STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425055	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jolley Acres Healthcare Center	1180 Wolfe Trail Orangeburg, SC 29115

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 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. 25335 Based on observation, interview, review of the facility policy and manufacturer labeling, the facility failed to ensure that medications were safely stored in 1 of 3 medication carts. Findings include: Review of the facility policy titled, General Guidelines for Medication Storage dated 6/21/2017 states Medications and biological's are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. On 9/18/24 at approximately 4:01 PM, inspection of the facility's treatment cart revealed one opened 100 ml (milliliter) bottle of Sterile 0.9% (percent) Normal Saline, USP (United States Pharmacopoeia) by Medline which was had been dated by the facility as opened on 9/18/24 and was approximately 90% full. During an interview on 9/18/24 at approximately 4:05 PM, Licensed Practical Nurse (LPN)2 read the manufacturer's label which states Contents sterile unless container is opened or damaged and the facility dating of the opened container and acknowledged that the contents were no longer sterile, since it had been opened and returned to the treatment cart.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 31846 Based on review of the facility policies, observations and interviews, the facility failed to follow proper infection control guidelines related to handling soiled clothes, and linens for transport in 3 of 3 soiled linen rooms. The facility further failed to ensure the proper handling of clean wet and dry linens, and the folding of clean linen in 1 of 1 main laundry room. Findings include: Review of the facility policy titled, Indications for Glove Use, states, The facility recognizes and implements Standard Precautions. The use of enhanced and transmission-based precautions is implemented as clinically indicated and recommended by health authorities. Procedures: Gloves are worn when: 3. Touching or having the potential to touch urine, stool or vomitus while providing care, treatment or services. 4. Handling items or environmental surfaces that are likely soiled with blood or body fluids, except sweat. 6. When staff has non-intact skin on the hands or wrist. Review of the facility policy titled, Hand Hygiene/Handwashing, revealed Hand Hygiene/Hand Washing is the most important component for preventing the spread of infection. Maintaining clean hands is important for patients/residents/visitors as well as staff. Procedures: A. After contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. C. After contact with a contaminated object or source where there is a concentration of microorganisms, such as mucous membranes, non-intact skin, body fluids, blood or wounds. Review of the facility policy titled, Laundry, states, Laundry services will comply with appropriate guidelines to assure that measures are implemented to provide pro effective laundry service. The procedures for personnel are, 5. Personnel in the laundry services are properly garbed at all times. When handling soiled linens, gowns, and gloves, at a minimum will be donned. These are removed as soon as possible after completing of duties involving soiled linens. Handwashing, Hands are washed after handling soiled linens even if gloves have been worn. At all times laundry service personnel are in compliance with the Facility Handwashing Policy. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All Linens, 1, Linens are to be handled in a safe manner to prevent contamination of the linen, the personnel and the environment. Clean linen is never held up against personnel's body. An observation on 09/19/2024 at 08:20 AM, revealed the laundry worker (LW) picking up soiled laundry from 3 shower rooms throughout the facility. The laundry worker went into the areas and took the lid off of bins and reached in with her bare hands and removed soiled clothes and soiled linens and placed them into a bin that she had brought into the soiled area. Some of the soiled clothes and linens were in bags and some were not. The LW continued the same practice in all three soiled areas. She brought the bin back to the laundry room and washed her hands and put on gloves and a gown and removed the lid from the bin of soiled linens and clothes and started to sort them into individual bins. The LW then removed the gown and gloves and opened the clothes dryer to remove dry linens to be folded. When she opened the dryer door, a washcloth fell to the floor and she picked it up and put it into a basket with other clean clothes to be folded. The LW then went to the washer and opened it, the clothes were ready for the dryer. Another washcloth fell to the floor, and as she was holding most of the clean wet clothes up against her uniform, she stepped on it, then picked it up and placed it with the clean wet clothes, she was putting in the dryer. The LW then turned on the dryer. She then put on a gown and gloves and pushed the bin of soiled clothes to the washer and placed them in the washer and turned it on. She then removed the gown and the gloves, washed her hands and started folding the clean basket of clothes. The sheets and bedspreads were observed touching the floor and the clothes she was wearing, while she was attempting to fold them. During an interview on 09/19/2024 at 08:45 AM with the LW, this surveyor informed the laundry worker of the following concerns. 1. Using bare hands to pull soiled clothes and linens from a bin in the 3 shower rooms. She had also failed to wash her hands after placing them in the bin. The LW confirmed that she had picked up the soiled clothes and linens without wearing gloves and a gown and did not wash her hands until she returned to the laundry room. 2. The laundry worker confirmed that she had picked up the clean washcloth from the floor and placed it with the clean linens to be folded and used for residents. 3. She also confirmed that the wet washcloth she had stepped on, she had picked it up and then placed in the clothes dryer with clean wet linens. She stated, I thought the dryer would get hot enough to kill any germs on it. 4. Lastly, the LW confirmed that the sheets and bedspreads had touched her uniform and had touched the floor during the folding process.