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	09/04/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on review of facility policy, observation, record review and interview, the facility failed to ensure a medication administration pass rate of less than 5% (percent), for 2 of 25 medications observed during medication pass administration. The medication error rate was 8% based on 2 medications not being administered at the correct time to Resident (R)21.Findings include:Review of the facility policy titled Medication Management Program revised on 01/15/25 revealed, Authorized staff must understand: .The 8 Rights for administering medication: . 4) the Right Time .On 09/03/25 at approximately 8:28 AM during medication pass observation, Licensed Practical Nurse (LPN)1 administered one tablet each of Lorazepam 0.5 mg (milligram), Tramadol 50 mg, Multivitamin, Docusate 100 mg, Meloxicam 7.5 mg and Bupropion 100 mg to R21 and stated she would have to pull Gabapentin 100 mg from the PYXIS (automated dispensing machine) since none was in the cart. Gabapentin 100 mg was administered to R21 approximately 10 minutes later.On 09/03/25 at approximately 8:50 AM during medication reconciliation, a review of the September 2025 physician orders and MAR (medication administration record) for R21 revealed the following orders: bupropion tablet 100 mg Administer three times a day at 6:00 AM, 2:00 AM, 10:00 AM and gabapentin 100 mg; administer 100 mg three times a day at 6:00 AM, 2:00 PM, 10:00 PM.During an interview on 09/03/25 at approximately 9:10 AM, LPN1 stated she administered bupropion 100 mg with the other meds around 8:30 AM, and after removing gabapentin 100 mg from the PYXIS machine, she had administered gabapentin 100 mg shortly thereafter. LPN1 was unable to verify the electronic medical record showing the times these two medications were scheduled and did confirm again that she had given the bupropion 100 mg and gabapentin 100 mg.On 09/03/25 at approximately 9:14 AM, the Director of Nursing (DON) was asked to provide a hard copy of R21's MAR and physician orders for 09/03/25.On 09/03/25 at approximately 10:12 AM, the DON provided copies of the MAR and physician order and stated that both bupropion 100 mg and gabapentin 100 mg should not have been administered by LPN1 during medication pass around 8:30 AM, since both medications had been administered according to schedule on 09/03/25 at 6:00 AM by the night shift nurse.

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