STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425112	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Simpsonville Post Acute	807 South East Main Street Simpsonville, SC 29681

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** Based on observation, interview, record review, and facility policy review, the facility failed to assess 1 of 1 residents reviewed (Resident (R)1) for self^administration of medications. This failure resulted in medications being left in the resident's room/possession, where they could be accessed by other residents or could place the resident at risk of being overly medicated. Findings include:Review of the facility's policy titled, Self-Administration of Medications, last revised February 2021, revealed As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.Review of the facility's policy titled, Storage of Medications, dated 2001, revealed Policy Interpretation and Implementation 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. 3. The nursing staff is responsible for maintaining medication storage.Review of R1's Face Sheet located in the electronic medical record (EMR) under the Resident tab revealed R1 was admitted to the facility on [DATE] with a primary diagnosis of wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing.Review of R1's annual Minimum Data Set (MDS) located in the EMR under the Resident Assessment Instrument (RAI) tab with an Assessment Reference Date (ARD) of 02/20/26, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was cognitively intact.Review of R1's Care Plan located in the EMR under the RAI tab, did not include a care plan related to self-administration of medications.Review of R1's Evaluations located in the EMR under the Evaluations tab did not include an assessment/evaluation for self-administration of medications.Review of R1's Orders located under the Orders tab of the EMR revealed R1 did not have an order for self-administration of medications. Additionally, R1 had orders for Gabapentin Oral Capsule 300 MG give one table by mouth every 12 hours for Neuropathy, Tums Oral Tablet Chewable 500 MG (Calcium Carbonate Antacid) give 500 mg by mouth every 6 hours as needed for indigestion, Lexapro Oral Tablet 20 MG (Escitalopram Oxalate) give 1 tablet by mouth one time da day for depression, Ondansetron HCl Oral Tablet 4 MG (Ondansetron HCl) give 1 table by mouth every 8 hours as needed for Nausea Vomiting.During an observation on 06/09/26 at 11:04 AM, R1 was sitting in her wheelchair in the hallway in front of the nursing station with a white bag with four (4) prescription bottles which included: Pantoprazole Sodium, Gabapentin, Ondansetron HCL, Escitalopram Oxalate.During an interview on 06/09/26 at 11:04 AM, Resident (R)1 revealed that she received medications from her doctor's appointment with her pain doctor the day before. R1 states that she took one of her Protonix pills because the nurse did not give her a tums as she requested.During an interview 06/09/26 at 11:10 AM, The Unit Manager (UM) confirmed the medications in the resident possession and stated that the resident went out to the pain doctor yesterday and she should have turned the medications in to the nurse along with the orders for the medications.During a follow up interview on 06/09/26 at 11:50 AM, The UM checked the prescription bottles for broken seals and confirmed that the seal was broken for Pantoprazole Sodium.During a 2nd follow up interview on 06/09/26 at 2:03 PM, The UM counted the contents for (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescription Pantoprazole Sodium and confirmed a count of 29 pills and confirmed there should have been 30 pills in the bottle. The UM revealed that the resident does not have an order to self-administer her own medications, and that she is not supposed to self-administer any medications. The UM explains that the resident should have given the medications to the nurse on the med cart when she returned from the doctor as she usually does but she is not sure why she didn't yesterday.During an interview on 06/09/26 at 2:11 PM, the Director of Nursing (DON) revealed that they do not have any residents in the facility with orders to self-administer medications. The DON explains that residents are usually transported by facility transportation to appointments and they usually handle all the paperwork and medications and return it to the nurses on the cart. The DON continues to explain that if family members transport the residents, they are supposed to turn in paperwork and medications to the nurse when they return from appointments. The DON states that R1 had a friend to take her to her appointment yesterday and R1 usually turns in her paperwork and medications to the nurse when she returns from appointments, but she is not sure why she didn't do that yesterday.