STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425061	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Musc Health Chester Nursing Center	1 Medical Park Drive Chester, SC 29706

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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 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** 28306 Based on record review and staff interview, the facility failed to ensure each Medicare resident and/or resident representative (RP) whose Medicare therapy services were terminated received a copy of form Centers for Medicare and Medicaid Services (CMS) 10123 Notice of Medicare Non-Coverage (NOMNC) and CMS -10055 Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) for two of three residents (Resident (R) 48, and R42) reviewed for beneficiary notices out of a total sample of 13 residents. This failure in not providing a copy of CMS 10055 and CMS form 10123 to the resident and/or resident representative could potentially impinge on the resident being able bill Medicare in appealing the non-covered services correctly and receive the Medicare Services Notice (MSN) for further instructions in the appeal process. Findings include: The facility's policy on beneficiary notices was requested but were not received prior to the exit conference on 04/11/24. 1. Review of R48's Face Sheet that was provided by the facility revealed on 08/08/23, R48 was admitted for rehabilitation and remained in the facility for long term care (LTC). R48's last covered day (LCD) of Medicare Part A services was 11/18/23. Review of the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) completed by the facility revealed R48 had a facility-initiated discharge from Medicare Part A services. The facility indicated R48 was provided with SNF ABN, Form CMS-10055 and NOMNC, Form CMS 10123. Review of R48's Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), provided by the facility, revealed the following options: Option 1. I want the care listed above. I want Medicare to be billed for an official decision on payment which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I will be responsible for paying, but I can appeal to Medicare by following the directions on the MSN. Option 2. I want the care listed above, but do not bill Medicare, I understand that I may be billed now because I am responsible for the payment of the care. I cannot appeal because Medicare won't be billed. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Option 3. I don't want the care listed above. I understand that I am not responsible for paying, and I can't appeal to see if Medicare would pay. Review of the SNF ABN revealed the Business Office (BO) 1 documented verbal consent was obtained from R48's family member ((F)2). None of the three above options were selected. Review of R48's NONMC, provided by the facility, was not signed by F2 or R48. During an interview on 04/11/24 at 9:16 AM, the Business Office (BO) 1 stated, I mailed them a copy, but I do not have documentation to say that this was done. I forgot to mark the option that R48'2 RP [resident representative] decided to go with. The BO said she got confirmation over the phone, however did not have any documentation. During an interview on 04/11/24 at 9:22 AM, the Administrator confirmed the areas on R48 NOMNC where the options were not marked needed to have been marked. The Administrator confirmed the verbal consents obtained for the NOMNC's should be documented on how the RP received copies of what was consented to over the phone. During a phone interview on 04/11/24 at 10:57 AM, F2 stated they had not spoken to BO1 about this. F2 stated, I would have remembered it because if we had to pay for it, then we would have told her that we could not afford it. I didn't get any paperwork on this either. 2. Review of R42's face sheet that was provided by the facility revealed R42 was admitted to the facility on [DATE]. Medicare Part A skilled services episode had a start date of 02/26/24 with the last covered date (LCD) on 03/15/24. R42 remained in the facility. Review of the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) completed by the facility revealed R48 had a facility-initiated discharge from Medicare Part A services. The facility indicated R48 was provided with SNF ABN, Form CMS-10055 and NOMNC, form CMS 10123. During an interview on 04/11/24 at 9:16 AM, BO1 stated, I mailed them a copy, but I do not have documentation to say that this was done. BO1 did not have copies of R42's SNF ABN or NOMNC. During an interview on 04/11/24 at 9:22 AM, the Administrator confirmed there was no documentation of the NOMNC or SNF ABN for R42. During a phone interview on 04/11/24 at 10:40 AM, F1, resident representative for R42, stated, I haven't received anything regarding this. Plus, I do not understand anything about what you are talking about. I don't remember any [BO1] calling me about [R42]. When asked if F1 had received paperwork explaining the termination of these services, F1 replied I haven't received anything talking about this.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on review of the facility policies, record reviews, and interviews, the facility failed to update and revise the code status on comprehensive care plans for two residents of 13 sampled residents (Resident (R) 14 and R22). Findings include: Review of the facility's policy MDS [Minimum Data Set] Comprehensive Care Plan, revised on [DATE] indicated . The Care Plan will reflect the current and best practice standards to provide care . The Care Plan will be revised on an on-going basis to reflect changes in the Resident and the services the Resident is receiving . Review of the facility's policy titled, "MDS Comprehensive Care Plan" revised [DATE] stated, ".The Care Plan will be revised on an on-going basis to reflect changes in the Resident and the services the Resident is receiving ." 1. Review of R14's "Face Sheet," provided by the facility, indicated R14 was admitted to the facility on [DATE]. Review of R14's "Care Plan," dated [DATE] and provided by the facility, indicated R14's code status was full code, indicating if the resident's heart stopped beating and/or stopped breathing, all resuscitation procedures (including cardiopulmonary resuscitation (CPR), chest compressions, intubation, and defibrillation) would be provided to keep them alive. Review of R14's quarterly MDS with an Assessment Reference Date (ARD) of [DATE], included a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating she was moderately cognitively impaired. Review of R14's "Physician Orders," provided by the facility and dated [DATE], included, "Allow natural death: do not provide resuscitative measures: (continue appropriate medical treatment). Review of R14's "Emergency Medical Services Do Not Resuscitate Order (DNR)" dated [DATE] and signed by R14 included ". no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest ." During an interview on [DATE] at 2:35 PM, R14 confirmed her code status was DNR. During an interview on [DATE] at 6:37 PM, MDS Coordinator (MDSC) confirmed R14's care plan indicated the resident's code status was full code, however, her physician order and signed advance directive stated DNR. MDSC stated she was probably not notified of the code status. Additionally, the Unit Managers and Social Workers perform monthly audits of code status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 6:37 PM, the Unit Manager (UM) confirmed that R14's care plan indicated R14 was full code, however, her physician order and signed Emergency Services DNR was DNR. Additionally, the UM stated that when a resident went out to the hospital they automatically returned as a full code and maybe that was why her care plan was not changed back to DNR status. The UM confirmed the status should have been updated to DNR after return from the hospital on [DATE]. During an interview on [DATE] at 9:19 AM, the Director of Nursing (DON) stated that normally the MDSC ran a report every morning, with weekly audits for code status, to verify physician orders match the advance directive on file. The DON stated they recently noticed that when residents had a leave of absence, the code status automatically fell off the order and was entered as full code. The DON stated R14 had a leave of absence to the hospital from [DATE]-[DATE] and maybe her status was not updated on her care plan but should have been. 28306 2. Review of R22's Face Sheet provided by the facility indicated R22 was admitted to the facility on [DATE]. Review of the R22's quarterly MDS with an ARD of [DATE] revealed the resident had a BIMS score of 15 out of 15, which indicated R22 was cognitively intact. Review of R22's care plan, provided by the facility, revealed a problem listed for Advance Care Directives revealed a description which stated, [R22] is a Full Code. Review of R22's active physician orders, provided by the facility revealed an order dated [DATE] which indicated, Allow Natural Death: Do Not [sic] provide resuscitative measures. During an interview on [DATE] at 6:00 PM, MDSC confirmed that code status was incorrect on the care plan which had the resident listed as full code. During an interview on [DATE] at 4:25 PM, the DON stated, We found out that the person that was doing the audits on advance directives was not including the person that updated the care plans.

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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** 28306 Based on observation, interview, and record review, the facility failed to ensure dependent residents received showers/baths including the washing of hair for one of one resident reviewed for activities of daily living (ADLs), (Resident (R) 46) out of a total sample of 13. R46 was observed with uncombed and greasy hair; and facility documentation of showers/baths was incomplete. Findings include: Review of the facility's policy titled Residents (sic) Activity of Daily Living revealed Ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and Ensuring (sic) that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs . Showers/baths will be offered to residents twice a week. Bed baths will be performed between shower days upon resident request . The policy also had Documentation and Patient management but there was no documentation noted under this heading in the facility's policy. An observation was made on 04/08/24 at 11:30 AM. R46's hair had the appearance of being uncombed and greasy. R46 stated, It doesn't feel good. Review of R46's Face Sheet, provided by the facility, revealed R46 was admitted on [DATE] with diagnoses including history of cerebral vascular accident (stroke) and generalized weakness. Review of R46's quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 02/08/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R46 was cognitively intact. R46 was also coded for shower/bathe self and personal hygiene as requiring substantial/maximal assistance with the helper performing more than half of the effort. Review of R46's care plan, dated 08/11/23 and provided by the facility, revealed Problem: ADLs with the Description as indicating [R46] has an ADL self-care performance deficit r/t [related to] hx [history] of CVA [cerebral vascular accident] and generalized weakness. [R46] required maximum assistance of one staff member to provide baths/showers as scheduled and as necessary. [R46] also required moderate to maximum assistance of one staff member for personal care and oral care. Review of R46's documentation of ADLs on the Flowsheet located in the EMR revealed beginning on 03/15/24 through 03/18/24, and 03/20/24 through 03/31/24, there were no showers and/or baths documented on the ADL Flowsheet, baths/showers were scheduled twice a week and as needed. Review of R46's documentation of ADLs under the GG tab in the EMR revealed no documentation for showers and/or baths documented for these dates. During an interview on 04/11/24 at 3:00 PM, Unit Manager (UM) confirmed there was no documentation in the EMR for baths and/or showers on the above documented dates. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/11/24 at 4:00 PM, the Director of Nursing (DON) stated, On 03/15/24, we began charting these [baths and showers] in a different way using 'GG' instead of the 'ADL' flowsheet. When the CNAs [certified nursing assistants] documented, it looks like they misunderstood how to answer the questions for bathing. The administrator stated, We didn't know there was a problem until you started asking for the documentation of the ADLs for bathing for this resident. The DON confirmed there was missing documentation for the above dates for bathing/showers in R46's EMR.

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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** 28306 Based on record review and facility staff review, the facility failed to initiate a physician order for an indwelling urinary catheter change for one of one resident reviewed (Resident (R) 46) for catheters out of 13 sampled residents. This failure could have resulted in R46's indwelling urinary catheter not being changed every four weeks as per the urologist's recommendation. Findings include: Review of R46's Face Sheet, provided by the facility revealed R46 was admitted on [DATE] with diagnosis of obstructive uropathy (urinary tract disorder that occurs when urine cannot drain through the tract). Review of R46's quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 02/08/24, revealed the resident had an indwelling urinary catheter. Review of the after visit note from R46's urologist appointment, dated 03/21/24 and provided by the facility, revealed R46's indwelling urinary catheter was to be changed every four weeks. Review of R46's care plan, dated 01/19/24 and provided by the facility, revealed the resident had an indwelling catheter with interventions of . Nursing staff to change Foley [type of indwelling urinary catheter] catheter and urinary bag as needed . Review of R46's physician orders, provided by the facility, revealed an order dated 03/25/24 which stated, Change Foley bag every month. And on 03/26/24, there was another physician order which stated, Change Foley Catheter PRN (as needed). There was not an order to change R46's catheter every four weeks, per the urologist's recommendation. During an interview on 04/10/24 at 6:12 PM, unit manager (UM) stated, I called Dr. [name of physician] on 03/20/24 and she gave me an order to change the Foley [catheter] at that time due to having problems with the existing Foley. When doing that, I forgot to write the order for the Foley [catheter] to be changed every four weeks. UM confirmed there should have been an order to change the Foley catheter every four weeks and there was not one written. During an interview on 04/11/24 at 4:02 PM, the Director of Nursing (DON) stated, There was an order for the Foley catheter to be changed prn [as needed] but there was not an order to have the catheter changed every four weeks.

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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** 40824 Based on observation, interview, record review, and policy review, the facility failed to remove loose pills from one of three medication carts and failed to return discontinued medications to the pharmacy for two residents (Resident (R) 13 and R42). Findings include: Review of facility's policy titled "Medication Storage" revised 02/02/24 stated, ". The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Drugs and biologicals shall be stored in the packaging, containers [sic] or other dispensing systems in which they are received . The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. Such drugs shall be returned to the dispensing pharmacy or destroyed . Medications will be discarded according to policy ." Review of facility's policy titled "Disposal of Medications and Medication-Related Supplies" dated October 2018 stated, "When medications are discontinued by the prescriber or the resident is discharged and medications are not sent with the resident, the medications are marked as discontinued and stored in a secure and separate area from the active supply, marked 'discontinued' and securely stored until destroyed . Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (such as unit-dose packages or sealed containers) may be returned to the pharmacy in accordance with the Medication Return policy . Discontinued medications not returned to the pharmacy are destroyed in accordance with the Medication Destruction policy ." Review of R13's "Face Sheet" provided by the facility indicated she was admitted to the facility on [DATE]. Review of R13's quarterly Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 02/07/24 indicated she had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating she was cognitively intact. Additionally, she had a diagnosis of depression. Review of R13's "Medication Orders" provided by the facility indicated sertraline (antidepressant medication) 25 milligram (mg) tablets were ordered 11/07/22 and discontinued 12/14/23. Review of R42's "Face Sheet" provided by the facility indicated she was admitted to the facility on [DATE]. Review of R42's quarterly MDS with an ARD of 02/09/24, indicated she had a BIMS score of 11 out of 15 indicating she was cognitively intact. Additionally, she had a diagnosis of manic depression. Review of R42's "Medication Orders" provided by the facility indicated citalopram (antidepressant medication) 10 mg tablets were ordered 09/07/23 and discontinued 02/26/24. (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 observation and interview on 04/10/24 at 9:48 AM revealed a medication cart for Hall One, in use by Licensed Practical Nurse (LPN)1, had one loose white tablet and one loose capsule in the medication cart. LPN1 confirmed loose medications were located in the cart and should have been removed. Additionally, R13 had eight discontinued sertraline hydrochloride (HCl) 25 mg tablets in the bottom drawer of the cart dispensed on 11/27/23. LPN1 confirmed sertraline HCl was discontinued on 12/14/23. R42 had six discontinued citalopram 10 mg tablets in the bottom drawer of the cart dispensed on 01/31/24. LPN1 confirmed citalopram 10 mg was discontinued on 02/26/24. LPN1 confirmed that discontinued medications should have been returned to the pharmacy. LPN1 stated that usually the night nurses log the medications to be returned to the pharmacy and place them in a box in the medication storage room. During an interview on 04/11/24 at 9:01 AM, the Unit Manager (UM) stated that when a medication was discontinued by the Nurse Practitioner or Medical Doctor, the nurse receiving the order entered the order in the EMR and should remove the medication immediately. The UM stated, typically, the night shift nurses remove all discontinued medications and place the medications in the medication room, write the medication on the medication reconciliation form and then send the discontinued medications back to the pharmacy. The UM stated her expectation was for the discontinued medications to be removed from the cart and verified that all nurses were trained in this process. The UM confirmed that R13's sertraline was started on 11/07/22 and discontinued 12/14/23. The UM confirmed that R42's citalopram was started on 09/07/23 and discontinued on 02/26/24. During an interview on 04/11/24 at 9:53 AM, the Director of Nursing (DON) stated she was made aware yesterday of the two loose pills and of discontinued medications for R13 and R42. Every nurse was trained to remove medications from the cart when they were discontinued. The DON stated there was a box in the medication room where the nurses should put the discontinued medications; the pharmacy then picks up any non-narcotic medications to be returned. The DON stated her expectation was for the nurses to follow facility policies.