STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425110	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Harbor Healthcare	921 Bowman Road MT Pleasant, SC 29464

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 28154 30067 Based on record review, interviews, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessments captured: hemodialysis treatments for Resident (R)17; pain requiring interventions daily for R29; and anticoagulant therapy for R113 to appropriately meet the resident's specialized care needs in the facility. This failure affected three residents (R17, R29, and R113) of 33 sampled residents reviewed for MDS assessment accuracy. Findings include: Review of the facility policy titled, Accuracy of Assessment (MDS 3.0), reviewed 05/21, showed: Policy: It is the policy of this facility to ensure that the assessment accurately reflect the resident's status. Purpose: To assure that each resident receives an accurate assessment by staff that are qualified to assess relevant care areas and knowledgeable about the resident's status, needs, strengths, and areas of decline. Procedures .3. The assessment sections are completed with utilization of the RAI [Resident Assessment Instrument] manual guidance, [sic] . Review of the October 2023 RAI Manual, Page N-7 showed: N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). N0415E2. Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days) . 1. Review of R17's Admission Record, dated 03/29/24 and found in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD) and dependence on dialysis. Review of R17's Order Summary Report, dated 03/29/24 and found in the EMR under the Orders tab, indicated an order for the resident to receive dialysis services three times weekly on Mondays, Tuesdays, and Fridays related to his diagnosis of ESRD. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R17's Renal Condition and Risk for Complications Care Plan, dated 10/03/22 and found in the EMR under the Care Plan tab, indicated the resident was receiving dialysis services three times weekly on Mondays, Tuesday, and Fridays. Review of R17's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/15/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident had intact cognition. The assessment incorrectly indicated the resident was not receiving dialysis services. During an interview on 03/29/24 at 11:30 AM, the MDS Coordinator (MDSC) confirmed R17 had been receiving dialysis services since his admission to the facility. The MDSC stated the 03/15/24 MDS assessment was incorrect and stated, I will have to modify that (the assessment to correctly reflect the resident's dialysis services). 2. Review of R29's Face Sheet found in the EMR, under the Profile tab, revealed R29 was admitted to the facility on [DATE] with diagnoses including dementia with behaviors, osteoarthritis, anxiety disorder, and a history of falls. Review of R29's most recent quarterly MDS with an ARD of 03/07/24 revealed a BIMS score of 00 which indicated R29 was rarely to never understood and could not make decisions regarding her care. The MDS assessment addressed pain. The assessment failed to capture that R29 was frequently in pain expressed by facial wincing, and grimacing or crying out. The resident had an order for narcotic pain medications that were available for pain and were administered at least once daily (and twice daily in most cases) during the seven days look back period of the MDS assessment. Review of R29's Medication Administration Record (MAR) for the month of March 2024 revealed an order for Hydrocodone 5/325mgs (milligrams) by mouth every six hours as needed. The review revealed R29 received the pain medication twice each day. Her first dose was usually upon rising, and a second dose was needed in the afternoon or evening. The medications were documented as effective in relieving R29's intermittent pain. During an interview on 03/28/24 at 3:00 PM, the Licensed Practical Nurse (LPN)1 revealed she cared for R29 regularly and stated, She [R29] speaks in word salad but can definitely let you know if she's hurting . LPN1 stated R29 had a history of falls and occasionally resisted care, especially if she's already hurting. LPN1 stated the pain medications ordered appeared to work well for her and it definitely increased her compliance with cares. 3. Review of R113's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses that included sepsis, quadriplegia, stage four pressure ulcer, chronic embolism and thrombosis, and pulmonary embolism. During an interview on 03/28/24 at 10:01 AM, R113 stated he did not think he took a blood thinner medication. Review of R113's MAR from the EMR Orders tab showed R113 was administered apixaban [anticoagulant] five milligrams (mg) twice a day. Further review of the Orders tab for anticoagulant medication showed that apixaban was ordered and started on 12/13/23 and had received the medication daily unless refused. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R113's quarterly MDS with an ARD of 01/24/24 showed no coding for R113 taking an anticoagulant medication. Review of R113's admission MDS, dated [DATE] and five day MDS, dated [DATE], showed R113 was coded for taking an anticoagulant. During an interview on 03/28/24 at 10:29 AM, MDSC reviewed R113's 01/24/24 MDS and stated, No, I did not code him for an anticoagulant. MDSC then reviewed R113's January 2024 MAR and commented, He was on it for AFib [atrial fibrillation] all of January. So that was my error. I was a baby MDS coordinator in January.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 18947 Based on observations, interviews, and record review, the facility failed to provide a splint device for contracture per plan of care for one of three residents (Resident (R) 112) reviewed for positioning/mobility of 33 sampled residents. Findings include: The facility's policies and procedures related to Range of Motion (ROM) and splinting were requested on 03/29/34 at 10:00 AM. During an interview with the Director of Therapy on 03/29/24 at 11:01 AM, she stated the facility did not have a policy/procedure to address the use of splints or ROM. Review of R112's Admission Record, dated 03/29/24 and found in the electronic medical record (EMR) under the Admission tab, indicated R112 was admitted to the facility on [DATE] with diagnoses including history of seizures. Review of R112's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/23 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) assessment was not completed because the resident was non- responsive. The assessment indicated the resident was completely dependent upon staff to complete all her ADLs (Activities of Daily Living), including movement in bed and range of motion. Review of R112's undated Alteration in Musculoskeletal Status r/t (Related to) Right Hand Contracture Care Plan, found in the EMR under the Care Plan tab, indicated R112 had an actual contracture to her right hand. The care plan indicated the use of a right-hand [NAME] guard/splint to prevent further worsening of the resident's right hand contracture. Review of R112's physician's orders, dated 03/29/24 and found in the EMR under the Orders tab, revealed no current order for the resident's use of a right-hand splint. Review of R112's Treatment Administration Records (TARs), dated 03/01/24 through 03/29/24 and found in the EMR under the Orders tab, revealed nothing to indicate the resident's right hand splint had been applied per her plan of care. R112 was observed on 03/28/24 at 9:44 AM, 10:50 AM, and 12:06 PM. The resident's right hand was severely contracted, and a splint was not observed to be applied to her right hand during the observations. The resident's hand splint was observed to be hanging on a hook on the wall at the resident's bedside. During an observation of R112 with Licensed Practical Nurse (LPN) 2 on 03/28/24 at 12:10 PM, LPN2 confirmed R112 was not wearing her right-hand splint per her plan of care and stated the splint should have been on R112's right hand per her plan of care. LPN2 applied the resident's splint to her right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/28/24 at 2:43 PM, the Director of Therapy confirmed R112 had a right-hand contracture and was dependent upon staff for all her daily care. She stated R112 was supposed to be wearing her right hand splint all day and that nursing staff had been provided with education related to the application of the splint. She stated orders had been in place for the resident's splint, and application of the resident's splint was expected to be documented in the TAR. The Director of Therapy stated the splint order had been omitted from the resident's physician order set and so had not been populating on the TAR to trigger nursing staff to apply the splint. She stated the order for the resident's splint had been put back into the EMR this day (03/28/24) and nursing had been made aware the splint was expected to be applied during the day every day. During an interview on 03/28/24 at 2:52 PM, the Director of Nursing (DON) stated R112's right-hand splint was expected to be applied according to her plan of care. The DON stated physician's orders were expected to be in place for the resident's splint, and stated his expectation was the application of the resident's splint to be documented in the TAR.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on record review, interviews, and facility policy review, the facility failed to ensure dialysis related medications were provided for one of two residents (Resident (R) 71) reviewed for dialysis of 33 sampled residents. Findings include: Review of the facility's policy titled, Dialysis (Renal), Pre- and Post-Care, dated 01/22, revealed, It is the policy of this facility to: Assist resident in maintain homeostasis pre- and post-renal dialysis; assess and maintain patency of renal dialysis access; assess resident daily for function related to renal dialysis; participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services .Hold any blood pressure medications and/or any other specified medications as ordered by physician. Review of R71's Admission Record, found in the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses including diabetes mellitus II, end stage renal disease, and dependence on renal dialysis. Review of R71's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/27/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident had intact cognition. The resident was documented to require dialysis while a resident. Review of R71's Care Plan, located in the Care Plan tab of the EMR, initiated 09/14/22 and last revised 12/02/22, documented that the resident had Hemodialysis r/t [related to] Renal failure. The interventions included for the resident to attend dialysis on Monday, Wednesday, and Friday. During an interview on 03/27/24 at 9:01 AM, R71 stated that he went to dialysis three times a week, approximately 4:50 AM. R71 stated that the facility sent him with food. He stated that he was not always given his Renvela on dialysis days, which was his only concern. R71 stated that when he asked the nursing staff about receiving the medication, he was told that other residents were receiving medication administration before him, and he would have to wait. Review of R71's Orders tab of the EMR revealed an order, dated 09/12/23, for Renvela Oral Tablet 800mg, give two tablet [sic] by mouth with meals for hyperphosphatemia related to end stage renal disease. Take with snack. To be administered 7:30 AM, 12:00 PM, and 5:00PM. Review of R71's Medication Administration Record (MAR) of the EMR under the Orders tab for January 2024, revealed Renvela Oral Tablet 800mg was not administered on 01/22/24 and 01/31/24 at 7:30 AM, coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R71's MAR of the EMR under the Orders tab for February 2024, revealed Renvela Oral Tablet 800mg was not administered on 02/21/24 at 7:30 AM and coded by nursing staff as out of the facility on scheduled dialysis date. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R71's MAR of the EMR under the Orders tab for March 2024, revealed Renvela Oral Tablet 800mg was not administered on 03/01/24, 03/06/24, 03/07/24, 03/13/24, 3/18/24, 03/20/24, 03/27/24, and 03/28/24 at 7:30 AM, coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R71's EMR under the Progress Notes tab revealed: -03/22/24 Renvela just got back from HD [hemodialysis] -03/29/24 Renvela at dialysis. During an interview on 03/29/24 at 11:01 AM, Unit Manager (UM) 2 stated that R71 went to dialysis very early in the mornings and did not always get his Renvela. UM2 stated that when the resident returned it was almost time for his lunch dose. During an interview on 03/29/24 at 11:05 AM, Nurse Practitioner (NP) stated that there should not be any outcome for R71 missing Renvela due to being at dialysis and was not sure if the resident needed to receive the medication on those mornings. NP stated that he was reviewing the resident's medication, and confirmed R71 was not currently receiving Renvela on numerous dialysis days per the physician order. During an interview on 03/29/24 at 11:44 AM, Director of Nursing (DON) stated he was not aware if there had been communication or review of the Renvela not being administered on numerous dialysis days for R71. DON stated that he would have to speak with the medical provider to determine if the medication should be reviewed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26446 Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure the kitchen was properly cleaned, food was properly handled, and the dish machine was working in accordance with professional standards for food service safety as required for 121 census residents who received meals from the facility kitchen. These failures had the potential to lead to food-borne illness among all facility residents. Findings include: The facility's policy titled, Dishwashing: Machine Operation, dated 2020, documented The Dining Services staff shall maintain the operation and manufacturer guidelines posted or contained in this guideline to ensure effective cleaning and sanitizing of all tableware and equipment used in the preparation and service of food . All dishwashing machines should be operated according to manufacturer recommendations .Check the dishwashing machine before first use. If the dishwashing machine has not been used for several hours, it is generally recommended to allow the dishwashing machine to cycle for one or two cycles to allow dishwashing machine to come up to proper function. The facility's policy titled, Proper Hand Washing and Glove Use, dated 2020, documented All employees will use proper hand washing procedures and glove usage in accordance with State and Federal sanitation guidelines .Employees will wash hands before and after handling foods, after touching any part of the uniform, face, or hair, and before and after working with an individual resident .Gloves are to be used whenever direct food contact is required .Hands are washed before donning gloves and after removing gloves .Gloves are changed any time hand washing would be required .if the gloves become contaminated by touching the face, hair, uniform, or other non-food contact surface, such as door handles and equipment. The facility's policy titled, Sanitizing Equipment and Food Contact Surfaces, dated 2020, documented Employees shall sanitize equipment and food contact surfaces utilizing the proper sanitizing solution. 1. During observations alongside the Dietary Manager (DM) on 03/27/24 at 7:00 AM revealed: -The walk-in refrigerator had a visibly soiled door and dark debris on the handle. -The walk-in freezer had multiple broken curtain slats with ice buildup on the curtain and around the door. 2. During observations alongside the DM on 03/28/24 at 10:15 AM revealed: -There was a knife storage box, with numerous knives stored into the slots. There were three knives that rested sideways on the top of the storage box. The lid was observed with dried dirt and debris on the exposed sides of the box, including the top where the knives rested. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The floor was observed with broken tile approximately 3/4 inch thick at the entrance to the pantry, with extensive dark debris built-up along the length of the door. -The dishwasher temperatures were monitored with multiple cycles run, which revealed: First run: Wash temperature of 90 F (Fahrenheit), a rinse temperature of 103 F, and 200 PPM (parts per million) of the sanitizer. Second run: Wash temperature of 100 F, and a rinse of 119 F, and 200 PPM of the sanitizer. Third run: Wash temperature of 112 F, and a rinse of 122 F, and 200 PPM of the sanitizer. Review of the March 2024 Temperature Log for the Dish Machine revealed the expected parameters of Wash: 120 F, Rinse 120 F, and Test Strip 50 PPM (parts per million). The log was documented for Breakfast, Lunch, and Dinner each day. The log was documented with temperatures of 100 F for all the Wash and Rinse cycles during Lunch on 03/02/24 through 03/10/24. A concurrent interview on 03/28/24 at 10:42 AM with the DM, Corporate Dining Consultant (CDC), and Registered Dietician (RD) confirmed that the facility had a new booster to improve hot water levels due to a history of low temperature concerns. They all confirmed the dishwasher required temperatures of 120 F and should have always been logged accurately, after ensuring the correct temperatures had been reached. During a meal service observation on 03/28/24 at 12:23 PM, Cook1 was observed plating food for lunch. Cook1 pulled on gloves, pulled up their pants, then continued to pick up a serving utensil and began to plate the food. Cook1 was observed touching the inside edge of the resident plates with the same gloved hands. On multiple occasions, Cook1 was observed using the same gloved fingers to touch the mixed vegetables that were on the scoop, to ensure the food did not fall out of the scoop while plating. Cook1 dropped a pair of tongs onto the stuffing, with the handle touching the food, then picked them back up with the same gloved hands. During an interview on 03/29/24 at 12:40 PM, DM confirmed that many of the dietary staff were new, and she had spoken many times to them, including Cook1, about wearing gloves and touching items they should not touch, including clothes. The DM stated she was still educating new dietary staff on cleaning processes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 28154 Based on observation, interview, and facility policy review, the facility failed to ensure effective hand hygiene during wound care and there was a way to restrict air flow between the dirty laundry and clean laundry area. This had the potential to cause wound infection and exposure to viruses and bacteria to any of the 121 residents in the facility. Findings include: Review of the facility's policy titled, Hand Hygiene, reviewed 12/23, showed: .3. Washing Hands a. Vigorous lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature .b. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink. c. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel . Review of the facility's policy titled, Departmental (Environmental Services) - Laundry and Linen, revised January 2014, showed: General Guidelines . 3. Consider all soiled linen to be potentially infectious and handle with standard precautions .Washing Linen and other Soiled Items .6. Keep soiled and clean linen, and their respective hampers and laundry carts, separate at all times. 7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts . Review of the facility policy titled, Infection Control Prevention and Control Program, reviewed 09/17, showed: .C. Prevention of Infection Staff and resident education is done to identify risk of infection and promote practices to decrease risk. Policies, procedures and aseptic practices are followed by personnel in performing procedures, linen handling and disinfection of equipment. The hand hygiene procedures will be followed by staff involved in direct resident contact . 1. During an observation of R113's ischial pressure ulcer on 03/29/24 at 10:15 AM, the Wound Care Nurse (WCN) entered the bathroom and performed a handwash of six seconds from soap push to turning the water off, then pulled a paper towel to dry hands. After pulling the privacy curtain and closing the blinds, WCN performed a hand wash at 10:16 AM that was five seconds from soap push to towel pull, then turned the water off. After adjusting the bed and removing the old dressing with gloved hands, WCN performed a hand wash at 10:19 AM that was nine seconds from soap push to towel pull (WCN dropped the normal saline and went to the door for another staff to retrieve one from the treatment cart). At 10:21 AM, WCN performed a handwash that was five seconds from soap push to water off, turned the water back on and washed nine seconds to pulling a paper towel, then turning the water off. WCN applied gloves and cleaned the wound, removed gloves, and performed a handwash at 10:23 AM that was ten seconds from soap push to water off, then pulled a paper towel. After treating and dressing the wound, WCN removed gloves and was waiting for staff to assist to provide other care to R113. (continued on next page)

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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 - Some	During an interview on 03/29/24 at 10:28 AM about effective handwashing, WCN stated that you should sing Happy Birthday while washing. When asked to sing the song how many times, WCN responded, Once, then thought about it and stated, yes, once; no wait, twice. When asked the sequence of effective handwashing, clarifying, when was the water to be turned off, WCN stated, Towel then water off. When advised of the observations, WCN stated One time I turned the water back on. During an interview on 03/29/24 at 1:25 PM, the Director of Nursing (DON) stated a handwash expectation of 20 seconds at a minimum. Clarified, the DON stated that was the scrub portion (vigorously rubbing hands together). When asked the sequence of handwashing, the DON stated, Turn on the faucet, soap, lather at least 20 seconds getting in between fingers and nails, rinse hands pointed down, grab a paper towel and dry hands, discard and get a new paper towel to turn off the water source. 2. During an observation of the laundry area and interview on 03/29/24 at 12:10 PM, the laundry room had no physical barrier to separate dirty laundry from the clean laundry area. Laundry Staff (LS) 1 was present during the observation and stated the blue line is the divider - nothing dirty past here & nothing clean over there . She confirmed there was no curtain, or any type of barrier used to separate the dirty laundry while it was sorted into the washing machines. During a second laundry area observation and interview on 03/29/24 at 12:30 PM, LS1 showed three gray large barrels that LS1 confirmed was dirty laundry for sorting and was not in any type of contained area (i.e. the laundry room was one large room). The washing machines were directly across the walkway from the barrels. Looking from the washing machines, there was a wash sink area between the washers and dryers and a blue line across a table with clean linen folded and stored approximately twelve inches from the tape, and tape on the floor that LS1 confirmed was the divider between clean and dirty. When asked if the blue line was the only thing to keep any bacteria/viruses that might be agitated during the sorting of the dirty laundry or the placement of the dirty laundry into the washing machines, LS1 stated That's what divides the clean and dirty. Above the 'blue line' divider was a large air vent that LS1 stated was output, not intake. The air would blow straight down and cause any settled bacteria/ viruses/ dust/ lint/ dirt on the dirty side of the table or floor to go airborne. During an interview on 03/29/24 at 12:20 PM, the Administrator stated the no barrier in the laundry was identified during their mock survey. During an interview on 03/29/24 at 1:33 PM the DON stated an expectation regarding laundry handling was There needs to be separation between clean and dirty; proper PPE [personal protective equipment worn] when sorting or putting in washer, and that the air does not flow from dirty to clean.