>Record review of R1's Nurses Notes dated 07/25/24 at 5:37 PM revealed called to hospital for an update, resident transferred to hospital hemoglobin 3.2 referred to urology and oncology.</p> <p>An interview on 10/03/24 at 11:11 AM with Registered Nurse (RN)1 revealed that R1 had been having ongoing issues with blood in her urine. Interventions that were put into place included holding the resident's Eliquis (an anticoagulant medication), drawing labs, and R1 was referred to urology related to the bleeding. During the month of July 2024, R1 had on again and off again blood in her urine and then on 07/25/24, R1 appeared to have a change in condition and was sent to the hospital. RN1 stated that there was not a Nurses Note or SBAR communication related to the residents change in condition on 07/25/24 and the only note from that date was after the resident was transferred to the hospital.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview on 10/03/24 at 11:34 PM with R1's Resident Representative (RR) revealed that they had ongoing concerns and spoke with facility staff about R1's bleeding initially at the end of June 2024. RR stated that the facility did not fully communicate that the resident was declining related to the bleeding. RR further stated that on 07/25/24, the facility had planned a care plan meeting related to R1 but called prior to the meeting and stated that the resident had a change of condition and was being sent to the hospital, but did not provide full details of the full situation.</p> <p>A phone interview on 10/03/24 at 12:57 PM with the Nurse Practitioner (NP) revealed that R1 recently had a yeast infection and was prescribed antibiotics and a topical treatment and it was later resolved. The NP stated, around the beginning of July or late June, R1 began to have some spotting, so I ordered labs to be completed which led to a finding of a positive UTI and then I ordered for staff to stop administering the resident Eliquis. I went in to see R1 several times during the month of July, however, during each observation the resident did not have any bleeding during the assessments. The NP then stated that they were unsure if they were notified appropriately when the resident had changes and increased bleeding and were unsure if all the labs were completed on R1 as requested, because some orders were provided to staff verbally.</p> <p>Record review of R1's labs revealed that labs were completed on R1 on 06/11/24, 06/27/24, 06/28/24, 07/09/24, and 07/11/24.</p> <p>An interview on 10/03/24 at 1:25 PM with the Director of Nursing (DON) revealed that they never observed the resident bleeding and there is not a way in the Electronic Medical Record to fully document how much blood the resident had during this time period, but expected staff to document in the SBAR about a change in condition to notify the Physician and Resident Representative. Interview with the DON further revealed that they were unable to locate appropriate documentation related to the change of condition for R1 on 07/25/24.</p>		