STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425070	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myrtle Beach Manor	9547 Highway 17, North Myrtle Beach, SC 29572

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 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. Based on facility policy review, record review, observation, and interview, the facility failed to ensure oxygen was administered at the ordered flow rate for 1 (Resident (R)61) of 2 residents reviewed for respiratory care. Findings include:Review of an undated facility policy titled Oxygen Administration indicated, This facility is dedicated to ensuring safe, effective, and appropriate oxygen administration for residents requiring supplemental oxygen therapy. Oxygen will be administered based on individual resident needs, physician orders, and established clinical guidelines to improve oxygenation and support respiratory function. The policy revealed, General Guidelines included 9. Administer oxygen at prescribed flow rates according to provider order.Review of R61's admission Record revealed the facility admitted R61 on 09/26/25. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of syncope (fainting) and collapse, chronic obstructive pulmonary disease (COPD), and unspecified chronic respiratory failure.Review of R61's Care Plan Report revealed a focused area initiated on 09/26/25 that indicated the resident had the potential and/or actual altered respiratory pattern due to an inability to maintain an effective airway clearance. Interventions directed staff to provide treatments as ordered.Review of R61's September 2025 Order Summary Report with active orders as of 09/29/25 revealed an order, dated 09/26/25, for oxygen to be provided at 3 liters per minute (L/min) via nasal cannula every day and night shift. During an observation on 09/29/25 at 11:36 AM, Certified Nursing Assistant (CNA)4 assisted R61 back to their room in their wheelchair. CNA4 picked up the resident's oxygen cannula off the floor and put it on the resident. The oxygen concentrator was set at 2 L/min.During an observation on 09/30/25 at 11:37 AM, it was revealed R61 was lying on their bed with their oxygen concentrator set at 2.5 L/min.During an interview and subsequent observation on 09/30/25 at 12:06 PM, Registered Nurse (RN)6 stated R61's oxygen should be set at 3 L/min. RN6 then looked at the oxygen concentrator's reading and stated that it was between 2.5 and 3 L/min but should be on 3 L/min since that was what the current order was.During an interview on 10/01/25 at 9:01 AM, the Director of Nursing (DON) stated that the nurses were to make sure residents' supplemental oxygen was administered per orders and were to check the setting against the order to ensure it was administered at the ordered flow rate. She stated that if the flow rate was ordered to be administered at 3 L/min, then it should be administered at 3 L/min, not 2 or 2.5 L/min.During an interview on 10/01/25 at 12:33 PM, the Executive Director (ED) stated that she expected supplemental oxygen to be administered at the correct setting.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425070	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myrtle Beach Manor	9547 Highway 17, North Myrtle Beach, SC 29572

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425070	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myrtle Beach Manor	9547 Highway 17, North Myrtle Beach, SC 29572

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy and procedure review, a review of the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precaution (EBP) signage, record review, observation, and interview, the facility failed to provide care in accordance with infection control standards for 1 (Resident (R)5) of 2 residents reviewed for EBP. Specifically, the staff failed to wear the required personal protective equipment (PPE) when providing care to R5. The facility also failed to properly store oxygen tubing and replace it when it was contaminated, which affected 1 (Resident (R)61) of 2 residents reviewed for respiratory care.Findings include:1. Review of an undated facility policy titled Enhanced Barrier Precautions revealed, It is the policy of this facility that Enhanced Barrier Precautions in conjunction with standard precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO, or residents with 'infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply.' The policy also indicated, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer or MDROs to staff hands and clothing. The policy also indicated, High-Contact Resident Care activities include, which included Dressing; Bathing/showering; Transferring (except with transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter induration); Providing hygiene; Changing linens; Changing briefs or assisting with toileting; Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; Wound care: any skin opening requirement [sic] a dressing other than as noted above; and Working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. The policy also indicated, Procedure included 3. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities; which included a. Dressing,; b. Bathing/showering; c. Transferring; d. Providing hygiene; e. Changing linens; f. Changing briefs or assisting with toileting; g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; h. Wound care: any skin opening requiring a dressing. Review of the CDC's undated ENHANCED BARRIER PRECAUTIONS signage revealed EVERYONE MUST: Clean their hands, including before entering and when leaving the room. The signage revealed, PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities, which included Dressing; Bathing/Showering; Transferring; Changing Linens; Providing Hygiene; Changing briefs or assisting with toileting; Device care or use, which included central line, urinary catheter, feeding tube, tracheostomy; and Wound Care: any skin openings requiring a dressing.Review of R5's admission Record revealed the facility admitted R5 on 02/01/25. According to the admission Record, R5 had a medical history that included but was not limited to diagnosis of extended spectrum beta lactamase (ESBL) resistance.Review of R5's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/28/25, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident had severe cognitive impairment. The MDS indicated R5 was dependent on staff for toileting hygiene and was always incontinent of bowel and bladder. The MDS indicated R5 had an MDRO. Review of R5's Care Plan Report included a focus area revised on 08/29/25 that indicated the resident was at risk for complications related to incontinence. The focus area indicated that as of 08/26/25, the resident had chronic long-term antibiotics for suppression of urinary tract infection (UTI)/ESBL (colonized). Interventions directed staff to check the resident every two hours and as required for incontinence (initiated 02/24/25) and to follow enhanced EBP when providing care per the CDC guidelines due to a drug-resistant organism (initiated 05/19/25).Review of R5's Order Summary Report, with active orders as of 09/29/25, contained an order, dated 08/21/25, for EBP to be used when providing care to the resident per CDC guidelines, every shift.During an observation on 09/29/25 at 12:02 PM revealed that outside R5's room, there was a CDC sign posted next to the door that indicated the resident required EBP. During an observation on 09/29/25 at 12:17 PM revealed Certified Nursing Assistant (CNA)2 and CNA3 walked into R5's room and shut the door. The CNAs did not put on PPE prior to entering the room. CNA2 exited R5's room at 12:22 PM with a clear bag that contained white linen items. During an interview at 12:22