STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425100	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure one resident (Resident (R) 108) of one resident out of a sample of 30 residents was given the opportunity to make choices regarding being able to utilize regular plates and utensils instead of Styrofoam containers and plastic utensils during a COVID-19 outbreak on the unit. This failure placed the resident for a diminished quality of life. Findings include: Review of the facility's policy titled, Resident Self-Determination and Participation, dated February 2021, revealed Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life . Review of an undated facility's policy titled, Isolation Precautions, dated December 2020, revealed .Dishes, Glasses, Cups, and Eating Utensils .No special precautions are needed for dishes, glasses, cups, or eating utensils .Reusable dishes and utensils are used for patients/residents on isolation . Review of the Face Sheet located in the Admission tab of the electronic medical record (EMR) revealed R108 was admitted to the facility on [DATE] and had diagnoses which included irregular heart rhythm, diabetes, and chronic kidney disease. Review of the admission Minimum Data Set (MDS) located in MDS tab of the EMR with and Assessment Reference Date (ARD) of 05/27/24 revealed R108 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated she was cognitively intact. During an observation and interview on 09/02/24 at 11:45 AM, R108 was observed with a meal tray in front of her on the over bed table. The tray consisted of a Styrofoam container, plastic utensils, and paper cups. R108 stated, Lately, we have been getting plastic silverware and paper plates at each meal. I don't have COVID, like others on my hall. I would prefer to have regular silverware and plates. (continued on next page)

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: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation and interview on 09/03/24 at 2:10 PM, Certified Nurse Aide (CNA)1 was observed picking up trays from resident rooms on the Damascus unit. When asked why all the trays contained Styrofoam containers and plastic utensils, CNA1 stated, They tell me if one person is on isolation, then all of the residents get Styrofoam. During an interview on 09/03/24 at 2:34 PM, the Registered Dietician (RD) was asked about the Styrofoam containers on the Damascus unit. The RD stated, I know that was a DON [Director of Nursing] and Administrator decision that was made. I think they go off the Lutheran policy. That is my understanding. During an interview on 09/03/24 at 4:58 PM, with the Administrator and the [NAME] President of Clinical Operations (VP) regarding residents right to have their preferences honored. The VP stated that was very important. They were asked about the usage of the Styrofoam containers and plastic utensils on the Damascus unit. The VP stated, Because it (Covid) has involved the unit, everybody will get Styrofoam and plastic utensils. The VP was asked if residents, who are not affected by Covid or in isolation, would require Styrofoam containers and plastic utensils. The VP stated, I did not know that she had expressed desire to have the regular plates and utensils, but it has been our process to use Styrofoam. During an interview on 09/03/24 at 5:18 PM, the DON stated that the policy from Lutheran was when most of the residents had Covid, then all the residents on the unit were given Styrofoam and plastic utensils.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 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** 32513 Based on interview, record review, and review of facility policy, the facility failed to ensure one of one resident (Resident (R) 95) reviewed for care planning of 30 sample residents was afforded the right to participate in his care planning process. This failure placed the resident at risk of not being aware of the goals and outcomes of his care. Findings include: Review of facility policy titled, Care Planning-Interdisciplinary Team, dated September 2013, revealed .Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident .The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan .Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family . Review of the Face Sheet located in the Admissions tab of the electronic medical record (EMR) revealed R95 was admitted to the facility on [DATE] with diagnoses which included osteoarthritis and major depressive disorder. Review of the significant change Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 07/09/24 revealed R95 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated he was cognitively intact for daily decision-making. Review of the Care Plan Documentation located in the Care Plan tab of the EMR revealed the last Care Plan Meeting was on 01/13/22. During an interview on 09/02/24 at 2:12 PM, R95 was asked if he attends his Care Planning Meetings. R95 stated, I don't know anything about them. During an interview on 09/03/24 at 4:36 PM, the Social Services Director (SSD) was asked if he was responsible for the Care Plan Meetings. The SSD stated, Yes. The SSD was asked how often the Care Plan Meetings were held. He stated, For long-term care residents, it's every 90 days. The SSD was asked if R95 had a Care Plan Meeting in the last 90 days. He stated, We did review with him on 07/18/24, but I did not do a full 'Care Plan Meeting.' The SSD was asked if there was documentation related to this meeting. He stated, I cannot find the documentation. The SSD confirmed that when the Care Plan Meetings were held with the resident and/or representative, the meeting was to be documented in the EMR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, record review, staff interview and policy review, the facility failed to ensure that a resident was assessed for self-administration of medications prior to medications being left at the bedside for one of 30 sampled residents (Resident (R)114). This failure had the potential for the resident to over medicate themselves or medications being accessed by other residents. Findings include: Review of R114's Face Sheet located under the Resident Info tab in the electronic medical record (EMR) revealed R114 was readmitted to the facility on [DATE] with the diagnosis of dementia, congestive heart failure and asthma. Review of R114's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/05/24 and located under the MDS tab in the EMR revealed R114 was coded as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which represented R114 was cognitively intact. Review of R114's Physician Orders located under the Orders tab in the EMR revealed an order dated 10/05/23 for Breyna 80 mcg (micrograms)-4.5 mcg/actuation HFA aerosol inhaler two puffs twice a day. There was an order dated 07/12/24 for medication clotrimazole-betamethasone 1%-0.05% topical cream apply as needed twice a day for 14 days. Neither of the medications were ordered to be kept at the bedside of R114. During an observation on 09/02/24 at 1:06 PM revealed R114 had an inhaler (Breyna) and one tube of clotrimazole-betamethasone cream lying on the resident's bed. R114 stated she uses the cream for itching on the neck area and the inhaler if she gets short of breath. During an observation and interview with Licensed Practical Nurse (LPN)7 on 09/03/24 at 11:14 AM, revealed R114 had a tube of the clotrimazole-betamethasone cream but could not find the inhaler. LPN7 confirmed that R114 was not to have the medication at the bedside. LPN7 stated, I found the inhaler this morning when I was giving medications to R114. I took it and placed it back in the medication cart because R114 wasn't supposed to have that either. LPN7 also confirmed the resident had not been assessed to self-administer these medications and there was no order for these medications to be left at the bedside. During an interview on 09/03/24 at 3:24 PM, the Director of Nursing (DON) confirmed R114 had not been assessed for self-administration of the inhaler and cream found by the bedside of R114 on 09/02/24. Review of the facility policy Self-Administration of Medications dated 02/21 stated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 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** 32513 Based on interview and record review, the facility failed to ensure the CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) was accurate and complete prior to discharge from Medicare part A skilled services for two of three residents (Resident (R) 40 and R120) reviewed for SNF Beneficiary Protection of 30 sample residents. This failure placed the residents and/or representatives at risk of not being fully informed. Findings include: 1.Review of the Face Sheet located in the Admissions tab of the electronic medical record (EMR) revealed R40 was admitted to the facility on [DATE] with a diagnosis of Parkinson's disease (a neurological disease). Review of the ABN notice provided to the resident representative indicated that R40 no longer required skilled care effective 03/16/24. Review of Section D of the ABN revealed, In patient stay at this facility .The patient no longer requires skill level nursing care. Medicare will not pay for your stay at this time unless skills care is needed .Estimated Cost: Private Pay. Review of Section G of the ABN Options revealed: Option 1: I want the D. Skill Care listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. Option 2: I want the D. Skill Care listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. Option 3: I don't want the D. Skill Care listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay. Section G was left blank, and no options were marked, as required. 2. Review of the Face Sheet located in the Admissions tab of the EMR revealed R120 was admitted to the facility on [DATE] with a diagnosis of dementia. Review of the ABN notice provided to the resident representative indicated R120 no longer required skilled level of care effective 06/07/24. Review of Section D of the ABN revealed, In patient stay at this facility .The patient no longer requires skill level nursing care. Medicare will not pay for your stay at this time unless skills care is needed .Estimated Cost: Medicaid Pending. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Section G of the ABN Options revealed: Option 1: I want the D. Skill Care listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. Option 2: I want the D. Skill Care listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. Option 3: I don't want the D. Skill Care listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay. Section G was left blank, and no options were marked, as required. During an interview on 09/03/24 at 9:20 AM, the Social Services Director (SSD) was asked why the estimated cost per day was not documented on the ABN. The SSD stated, I wasn't aware that the cost per day needed to be in the box. The SSD was asked why the Options box was not checked. He stated, The options box should have been checked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on interview, record review, and policy review, the facility failed to ensure Care Plans for behavioral symptoms were developed for three (Residents (R)115, R120, and R25) of 30 sampled residents reviewed for care plans. This failure could cause unmet care needs for the residents. Findings include: Review of the facility policy titled Care Plans, Comprehensive person-Centered revised 12/26, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 2. The care plan interventions are derived from a thorough analysis of the information gathered as part other comprehensive assessment . 8. The comprehensive, person-centered care plan will: . b. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 10. identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process . 11. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. 1. Review of R115's quarterly MDS with an ARD date of 06/12/24, located in the MDS tab of the EMR, revealed an admitted [DATE]. R115 had a BIMS score of 13 out of 15 indicating R115's cognition was intact. R115 had diagnoses diabetes mellitus, depression, and heart failure, and no behaviors exhibited. Review of R115's Clinical Notes dated 07/23/24, located in the EMR under the Note tab revealed .Res yelling out most of 2nd and 3rd shift. Repetitively asks for remote to tv or bed even when she's holding them. Often states she doesn't know why she's calling out or that she's forgotten. Several alert and oriented residents have made complaints of res disruptive behavior stating at night she keeps them awake . Review of R115's Orders located in the EMR under the Order tab revealed Lorazepam 0.5 mg tablet (1 tablet) Tablet Oral for unspecified dementia, severe, with anxiety, dated 08/03/24 and sertraline 100 mg tablet (I tab) tablet oral, for depression, unspecified, dated 08/20/24. Review of R115's Clinical Notes dated 08/11/24, located in the EMR under the Note tab revealed Resident was up out of bed this shift and ate lunch in unit dining room and is showing s/s [signs/symptoms] of anxiety of yelling out so much residents and families of residents were complaining. So resident was then sitting at nurses station and continued to yell out hello over and over. When not talking to resident she is constantly yelling out hello, denies any pain. Review of R115's Clinical Notes dated 08/17/24, located in the EMR under the Note tab revealed Rsd [Resident] continuously yelling out, Lorazepam 0.5 mg given at 1:20 AM, seemed to be effective about 30 min after given. rsd started yelling again around 2:30 [NAME] has continued to do so through remainder of night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review R115's Care Plan located in the EMR under the Care Plan tab revealed there was no evidence the resident had a Care Plan for managing behavioral symptoms of yelling continuously. During an interview on 09/03/24 at 3:20 PM, Licensed Practical Nurse (LPN)4, LPN4 stated R115 had been exhibiting behaviors of yelling out continuously for about one month. LPN4 stated R115 is given PRN (as needed) Ativan. LPN4 stated R115's yelling was due to her constant desire for companionship. LPN4 stated when R115 is up, out of bed, she doesn't scream or when staff is with her, she doesn't scream. 2. Review of R120's admission MDS with an ARD date of 05/27/24, located in the MDS tab of the EMR, revealed an admitted [DATE]. R120 had a BIMS score of six out of 15 indicating R120's cognition was severely impaired. R120 had diagnoses of dementia, chronic kidney disease, unspecified protein-calorie malnutrition, and macular degeneration and no behaviors exhibited. Review of R120's Care Plan dated 05/15/24 to present, located in the EMR under the Care Plan tab revealed Potential for negative side effects from the use of psychotropic medication(s) risperidone and escitalopram. The goal included R120 will have no negative side effects from medications through next review period. An intervention included Observe for signs of depression, mood and behavior changes such as poor appetite, weight loss or excessive weight gain, loss in social interests. No care plan was found addressing R120's behaviors that caused her to be prescribed psychotropic medication. Review of R120's orders, located in the EMR under the Order tab revealed escitalopram 10 mg tablet (1 tablet) Tablet Oral, every one day, for anxiety disorder, unspecified, dated 05/21/24 and risperidone 1 mg disintegrating tablet 1 mg (1 tablet) Tablet, disintegration Oral for restlessness and agitation, dated 05/22/24. Review of R120's August 2024 and September 2024 Medication Administration record (MAR) located in the EMR under the Order tab revealed No Behaviors Noted. Review of R120's clinical notes, dated 05/10/24 to 09/04/24, located in the EMR under the Note tab revealed no documentation of behavioral symptoms. 3. Review of R25's admission MDS with an ARD date of 06/13/24, located in the MDS tab of the EMR, revealed an admitted [DATE]. R25 had a BIMS score of nine out of 15 indicating R25's cognition was moderately impaired. R25 had diagnoses of dementia, anxiety, and hypertension, and no behaviors exhibited. Review of R25's Orders located in the EMR under the Order tab revealed orders for buspirone 5 mg tablet, once a day for anxiety disorder, unspecified, dated 06/07/24, risperidone 0.25 mg tablet, once a day for anxiety disorder, unspecified, dated 06/07/24, Quetiapine 25 mg tablet, two times a day for anxiety disorder, unspecified, dated 09/03/24, and Lorazepam 0.5 mg tablet as needed every two hours, for anxiety disorder, unspecified, dated 06/07/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R25's Care Plan dated 06/10/24 to present, located in the EMR under the Care Plan tab revealed Potential for negative side effects from the use of psychotropic medication(s). The goal included R25 will have no negative side effects from medications through next review period. An intervention included Observe for signs of depression, mood and behavior changes such as poor appetite, weight loss or excessive weight gain, loss in social interests. No care plan was found addressing R25's behaviors that caused her to be prescribed psychotropic medication. Review of R25's August 2024 and September 2024 Medication Administration record (MAR) located in the EMR under the Order tab revealed behaviors of refusing care, crying out/screaming, verbally abusive, hallucinations, disruptive behavior, delusions, hitting, kicking, etc. During an interview on 09/03/24 at 4:49 PM, LPN6 stated R25 gets medication for anxiety. LPN6 stated R25 yells out and exhibited other anxiety symptoms. LPN6 stated R25 had a sitter but the sitter doesn't come any more. LPN6 stated she has observed R25 exhibit such behaviors. During an interview on 09/04/24 at 2:49 PM, the Social Service Director (SSD) stated, there were no care plans for specific behaviors, just side effects for the medications used for the behaviors. The SSD stated the MDS person does those care plans which include the development and updates. SSD stated they discuss behaviors in the morning meetings. During an interview on 09/04/24 at 5:47 PM, the MDS Coordinator (MDSC) was asked who care planned behavioral symptoms for R120 and R25. MDSC stated the SSD has always care planned the behaviors because she did the medication side effects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 32513 Based on interview, record review, and review of facility policy, the facility failed to ensure the Comprehensive Care Plan was accurate for one resident (Residents (R) 40) of 30 sample residents reviewed for care plans. This failure placed the resident at risk of unmet care needs. Findings include: Review of the facility's policy titled, Care Plans-Comprehensive Person-Centered, dated December 2016, revealed .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan will .Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Review of the Face Sheet located in the Admission tab of the electronic medical record (EMR) revealed R40 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a neurological disease) and dementia. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an ARD of 06/26/24 revealed R40 had a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated he was severely impaired in cognition, had no behaviors and was receiving hospice care. Review of R40's Nutrition Care Plan, dated 02/27/24 and located in the Care Plan tab of the EMR revealed, [R40] is at risk for Nutrition/Hydration problems R/T [related to] mechanically altered diet as ordered . Interventions included the following but not limited to: Observe for diabetic problems-hyper/hypoglycemia to include headaches, nausea, weakness, appetite changes, dry skin, dry mouth, excessive thirst, blurred vision .FSBS [finger stick blood sugar] by licensed nurse as needed if symptomatic . During an interview on 09/03/24 at 2:36 PM, the Registered Dietician (RD) stated, I am responsible for the development of the Comprehensive Nutritional Care Plan. The RD was asked if R40 was diabetic. She stated, No. The RD was asked why R40's Care Plan had interventions for diabetics. The RD stated, I don't know why those interventions are on his Care Plan. The RD further stated that her expectation was that the care plan interventions were to be accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and policy review, the facility failed to ensure one Resident's (R) 94 heels were elevated as ordered out of three residents reviewed for pressure ulcers out of a sample of 30 residents. This failure had the potential for R94's deep tissue injury to reoccur. Findings include: Review of the facility policy titled Prevention of Pressure Injuries revised April 2020, revealed 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Review of R94's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/11/24, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE]. R94 had no Brief Interview for Mental Status (BIMS) score and R94's cognition was severely impaired. R94 had diagnoses of hemiplegia or hemiparesis, anxiety, and depression, at risk for pressure ulcers, and had no deep tissue injury. Review of R94's Care Plan dated 01/13/22 to present, located in the EMR under the Care Plan tab revealed Alteration in skin integrity related to limited mobility, incontinence. At increased risk for skin tears related to frail aging skin Moisture Associated Skin Damage to Right Buttock. Interventions included Administer medications/treatments as ordered and Treatments as ordered. See MAR/TAR [medication administration record/treatment administration record]. The Care Plan included a diagnosis of Pressure-induced deep tissue damage of right heel. Review of R94's Orders located in the EMR under the Order tab revealed Heels Up, By Shift, Ensure heels are floated on device while in bed, dated 07/13/23. Review of R94's September 2024 TAR located in the EMR under the Order tab revealed documentation R94's heels were up on 09/03/24 on the day shift, evening shift, and night shift and on 09/04/24 on the day shift. During observations on 09/02/24 at 6:55 PM, 09/03/24 at 10:29 AM, and 4:35 PM, R94 was observed in bed. R94's feet did not appear elevated and had no obvious positioning device in place. During an observation and interview on 09/03/24 at 5:11 PM, Licensed Practical Nurse (LPN)6, came into R94's room and checked R94's feet. LPN6 confirmed R94's feet were not up stating R94's feet should be elevated. LPN6 confirmed R94 had past skin issues and stated, that's why R94 is on an air mattress. During an observation and interview with Certified Nurse Aide (CNA)3 on 09/04/24 at 8:13 AM, R94 was observed in bed with her feet under the covers. The residents feet were not elevated. CNA3stated she didn't know if R94's feet should be elevated. CNA3 confirmed this R94's feet were not elevated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/04/24 at 8:53 AM, LPN5 stated R94's wounds are healed and there were no current open wounds. LPN5 was unaware if R94 should have her feet elevated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and facility policy review, the facility failed to carry out orders for a splint/palm protector for one (Resident (R)94) of two residents reviewed for range of motion (ROM) out of a sample of 30 residents. This failure had the potential cause further decrease of ROM and/or pain for the resident. Findings include: Review of the facility policy titled Resident Mobility and Range of Motion revised 07/17, revealed . 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. Review of R94's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/11/24, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE]. R94 had no Brief Interview for Mental Status (BIMS) score and R94's cognition was severely impaired. R94 had diagnoses of hemiplegia or hemiparesis, anxiety, and depression, and no splint or brace assistance. Review of R94's Care Plan dated 01/13/22 to present, located in the EMR under the Care Plan tab revealed Self-care deficit related to CVA [cerebral vascular accident] with right sided weakness, aphasia, HTN [hypertension], HPLD [hyperlipidemia], GERD [gastroesophageal reflux disease] and depression. Interventions included Observe for pain which may interfere with ADL progress/status. Allow resident to rest, assist with positioning/meds [medications] . and Turn and reposition on a frequent and routine basis and as needed for comfort. Use pillows for positioning and comfort. The Care Plan did not address R94's contracture or the splint/palm protector. Review of R94's Orders located in the EMR under the Order tab revealed Splint continuous - R [right] Palm protector to be used PRN [as needed] for positioning and contracture mgt [management]. Skin checks per company policy, PROM [passive range of motion] R UE [upper extremity] with ADLs [activities of daily living], pillows under R UE for positioning, turn schedule per company policy to decrease risk of skin breakdown, dated 09/13/23 and Splint PRN - Clarification: R UE palm protector and/or elbow splint to decrease contracture, increase positioning and decrease risk of skin breakdown to be worn PRN or per pt [patient] tolerance, dated 08/21/23. Review of R94's September 2024 Treatment Administration Record (TAR) located in the EMR under the Order tab revealed no documentation of R94's splint/palm protector being applied. During an observation on 09/02/24 at 11:40 AM, at 2:36 PM, at 6:55 PM, on 09/03/24 at 10:29 AM, at and 4:35 PM R94 was observed in her chair in her room. R94's hands were observed resting on her chest with no device in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER: The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 Fortress Drive White Rock, SC 29177	

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview and observation on 09/03/24 at 5:11 PM, with Licensed Practical Nurse (LPN)6, LPN6 walked into R94's and observed R94's hands. LPN6 confirmed there were no splints in place and there should be per the order. LPN6 checked and found a blue hand roll in a top drawer and two splint-like devices in another drawer. During an observation with Certified Nurse Aide (CNA)3 on 09/04/24 at 8:13 AM, R94 was in bed, there were no splints observed. During an interview on 09/04/24 at 8:53 AM, LPN5 sated she didn't know if R94 should have splints in place. During an interview on 09/04/24 at 9:57 AM, the Director of Therapy (DT) stated R94 had a palm protector and not a splint for one hand, but he wasn't sure if left or right hand. The palm protector was for hygiene, to prevent breakdown, and further prevention of contracture for hygiene purposes. The DT stated it's a PRN order and at the staff's discrepancy but the orders, continuous verses PRN did contradict each other. During an observation and interview on 09/04/24 at 10:07 AM, the DT came into R94's room and found the same blue hand roll LPN6 found. The DT stated, this hand roll would do. The DT opened R94's right hand and stated, R94 definitely needs it. During an interview on 09/04/24 at 12:26 PM, the Occupational Therapist (OT) stated there was no choice in the EMR system to add a palm protector, so she used splint. The OT stated she wanted the order to reflect PRN but another therapist put in the order for continuous. The OT stated she last saw R94 one year ago and that was when the hand device was put in place for prevention of further contracture. However, since there were new nursing staff, she wasn't sure how or when the order was being carried out. The OT stated the order should be used for prevention of further contracture. During an interview on 09/04/24 at 5:31 PM, the Director of Nursing (DON) was asked about R94's splint/palm device order and where it was documented when it was applied. The DON stated it should pop up on the TAR but she would have to review the order. During an interview on 09/04/24 at 6:05 PM, DON provided the September 2024 TAR. Review of the TAR revealed no documentation that the splint/palm protector had been applied.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER: The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 Fortress Drive White Rock, SC 29177	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, record review, interview, and facility policy review, the facility failed to properly store an oxygen tank in one of three resident's room out of 30 sampled residents (Resident (R)100) and in one of four storage rooms ([NAME] unit). This failure had the potential for the pressurized oxygen inside the tank to rapidly escape causing injury or damage to surrounding objects or residents. Findings include: 1.Review of R100's Face Sheet located under the Resident Info tab in the electronic medical record (EMR) revealed R100 was admitted to the facility on [DATE] with the diagnosis of acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and other viral pneumonia. Review of R100's Physician Orders located under the Orders tab in the EMR revealed an order dated 05/23/24 for Oxygen (O2) at 3 L/min [sic] [liters per minute]. During an observation on 09/02/24 at 12:20 PM, revealed an oxygen tank was free standing on the floor in R100's room without being secured in a holder. The oxygen tank holder was sitting directly behind the oxygen tank. During an observation and interview on 09/02/24 at 12:33 PM with Licensed Practical Nurse (LPN)7 stated, This [O2 tank] should not be sitting like this. Then LPN7 placed the oxygen tank in the holder to secure the tank. 2.During an observation and interview on 09/02/24 at 12:48 PM, LPN7 revealed in the storage room where extra oxygen tanks were to be stored was one oxygen tank was observed to be free standing on the floor and not in the storage bend. LPN7 confirmed the oxygen tank should have been sitting in the storage bend that was provided in the storage room. During an interview on 09/03/24 at 10:28 AM, Unit Manager (UM)1 stated, .in the storage rooms, the containers [oxygen tanks] are stored upright in the bends. When asked how the oxygen tanks are to be stored if they are in the resident's rooms, UM1 stated, . placed in the rolling carts . During an interview on 09/03/24 at 10:37 AM, the Director of Nursing (DON) stated, They [oxygen tanks] should be in the stands, and if in the resident's rooms they [oxygen tanks] should be stored in the cylinder carts and not free standing on the floor. Review of the undated facility's policy Oxygen Safety and Prevention stated, .Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave the oxygen cylinders free-standing .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36190

Based on observation, interview, record review and policy review, the facility failed to maintain acceptable nutritional parameters by not monitoring weights for accuracy, accurately assessing weight changes after readmission, monitoring meal intake, providing meal assistance, providing meal set-up, and/or providing a meal tray for three (Residents (R)68, R120, and R115) of eight sampled residents reviewed for nutrition. This had the potential to cause further weight loss without a root cause analysis and/or additional interventions put in place.

Findings include:

Review of the facility policy titled Weighing The Resident dated 01/08/24, revealed . 2. If the month-to-month weight shows more than a five-percent gain or loss, the patient/resident is reweighed.

Review of the facility policy titled Food and Nutrition Services revised 10/17, revealed Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident . 1. The multidisciplinary staff, including nursing staff the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization . 7. Nursing personnel, with the assistance of the food and nutrition services staff will observe for . a Variations from usual eating or intake patterns will be recorded in the resident's medical record and brought to the attention of the nurse.

1. Review of R120's admission Minimum Data Set with an assessment reference date (ARD) of 05/27/24, located in the MDS tab of the EMR revealed an admitted [DATE]. R120 had a Brief Interview for Mental Status (BIMS) score of six out of 15 indicating R115's cognition was severely impaired and was independent with eating. R120 had diagnoses of dementia, unspecified protein-calorie malnutrition, and no weight loss with an admission weight of 123 pounds (lbs.).

Review of R120's Care Plan dated 05/15/24 to present, located in the EMR under the Care Plan tab revealed R120 had a potential for nutrition risk R/T [related to] PMH [past medical history] including sepsis, CKD [chronic kidney disease], hx [history] of significant weight changes and HTN [hypertension]. She is on a regular diet, eating independently. Interventions included to provide diet as ordered, assist with tray set up in location of resident's choice and offer alternates pm [evening]. Encourage 75-100% completion of meals, fluids, and snacks. Observe and document intake of meals and snacks all shifts,. Encourage self-feeding after set up, cue as needed, spoon feed PRN [as needed] to ensure adequate completion of meal, and provide food and drink preferences as requested, available, and allowable per diet order.

Review of R120's Orders located in the EMR under the Order tab revealed Regular, Thin Liquids dated 05/21/24 and Magic cup [nutritional supplement] QD [everyday] with lunch meal for weight stability, dated 08/13/24.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of R120's Nursing Note dated 05/22/24, located in the EMR under the Note tab revealed Res [resident] is A[alert]&O[oriented] x 1 with confusion. Takes meds [medications] whole. On a regular diet, thin liquid. Able to feed after tray set up at times but may need feeding assistance due to weakness .

Review of R120's Nutritional Evaluation dated 08/13/24, located in the EMR under the Assessment tab revealed RD [Registered Dietitian] review for quarterly assessment. Resident is on a regular diet with thin liquids. Tolerating diet as ordered without noted chewing/swallowing difficulties. Dietary tray card updated this date. PO [oral] intake 25-75% of meals per nursing. Per RN [Registered Nurse] on duty, resident mostly eats sweets on her tray, CBW [current body weight]106.6# [pounds], BMI [body mass index] 18.4-slightly underweight. Weight triggers for a significant weight loss x 30 days, from 125# on 7/6 (-14.4%) and x 90 days from 123# on 5/13 (-13%.) Resident would benefit from weight maintenance vs gradual therapeutic weight gain until BMI wnl [within normal level]. RD requested re-weight of August monthly weight this date to verify significant change. Skin intact, no edema noted. RD recommends re-weight for verification. Recommend adding Magic cup QD with lunch meal to provide an additional 290kcal and 9g protein. Continue weights per protocol. Encourage PO intake of meals and snacks. CP [care plan] updated this date. Will continue to monitor weight and follow up prn.

Review of R120's Meal Consumption Logs for August 2024 provided by the facility, revealed 12 of 93 meals were documented, four of the meals R120 ate 25%.

Review of R120's weight history, located in the EMR under the Weight tab, revealed R120 had lost 13 percent (%) of her body weight in two months:

09/03/24 at 108.60 lbs.

08/14/24 at 106.60 lbs.

08/07/24 at 106.60 lbs.

07/08/24 at 125.20 lbs.

06/06/24 at 124.30 lbs.

During an observation on 09/03/24 at 1:23 PM, R120 was served her lunch in the dining room that included hamburger steak, spinach, squash casserole, a magic cup, a fruit cup, and tea. R120 was observed to only eat the magic cup [nutritional supplement] and the fruit cup. R120 was asked why she wasn't eating, and R120 said, I'm just not hungry, the food doesn't taste good. Staff were not observed to encourage her or to offer R120 an alternative.

During an interview on 09/03/24 at 2:51 PM, the RD stated she thought the weights were inaccurate but confirmed the weight of 108 lbs. was a reweight. RD acknowledged it was necessary the weights be accurate for her to assess R120's nutritional needs appropriately.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 09/04/24 at 8:06 AM and at 8:22 AM, R120 was observed with her eyes closed in bed, with her breakfast tray on the overbed table. R120's breakfast included scrambled eggs, bacon, grits, orange juice, a carton of milk, and toast. The only items consumed was half of the bacon and the orange juice. The carton of milk was not opened, the grits was still covered with a plastic lid, the toast remained in the paper sleeve, and the silverware was still wrapped in the napkin. During an interview and observation on 09/04/24 at 8:40 AM, with Certified Nurse Aide (CNA)2 was observed to remove R120's breakfast tray out of her room and placed it on the cart. CNA2 stated she did not open the milk, toast and cereal because R120 didn't like the white milk and grits. CNA2 was asked if she knew R120 didn't like these items, should she get R120 something she did like. CNA2 stated No, because she doesn't like it. During an interview on 09/04/24 at 8:44 AM, Licensed Practical Nurse (LPN)4 stated it was their policy to offer something else when a resident didn't like a food item. During a follow up interview on 09/04/24 at 9:07 AM, RD was informed CNA2 was aware R120 didn't like items on her tray but didn't offer R120 an alternative. RD stated the CNA should have gotten a replacement for the food items R120 didn't like. RD reviewed R120's meal intake sheets and confirmed the documentation was not complete with numerous days/meals were missing. RD confirmed she used the data for her assessments, but she also observed the actual trays. 2. Review of R115's quarterly MDS with an ARD of 06/12/24, located in the MDS tab of the EMR revealed an admitted [DATE]. R115 had a BIMSscore of 13 out of 15 indicating R115's cognition was intact and required set-up or clean-up assistance. R115 had diagnoses of diabetes mellitus, and no weight change. Review of R115's Care Plan dated 12/14/24 to present, located in the EMR under the Care Plan tab revealed the resident had the potential for alteration in nutrition/hydration R/T mechanically altered diet as ordered. Interventions included to open all containers; provide special utensils as needed. Allow adequate time to eat; provide cues; encouragement. Feed R115 remaining food items. Monitor food intake at each meal. Document % eaten. Review of R115's Orders located in the EMR under the Order tab revealed Puree diet, Thin Liquids, dated 07/31/24, and a Dietary Supplements BID [twice daily] between meals for weight stability, dated 07/11/24. Review of R115's Nutrition Evaluation dated 06/13/24 located in the EMR under the Assessment tab revealed, resident is on a mechanical soft (ground meats) diet with thin liquids. Tolerating diet as ordered without noted chewing/swallowing difficulties. PO intake 50-100% of most meals. Snacks accepted between meals. Height requested with nursing staff this date. Resident appears to be ~UBW [usual body weight] with no recent reports of significant weight changes. Medications reviewed, skin intact, edema noted to bilateral ankles, per nursing body audit. No nutrition related concerns were identified at this time. RD recommends continuing current POC [plan of care]. Will continue to monitor weight trends and PO intake. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER: The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 Fortress Drive White Rock, SC 29177	

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R115's Dietary Notes dated 07/11/24 revealed, resident's CBW 171#, taken and verified by RN on duty this date. Weight is down from weight entered on 7/8 of 186.9# (-8.5% significant weight loss.) Previous weights stable ~186-189#, however, questionable weight accuracy of weight on 7/9. Resident continues on a mechanical soft (chopped) diet with thin liquids. PO intake variable, generally 0-50% of most meals. Resident started on Megestrol 7/10, which may attribute to an increased appetite. RD recommends increasing Boost breeze to BID between meals to aid in meeting EER [Estimated Energy Requirement]. Continue weights per protocol, recommend using hoyer lift for all weights for dependable accuracy. RD will continue to monitor weight/PO intake and follow up as appropriate. Review of R115's Nursing Note: dated 07/26/24, located in the EMR under the Note tab revealed, resident continues on mechanical soft diet with thin liquids. Resident observed pocketing food while eating by staff. Resident continuously chews food but does not swallow. Staff encourages resident to swallow food Resident states, I'm trying. No aspiration noted NP notified. Referral to Speech therapy for further evaluation. Review of R115's General Note dated 07/31/24, located in the EMR under the Note tab revealed, Diet downgraded to puree with thin liquids. Review of R115's Meal Consumption Logs for August 2024 provided by the facility, revealed six of 78 meals were documented. This included four refusals and two meals at 25%. Review of R115's Clinical Notes dated 08/22/24, located in the EMR under the Note tab revealed, Resident sent to [hospital] for further treatment and assessment related to dysuria [painful urination] RP [resident representative] notified unit manager notified MD [physician] notified. Review of R115's Clinical Notes dated 08/30/24, located in the EMR under the Note tab revealed, Resident returned to SNF from [hospital]. Review of R115's weight history, located in the EMR under the Weight tab, revealed R115 had lost 15% of her body weight in five months and then a 26% weight gain in eight days. 08/30/24 at 206.20 lbs. 08/16/24 at 163.60 lbs. 08/08/24 at 171.00 lbs. 07/11/24 at 171.10 lbs. 07/09/24 at 171.10 lbs. 07/08/24 at 186.90 lbs. 06/13/24 at 187.00 lbs. 06/05/24 at 187.00 lbs. 05/09/24 at 186.00 lbs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/07/24 at 186.00 lbs. 04/11/24 at 188.50 lbs. 04/08/24 at 188.60 lbs. 03/14/24 at 194.00 lbs. During an interview on 09/03/24 at 2:34 PM, the RD stated she reviewed the monthly weights, but not the weekly weights. The RD stated the weights were documented in a progress note and from there she made her recommendations. The RD stated here recommendations were based on food first such as double portions, snacks, and supplements were a last resort. The RD stated she requested a reweight for R115 today (09/03/24) due to her weight from 08/30/24. The RD stated R115 was sent to the hospital for a few days, 08/22/24 to 08/30/24, and RD was surprised to see R115's weight so high when R115 came back. The RD stated she reviewed meal consumption logs and used the information for her assessments. During an observation on 09/04/24 at 8:05 AM and 8:24 AM, R115 was observed in bed with her eyes closed. There was no breakfast tray served. At 8:47 AM CNA2 was observed pushing the breakfast cart off the unit towards the kitchen. R115 still didn't have a meal tray. During an interview on 09/04/24 at 8:48 AM, LPN4 stated she asked all the CNAs and no one fed R115 her breakfast. LPN4 confirmed R115 most likely didn't receive a breakfast tray. During a follow up interview on 09/04/24 at 9:08 AM, RD stated her expectation was for R115 to receive a tray at each meal. The RD reviewed R115's August 2024 and September 2024 intake sheets and confirmed the documentation was not complete, with numerous days/meals missing. RD acknowledged she used the information for her assessments, but she also observed trays as well. During an interview on 09/04/24 at 5:40 PM, the DON stated her expectation would be for R115's needs to be addressed and implement interventions. The DON further said, if the food/meals are refused, then offer an alternate. 32513 3.Review of the Face Sheet located in the Admission tab of the EMR revealed R68 was admitted to the facility on [DATE] with a diagnosis of diabetes. Review of R68's admission MDS located in the MDS tab of the EMR with an ARD of 07/26/24 revealed a BIMS score of 13 out of 15 which indicated she was cognitively intact, weighed 264 lbs., and had weight loss. Review of R68's Nutrition Care Plan, dated 07/22/24, revealed [R68] is at risk for Nutrition/Hydration problems R/T [related to] therapeutic diet as ordered, Resident noted with a hx [history] of significant weight changes. The Goal revealed [R68] will lose 1-3# [pounds] with adequate nutrition and proper consistency. Review of R68's weights located in the Vitals tab of the EMR revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/22/24: 279.60 pounds. 08/16/24: 264.50 pounds (reweight) 08/22/24: 246.80 pounds. There have been no further weights taken since 08/22/24. The resident had 11.69% weight loss since admission. During an interview on 09/03/24 at 8:47 AM, R68 was asked about her weight loss since admission. R68 stated, I have not been aware of any weight loss, but I do have a lot of things going on in my life both medically and personally. During an interview on 09/04/24 at 8:49 AM, the RD was asked about R68's documented weights. The RD stated, I looked at her closely, those weights from admission, I suspect were inaccurate. I did ask for a reweight and on 08/16/24 her weight was 264.50 so I assumed that this was her baseline weight. I did add boost breeze at that time as a supplement. I do ask for reweights during the morning meetings. I see more errors in weights upon admission. I have recently started an intake book and asking staff to document how they weigh the residents as it varies from staff and the time of day. The RD was asked if there were weekly or monthly nutrition at risk meetings when identified residents were discussed and interventions were formulated. The RD stated, No, we do not have this, we only discuss them in morning meetings and that is when I ask for the reweights. The RD further confirmed that having consistent weights had been a problem throughout the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Note: The nursing home is disputing this citation.

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32513

Based on interview and record review the facility failed to ensure trigger behaviors were identified for the use of an antipsychotic medication for one resident (Resident (R) 40) and failed to ensure psychotropic medications had an end date for three residents (R71, R10, R57). This failure placed the residents at risk of unmet care needs and a diminished quality of life.

Findings include:

1. Review of the Face Sheet located in the Admission tab of the electronic medical record (EMR) revealed R40 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a neurological disease) and dementia.

Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with and assessment reference date (ARD) of 06/26/24 revealed R40 had a Brief Interview for Mental Stats (BIMS) score of zero out of 15 which indicated he was severely cognitively impaired, had no behaviors, and was administered an antipsychotic medication daily during the observation period.

Review of R40's Psychotropic Medication Care Plan, dated 02/27/24, revealed Potential for negative side effects from the use of psychotropic medications. Interventions included the following: Anticipate needs and meet as needed. Medications as MD ordered. See MAR [Medication Administration Record.] .Observe for and document behavioral issues PRN [as needed.] . Observe for over-sedation, increased confusion or lethargic behavior report as needed .Observe for signs of depression, mood, and behavior changes such as poor appetite, weight loss or excessive weight gain, loss in social interests .Provide diversion activities prior to using PRN medications as appropriate .Coordinate all care with [name withheld] hospice and family.

Review of R40's Physician Order, dated 05/21/24 and located in the Orders tab of the EMR revealed, Quetiapine (an antipsychotic medication) 25mg Give 2 tablets by mouth every day for unspecified Dementia with other behavioral disturbances. In addition, there was a Physician Order, dated 05/22/24, which revealed Quetiapine 50mgs Give one and a half tablets (75mg) at bedtime for unspecified Dementia with other behavioral disturbances.

During an interview on 09/04/24 at 8:22 AM, Licensed Practical Nurse (LPN) 3 was asked what specific behaviors were being monitored for the use of the antipsychotic medications. LPN3 stated that behaviors and monitoring are documented on the Treatment Administration Record (TAR) LPN3 pulled up the TAR and stated, I don't see any behaviors listed that are being monitored.

During an interview on 09/04/24 at 1:02 PM, the Director of Nursing (DON) was asked what behaviors were being monitored for the use of an antipsychotic medication. The DON reviewed the EMR and stated, There is a note that states 'Behavior monitoring' however, there is nothing specific being monitored.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER: The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 Fortress Drive White Rock, SC 29177	

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 09/04/24 at 2:49 PM, the Social Services Director (SSD) stated, We discuss behaviors, but there are no specific behaviors for [R40]. 28306 2. Review of R71's Face Sheet located under the Resident Info tab in the EMR revealed R71 was admitted to the facility on [DATE] with the diagnosis of anxiety disorder, vascular dementia with behavioral disturbances, dementia, and mood disorder. Review of R71's Physician Orders located under the Orders tab in the EMR revealed orders dated 11/09/23 and 08/15/24 for Lorazepam Intensol two mg/ml (milligram per milliliter) Give one ml (milliliter) by mouth every four as needed for anxiety. There was no end date ordered for this medication either time the physician ordered this medication for R71. 3. Review of R10's Face Sheet located under the Resident Info tab in the EMR revealed R10 was admitted to the facility on [DATE] with the diagnosis of altered mental status, dementia, and major depressive disorder. Review of R10's Physician Orders located under the Orders tab in the EMR revealed an order dated 01/29/24 for Lorazepam 0.5 mg one tablet twice a day as needed for the diagnosis of altered mental status. The review also revealed an order for Lorazepam 0.5 mg one tablet every four hours as needed for the diagnosis of neurocognitive disorder with Lewy bodies. There was no end date ordered for this medications either time the physician ordered this medication for R10. 4. Review of R57's Face Sheet located under the Resident Info tab in the EMR revealed R57 was admitted to the facility on [DATE] with the diagnosis of stroke, bipolar disorder, and dementia. Review of R57's Physician Orders located under the Orders tab in the EMR revealed an order dated 08/26/24 for clonazepam 0.5 mg 1 tablet by mouth one time a day as needed for the diagnosis of anxiety disorder. There was no end date ordered for this medication. During an interview on 09/04/24 at 3:00 PM, the Pharmacy Consultant (PC) stated .as needed psychotropic medications have to have an end date . During an interview on 09/04/24 at 5:30 PM, the Director of Nursing (DON) confirmed the medications ordered for R71, R10, and R57 needed to have end dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, record review, staff interview, and policy review, the facility failed to ensure three Residents (R)282, R71, and R36) discontinued medications were removed from two of four medication carts. This had the potential for the medications to be diverted or for residents to receive medications with no current physician order. Findings include: Review of the facility policy Medication Labeling and Storage dated 02/23, provided by the facility, revealed . If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items . 1.During an observation on 09/04/24 at 10:07 AM, with Licensed Practical Nurse (LPN)1, of the A cart, revealed R282 had dronabinol (for nausea) 2.5 mg (milligram) and oxycodone (pain medication) 15 mg in the narcotic drawer of the medication cart. LPN1 confirmed R282's dronabinol 2.5 mg and oxycodone 15 mg were in the medication cart with no current orders in place for these medications and should have been removed from the medication cart. There were seven pills of dronabinol 2.5 mg left in the blister pack and seven pills of the oxycodone 15 mg left in the blister pack dispensed from the pharmacy. Review of R282's undated Face Sheet located under the Resident Info tab in the electronic medical record (EMR) revealed R282 was admitted to the facility on [DATE]. Review of R282's Physician's Orders) located under the Orders tab in the EMR revealed an order dated 08/13/24 for dronabinol 2.5 mg give one capsule two times a day for five days for the diagnosis of adult failure to thrive. The end date documented on the order was 08/18/24. R282 also had an order dated 08/13/24 for oxycodone 15 mg give one tablet every eight hours as needed for five days for the diagnosis of unspecified pain. 2.Druing an observation on 09/03/24 at 11:59 AM, with Registered Nurse (RN)2, of the B cart, revealed R71 had alprazolam (anti-anxiety) 0.5 mg in the narcotic drawer of the medication cart. RN2 confirmed R71's alprazolam 0.5 mg was in the medication cart with no current order in place for the medication and should have been removed from the medication cart. There were 26 pills left in the blister pack dispensed from the pharmacy. Review of R71's undated Face Sheet located in the resident's Electronic Medical Record (EMR) under the Resident Info tab revealed the resident was admitted to the facility on [DATE]. Review of R71's Physician Orders located under the Orders tab in the EMR revealed an order dated 01/04/24 for alprazolam 0.5 mg (milligram) Give one tablet as needed every eight hours times 45 days for the diagnosis of generalized anxiety disorder. The end date was documented on the order as being 02/18/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER: The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 Fortress Drive White Rock, SC 29177	

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	3.During an observation made on 09/04/24 at 10:34 AM, with LPN5, of the A cart, revealed R36 had hydrocodone (pain medication) 5 mg-acetaminophen 325 mg and tramadol (pain medication) 50 mg in the narcotic drawer of the medication cart. LPN5 confirmed hydrocodone 5 mg-acetaminophen 3325 mg and tramadol 50 mg were in the medication cart with no current orders and should have been removed from the medication cart. There were 11 pills of hydrocodone 5 mg-acetaminophen 325 mg, and 17 pills of tramadol 50 mg left in the blister packs dispensed from pharmacy. Review of R36's undated Face Sheet located under the Resident Info tab in the EMR revealed R36 was admitted to the facility on [DATE]. Review of R36's Physician's Orders located under the Orders tab in the EMR revealed an order dated 04/24/24 for hydrocodone 5 mg-acetaminophen 325 mg give one tablet every six hours as needed for 14 days for the diagnosis of unspecified pain. The end date documented on this order was 05/07/24. There was also an order for tramadol 50 mg give one tablet every six hours as needed for 14 days. The end date documented on this order was 06/17/24. During an interview on 09/04/24 at 3:00 PM, the Pharmacy Consultant (PC) stated, When the narcotics have ended, they are to be taken off the medication carts and disposed of properly. During an interview on 09/04/24 at 5:30 PM, the Director of Nursing (DON) was notified of the above documented narcotics being left in the medication carts with no current orders. The DON stated the process of removing medications/narcotics from the medication carts was for the nurse to notify the unit manager and the unit manager would take these to her and together they would fill out the log sheet and place the medications/narcotics in a locked container until pharmacy came in and they were disposed of properly. The DON confirmed these medications/narcotics should have been removed from the medications carts when they were discontinued, or the end date had passed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER: The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 Fortress Drive White Rock, SC 29177	

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review, the facility failed to ensure a prophylactic antibiotic was monitored to ensure continued efficacy for one of two residents (Resident (R) 16) of 30 sample residents reviewed for antibiotic stewardship. This failure placed the resident at risk of unmet care needs related prolonged use of an antibiotic. Findings include: Review of the facility's policy titled, Infection Prevention and Control Program, dated October 2018, revealed . An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Antibiotic Stewardship .Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities .Medical criteria and standardized definitions of infections are used to help recognize and manage infections .Antibiotic usage is evaluated and practitioners are provided feedback on reviews . Review of the Face Sheet located in the Admission tab of the electronic medical record (EMR) revealed R16 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure and dementia. Review of R16's quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 07/14/24 revealed R16 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated she was cognitively intact and had been on an antibiotic daily during the seven-day observation period. Review of R16's Comprehensive Care Plan, dated 05/22/23 and located in the Care Plan tab of the EMR, revealed Potential for UTI [urinary tract infections]/ Constipation. History of chronic UTI's. Interventions included the following: Diet as ordered. Offer fluids in between meals and at medication pass as appropriate . Observe for s/s [signs and symptoms] of infection such as color, odor, consistency, burning upon urination while voiding, flank pain, change in mood or increased confusion, altered mental status, fever, chills, frequent urination, and hematuria .Administer medications for confirmed UTI infections. MD [Medical Doctor] diagnosis UTI, labs to indicate UTI and patient exhibiting s/s UTI .Incontinence checks q [every] 2 hours and as needed. Use adult briefs or pull ups for containment and dignity. Review of the Comprehensive Care Plan located in the Care Plan tab of the EMR, did not address prophylactic use of the antibiotic. Review of the Physician Order, dated 05/10/23 and located in the Orders tab of the EMR revealed, Nitrofurantoin (an antibiotic) 25mg one capsule every day for personal history of urinary tract infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Note to Attending Physician/Prescriber, dated 05/22/24 and provided by the Director of Nursing (DON) revealed, This resident has received chronic antibiotic prophylaxis for urinary tract infections. Please consider discontinuation of the following antibiotic with documentation of symptom monitoring. Nitrofurantoin 25mg every day. The disagree response from the provider, dated 05/28/24, indicated stable on current regimen. There was no documentation of symptom monitoring or rationale provided for the continued use of the antibiotic. During an interview on 09/04/24 at 8:20 AM, Unit Manager (UM) 1 stated, We have infection control meetings monthly in the QA [quality assurance] meetings. The physician and the pharmacist attend. We do review the prophylactic antibiotic use, but we do not talk about the short-term antibiotics. During an interview on 09/04/24 at 12:51 PM, the [NAME] President of Clinical Operations (VP) stated, The pharmacy looks at that every month and review all medications in the chart. During an interview on 09/04/24 at 2:04 PM, the Pharmacy Consultant (PC) stated, I sent a letter to the physician on 05/22/24 regarding the prophylactic antibiotic. I have not sent a letter since. When asked about long-term use, the PC stated, I would be concerned with antibiotic resistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heritage at Lowman Rehab and Healthcare	201 Fortress Drive White Rock, SC 29177

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview, record review, and review of facility policy, the facility failed to ensure pneumonia vaccinations were offered and/or provided for three of five residents (Residents (R) 25, R43, and R100) reviewed for immunizations of 30 sample residents. This failure placed the residents at risk for pneumonia. Findings include: Review of facility's policy titled, Vaccination of Residents, dated April 2023, revealed .All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated . Review of the undated CDC (Centers for Disease Control) located at www.cdc.gov revealed Complete series: PCV [Pneumococcal conjugate vaccine] 13 at any age & PPSV [Pneumococcal polysaccharide vaccine] 23 at [AGE] years of age or older and then at five years. Together, with the patient, vaccine providers may choose to administer PCV20 to adults greater than [AGE] years of age who have already received PCV13 or PPSV 23 at or after age [AGE] years. 1. Review of the Face Sheet located in the Admissions tab of the EMR revealed R25 was admitted to the facility on [DATE] and was [AGE] years old. Review of the Immunizations tab of the EMR revealed R25 had the PCV 13 on 02/29/16 and the PPSV 23 on 03/22/05. There was no further pneumonia vaccines documented. Review of the admission Vaccination Consent Form provided by the Director of Nursing (DON), revealed on 06/07/24, R25's resident representative showed no documentation that a consent for an up-to-date pneumonia vaccine was provided or refused. 2. Review of the Face Sheet located in the Admission tab of the EMR revealed R43 was admitted to the facility on [DATE] and was [AGE] years old. Review of the Immunizations tab located in the EMR revealed R43 had been administered the PPSV 23 on 10/27/22. There was no other pneumonia vaccines documented. Review of the admission Vaccination Consent Form provided by the DON, revealed R43 consented to receiving the updated pneumonia vaccine on 05/22/23 however, it was not administered. 3. Review of the Face Sheet located in the Admission tab of the EMR revealed R100 was admitted to the facility on [DATE] and was [AGE] years old. Review of the Immunizations tab of the EMR revealed R100 had the PCV13 vaccine on 06/18/15. There was no further documentation of pneumonia vaccinations. Review of the admission Vaccination Consent Form provided by the DON, revealed R100 did not indicate whether she consented to having the pneumonia vaccine or refuse to consent on 12/05/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Heritage at Lowman Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Fortress Drive White Rock, SC 29177	

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/04/24 at 3:02 PM, the DON stated, I have only been here for three weeks and after review of the Vaccination Consent Forms she confirmed that the pneumonia vaccines was not administered.