STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425053	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Walterboro	401 Witsell Street Walterboro, SC 29488

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on review of the facility policy, record review, and interview, the facility failed to invite Resident (R) 65 to the initial comprehensive care plan meeting for 1 of 4 residents reviewed for resident rights, to participate in planning care. Findings include: Review of the facility policy with a revised dated of 07/27/2023 titled, Care Plans revealed under the policy, Care plan meetings including interdisciplinary team, resident and or resident representative attendance should be documented in care conference notes. Record review of R65's face sheet revealed R65 was admitted to the facility on [DATE] from a sister facility with diagnoses that include but not limited to heart failure, hereditary spastic paraplegia and a pressure ulcer. Review of R65's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/2024 revealed R65 has a Brief Interview Mental Status (BIMS) score of 15, indicating R65 is cognitively intact. During an interview on 12/16/2024 at 08:58 AM, R65 stated, They've not participated in a care plan with me since I came here. I do not have any family that would attend. I make all of my decisions. On 12/16/2024 at 10:26 AM, an interview with the MDS Nurse revealed, We mail out a letter to the family to invite them to attend. If the resident is alert and oriented, we can hold the meeting in the resident's room. Everyone who participates, we will have them all sign. We upload the signature sheet into the electronic medical record. The initial care plan meetings are completed by the Nurse Navigator, shortly after admission. I do not see it uploaded (referring to R65's care plan meeting). During an interview on 12/16/2024 at 10:31 AM, the Nurse Navigator stated, She got transferred to us, from a sister facility. I thought if she transferred to us, she continues the same Omnibus Budget Reconciliation Act (OBRA) assessment and it does not start new. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/2024 at 4:10 PM, an interview was conducted with both the MDS Nurse and the Nurse Navigator. They confirmed R65 was admitted in October. The Nurse Navigator said she reviewed the last care conference at the sister facility dated 08/06/2024. The MDS Nurse confirmed R65's OBRA assessment would start over and her quarterly assessment would not be due until mid January. The Nurse Navigator confirmed, We did not have a care plan meeting. She confirmed there was no documentation that a care plan meeting was held.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on review of the facility policy, interview, and record review, the facility failed to ensure incontinence care was provided for 1 of 2 residents (R)61, requiring incontinence care. Findings include: Review of the facility policy titled, Assisting a Client with Bladder Incontinence referenced and adapted from National Institute on Aging 2022 revealed, A checklist identifies the steps needed to assist a person with bladder incontinence. There was no guidance of how often or when to perform bladder incontinence. Review of the facility policy titled, Documentation: Charting Activities of Daily Living (ADLs) revised 02/18/2021 revealed under the policy, For facilities utilizing Care Assist, ADL's should be documented at the point of care each time care is given. Record review of R61's facesheet revealed R61 was admitted to the facility on [DATE] with diagnoses that include but are not limited to heart failure, atrial fibrillation, hypertension and anxiety. Record review of R61's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date of 11/19/2024 revealed her cognitive status from a Brief Interview Mental Status (BIMS) as 11, indicating moderate cognitive impairment. Record review of Point of Care History dated 12/15/2024 revealed a section titled, Bowel and Bladder Coded in this area had 1 recording of incontinent care between 7am-7pm, which was recorded at 11:40 AM, as incontinent. Record review of Point of Care History dated 12/16/2024 revealed on Bowel and Bladder had 1 recording of incontinent care between 7am-7pm, which was recorded at 12:41 PM, as incontinent. Additionally, the question, How did the resident toilet, recorded Activity did not occur. On 12/15/2024 at 2:18 PM, during an interview with R61, she stated, Certified Nurse Assistant (CNA)2 said, You could tell they were not changed, they were wet through the sheets and pads. Mine were soaked all the way through this morning. That is the 1st time that has happened. On 12/16/24 at 10:57 AM during a second interview with R61, she stated, I've not been changed all morning. I'm wet. On 12/16/2024 at 12:08 PM, an interview with CNA1 revealed, When I come in, I do my vital signs first. I had 5 of them to do. Then I checked on 3 residents. R61 was not one of them. The breakfast trays came out at 7:50 AM. I did not go to her room until 11:20 AM this morning. R61 is incontinent. She was wet when I changed her. I should have checked on her earlier. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/2024 at 12:05 PM, an interview with CNA2 revealed, I worked Saturday and Sunday. Sunday, I had R61. R61 was saturated, it did go through the padding, she was over wet. I made a comment to my orientee with me that, They must have been short last night because this isn't the first resident that is saturated. Beside her, there were 4 residents with beds that were completely gone, soaked all the way through. I was in R61's room when I made that comment. I had to change everything. During an interview and observation with the Director of Nurses (DON) on 12/17/24 at 11:36 AM, when asked for a policy for incontinent care, this surveyor was given a description (used only a guide in performing the skill). The DON stated, That is all we have. The CNAs should check at minimum every 2 hours for incontinent care. During a follow up interview on 12/17/2024 at 2:04 PM with the DON revealed, The expectation is that the CNA receive assignments, do rounding, ensure they have their needs met; call bell, ice water, no brief change needed with the resident, and Activity of Daily Care (ADL) care before breakfast. Residents with early morning appointments are needed to get up first. Breakfast starts around 8:00 AM. They are to ensure each resident is dry when doing the AM rounds, on any shift.

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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** 49801 Based on observations, interviews, record review and facility policy, the facility failed to ensure there was an order for changing respiratory supplies for Resident (R)109 for 1 of 1 residents reviewed for respiratory care. Findings include: Review of the facility's policy titled, Medication Administration: Nebulized Medications with revised date 12/13/2021 revealed, Policy Statement: It is the policy of PruittHealth Pharmacy that a method for the aerosolization of pharmacologic agents for administration via oral inhalation be provided. Procedure: 2. confirm directions, comparing with MAR or E-MAR. 15. Document the procedure. Review of R109's Electronic Medical Record (EMR) revealed R109 was admitted to the facility on [DATE] with diagnoses including but not limited to: Nasal congestion, acute cough, and anxiety disorder. Review of R109's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/26/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R109's cognition is intact. Review of R109's Medication Administration Record (MAR) with a start date of 12/01/24 documented, Albuterol Sulfate solution for nebulization; 2.5 milligrams (mg) /3 milliliters (mL) (0.083 %); amt: one vial; inhalation. Special Instructions: Administer 1 vial as needed Q4H for cough. Review of R109's Physician Orders with a start date of 12/16/24 documented two new orders, Oxygen: Change respiratory circuit/supplies as needed. Oxygen: Change respiratory circuit/supplies weekly once a day on Sunday 9 am. During an observation on 12/15/24 at 11:16 AM, the nebulizer mask was observed on the bedside table. There was no order to change respiratory supplies. During an observation on 12/15/24 at 1:11 PM, nebulizer mask observed on bedside table. There was no order to change respiratory supplies. During an observation on 12/16/24 at 8:12 AM, nebulizer mask observed in a bag. There was no order to change respiratory supplies. During an observation on 12/16/24 at 3:44 PM, nebulizer mask is covered and there was no order to change respiratory supplies. During an interview on 12/16/24 at 3:45 PM Licensed Practical Nurse (LPN)1 stated that the nebulizer supplies are stored in bags and placed in drawer. LPN1 stated that they are usually changed weekly on Sunday. When asked if LPN1 saw an order in the chart to change supplies weekly in the computer, LPN1 stated I do not. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/24 at 3:57 PM, the Director of Nursing (DON) was asked when are nebulizer supplies changed. The DON stated that the respiratory supplies are changed weekly and as needed. When asked how a nurse knows to change the supplies, the DON stated there would be an order to alert the nurse. The DON was asked to look for the order and verbalized there was an order, however, the date of the ordered reflected it had been entered by LPN1 on 12/16/24 at 3:52 PM, after the interview with LPN1 on 12/16/24 at 3:45 PM.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25335 Based on review of the facility policy, record reviews, and interviews, the facility failed to ensure that a snack was sent to dialysis for 1 of 1 residents (R)107, reviewed for dialysis. Findings include: Review of the facility policy titled, Dialysis Care Pre and Post Dialysis revised 8/22/22 states Provide snack or meal as indicated to take with resident to dialysis. R107 was admitted to the facility on [DATE] with diagnoses including, but not limited to; end stage renal disease, dependence on renal dialysis and type 2 diabetes mellitus with hyperglycemia. On 12/16/24 at approximately 2:21 PM, a review of the EMR (electronic medical record) revealed that all Dialysis Center Communication forms state under the Long Term Care portion that no snack sent and under the Dialysis portion states no snack sent. On 12/16/24 at approximately 2:51 PM, during an interview, R107 stated, She gets dialysis at 5:30 AM on Monday, Wednesday, and Friday and has to leave before getting breakfast here in the facility. The facility staff does not send a snack with her, even though she has asked is told that ever since Covid, they do not sent snacks with dialysis residents. R107 stated, She frequently takes her own snack such as crackers or orders from Door Dash because she gets hungry. R107 stated her weight varies a lot because of her lymphedema and other than not getting the snack, she gets enough to eat from her personal supplies and feels that between her getting a supplement and once her wound heals that she will start gaining weight again. On 12/16/24 at approximately 3:37 PM the Director of Nursing (DON) when asked, stated if food of any kind is available for R107 to take to dialysis and she stated the Dialysis Center does not allow residents to eat at the Center. The DON acknowledged that R109 a physician order stating Snack sent with resident to dialysis to and the completed Dialysis Communication forms which documents no snack sent for both Long Term Care Center and for the Dialysis Center. When asked, stated the facility could prepare something for her to eat prior to leaving. On 12/17/24 at approximately 3:42 PM, the Dietary Manager stated snack bags for dialysis are made up and kept in the dietary refrigerator, but are not specific for any particular resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on observations, record review, interviews and facility policy, the facility failed to ensure medications were properly stored for Resident (R)82 for 1 of 9 residents reviewed for accident hazards. Findings include: Review of the facility's policy titled, Self-Administration of Medications by Patients/Residents with revised date 01/28/20 revealed, Policy Statement: Each patient/resident who desires to self-administer medication is permitted to do so if they healthcare center's Licensed Nurse and physician have determined that the practice would be safe for the patient/resident and other patients/residents of the healthcare center . Procedure: 1. The opportunity to self-administer medications is reviewed during the routine assessment by the healthcare center's interdisciplinary team utilizing the Electronic Health Record Observation tool, Medication Self-Administration Observation. 2. If the patient/resident or family member desires to self-administer medications, an assessment is conducted by the Licensed Nurse to assess the individual's cognitive, physical, and visual ability to carry out this responsibility. Also, the resident or family member should, in conjunction with the facility nurse, utilize the Electronic Medical Record Observation tool, Medication Self-Administration Observation to complete the administration of the medication. 3. If the Licensed nurse determines the patient/resident or family member to be capable of self-administration of medications, the attending physician must write an order to that effect that includes the specific medications based off the Self-Administration Medication Observation. Review of R82's Electronic Medical Record (EMR) revealed R82 was admitted to the facility on [DATE] with diagnoses including but not limited to: Glaucoma with increased episcleral venous pressure, gastro-esophageal reflux disease without esophagitis and personal history of other malignant neoplasm of stomach. Review of R82's Orders revealed no self-administration order to have medications at bedside. Review of R82's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 12/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R82's cognition is intact. During an observation on 12/15/24 at 10:45 AM observed a clear plastic medication cup on the overbed table with a total of 11 pills. Resident stated he was not aware they were there. R82 was asked to press the call light. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/15/24 at 10:48 am Licensed Practical Nurse (LPN)1 entered the room to answer call light and was asked what they saw on the overbed table that should not be in the room. LPN1 stated pills. When asked how this happened it was reported that it slipped their mind to administer the medication and was a little disorganized with the agency's presence for the annual survey. LPN1 reported that this was not normal to leave medications at the bedside, but the medication had been brought in then LPN1 went to check the medication cart to ensure it was locked. This is when LPN1 was pulled to another resident and forgot to come back. LPN1 reported that they normally worked on the long-term hall and this was the rehabilitation hall. During an interview on 12/15/24 at 11:25 AM, the Director of Nursing (DON) reported that their expectations for medication administration was that medication should not be left at the bedside and the resident should be watched until they have been consumed. The DON stated that this is for both pills and prescribed creams.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on review of facility policy, observations, and interviews, the facility failed to ensure foods stored in the main walk in refrigerator and freezer were labeled, dated and not expired. Additionally, the bin in the kitchen contained flour with the scoop in the flour. This failure could potentially affect 114 residents who consume foods from the kitchen. Findings include: Review of the facility policy titled, Food Ordering, Receiving, and Storage, with a revised date of [DATE], states, Date all stock items with a delivery date. There was no policy forthcoming regarding when to discard open items or freezer burnt foods. During an observation on [DATE] at 10:26 AM, the following items were observed in the walk in refrigerator and freezer and verified by the Certified Dietary Manager (CDM): A package of American cheese, there was no label and no open date. A bag of freezer mixed vegetables, there was no label and no open date. A bag of meat patties, in an open bag contained in an opened box that appeared freezer burnt. The CDM stated, It looks freezer burnt. An observation in the kitchen on [DATE] at approximately 10:45 AM revealed flour in a storage bin, with the scoop in the flour. The CDM stated, The scoop hangs above, it must have fallen in. An interview with the CDM on [DATE] at 8:18 AM revealed, Every Friday, I do a full walk through from the kitchen, observing labels, everything. On the weekends, it is the AM and PM cook that are supposed to check the dates. Once a week, I have someone assigned to the coolers, to ensure everything is up to par. During an interview with the Administrator on [DATE] at 8:45 AM, he stated, Typically, one of the first things I do is walk around, speak to everyone. They are making breakfast. I look at food storage for labels, etc. I heard about the expired items and no labels, they were all discarded. All foods should be labeled and dated so you know when to discard open food items.