STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425113	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Dillon	413 Lakeside Court Dillon, SC 29536

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 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49918 Based on interview, record review, and facility policy the facility failed to ensure Resident (R)369 was free from chemical restraints when it was identified that R369 was administered Haloperidol (An antipsychotic used to treat certain types of mental disorders (eg, schizophrenia). It can also control symptoms of Tourette syndrome) for 'exit-seeking behaviors, for 1 of 5 residents reviewed for unnecessary medications. On 06/20/24 at 2:09 PM, the survey team notified the Administrator and DON that the failure to ensure residents are free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the residents medical symptoms constituted IJ at F605. On 06/20/24 at 2:09 PM, the survey team provided the Administrator and DON with a copy of the CMS IJ template and informed them that IJ existed as of 06/17/24, due to Resident (R)369 receiving a Haldol injection after displaying exit seeking behaviors and staff being unable to redirect the resident from wandering. The IJ was related to S483.12 Freedom from Abuse, Neglect, and Exploitation. On 06/21/24, the facility provided an acceptable IJ Removal Plan. On 06/21/24 at 8:17 AM, the survey team validated the facility's corrective actions and removed the IJ as of 06/21/24. The facility remained out of compliance at F605 at a lower scope and severity of D. An Extended Survey was conducted in conjuction with the Recertification and Complaint Survey, for noncompliance at F605. Findings include: Review of the facility policy titled Unnecessary Medications Use and Monitoring with a reviewed date of 01/03/24, documented, Procedure: 1. The regulations associated with medication management include consideration of: Indication and clinical need for the medication . 2. Psychotropic medication requires additional regulations: Psychotropic medications are only given when necessary to treat a specific diagnosed or documented condition. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Manufactures Recommendation for the medication Haldol revealed, Increased Mortality in Elderly Patients with Dementia-Related Psychosis Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. HALDOL decanoate is not approved for the treatment of patients with dementia related psychosis. HALDOL decanoate 50 and HALDOL decanoate 100 are indicated for the treatment of patients with schizophrenia who require prolonged parenteral antipsychotic therapy. Review of R369's Face Sheet revealed R369 was admitted to the facility on [DATE], with diagnoses including but not limited to: dementia, major depressive disorder, anxiety disorder, and adjustment disorder. Review of R369's Care Plan with a start date of 07/16/24 documented, Presence of Behaviors: Wanders, requires Wanderguard. Further review of the Care Plan revealed the following approach, Administer and monitor the effectiveness side effects of medications as ordered-see physician orders and MAR. Review of R369's Care Plan revealed, R369 was care planned on 07/16/24 for Presence of Behavioral Symptoms: Wanders; EMD in place as evidenced by: wandering about facility looking for family to take home. Review of R369's Physician Orders revealed an order for, haloperidol 5 mg oral one time with a start date of 06/17/24. No indications of use were noted on the order. Review of R369's Medication Administration Record (MAR) revealed, on 06/17/24 at 3:00 PM, R369 was administered 5 mg of oral Haloperidol. Further review revealed documentation of R369's Behavior Monitoring chart which indicated R369 behavior as wanders. Review of R369's Progress Notes revealed, on 06/17/24 at 2:56 PM, Patient has attempted several times to leave facility. Called MD see new order for Haloperidol 5mg x 1 dose until he sees her in the morning for anxiety, RR made aware. During an interview on 06/19/24 at 3:40 PM, Licensed Practical Nurse (LPN)2 revealed that the resident had been exit seeking since being admitted to the facility on [DATE] which is why she decided to place the resident on a 1:1 intervention and place an Electronic Medical Device (EMD) on the resident. LPN2 stated that she notified the Medical Director (MD) of the resident's behaviors, and he put in an order for a one time use for a Haldol injection. During an interview on 06/19/24 at 4:51 PM, MD1 revealed R369 was displaying exit seeking behaviors shortly after finishing her admission evaluation. MD1 stated that they overheard the EMD alarm sounding off while they were at the facility and witnessed staff having difficulty redirecting the resident from that behavior. MD1 further stated due to the resident having exit seeking behaviors and staff being unable to redirect the resident and due to the resident's agitation, a one-time order of Haldol was placed for the resident's agitation. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/20/24 at 11:05 AM, LPN1 revealed R369 was agitated and constantly exit seeking and saying things such as He knows not to leave me here. I am going with my family. LPN1 further stated Haldol was given one time and the MD stated that he would come to re-evaluate R369 the next day. During a follow up interview on 06/20/24 at 12:36 PM, MD1 stated, She was agitated, she was trying to leave the facility and they didn't want to use physical restraints. I prescribed Haldol. I use Haldol with psychosis. Do I need legal counsel? She was agitated and wanted to leave, so I gave Haldol. I use this medication short term until I can get them on something long term or until I can prescribe something else. MD1 concluded, Educate me on what I should use. On 06/21/24, the facility provided an acceptable IJ Removal Plan, which included the following: Implementation of the removal plan for F605 include: R369 was admitted to the facility on [DATE] with a diagnosis including but not limited to unspecified dementia without behaviors, major depressive disorder, anxiety disorder, and adjustment disorder. R369 displayed exit seeking behaviors upon admission and throughout her stay within the facility. Interventions of 1:1 supervision and placement of an Electronic Monitoring Device (EMD) were put into place to ensure resident safety and security. While R369 was in the facility, partners/staff attempted to redirect the resident when she displayed exit seeking behaviors and she stated, I am going home with family . He knows not to leave me here. Medical Director (MD)1 witnessed R369 displaying exit seeking behaviors and that the partners/staff were having difficulty redirecting the resident due to the resident's agitation. MD1 placed a one-time order of Haloperidol 5 mg oral tablet for the resident's agitation. Methods to identify any other resident who might be affected include: all ambulatory residents with exit seeking behaviors and increased agitation. Systemic Changes include: the facility regional Area [NAME] President (AVP) and or Senior Nurse Consultant (SNC) has scheduled an in-service on 06/20/24 to be instructed by our Chief Medical Officer to the facility MD (MD1). This in-service will include recommendations of interventions for residents with increased agitation while displaying exit seeking behaviors that are following the manufacturer's recommendations of the medication while meeting the Center's of Medicare and Medicaid (CMS) regulations/guidelines for not chemically sedating. New orders for psychotropic will be reviewed with the MD and Quality Assurance and Performance Improvement (QAPI) committee monthly to ensure/confirm rational and appropriate usage. The date of substantial compliance is set at 06/21/24. Monitoring includes: the Administrator will present results of reviews to the QAPI Committee monthly for three months and or until substantial compliance is achieved.

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49918 Based on observation, interview, record review, and facility policy review, the facility failed to provide Resident (R)369 and her Resident Representative with sufficient preparation and presentation to ensure an orderly and safe discharge from the facility, for 1 of 6 residents reviewed for transfer/discharge. On 06/19/24 at 9:09 PM, the Administrator and Director of Nursing (DON) were notified that the failure to provide and document sufficient preparation and orientation to ensure residents have a safe and orderly discharge from the facility constituted Immediate Jeopardy (IJ) at F624. On 06/19/24 at 9:09 PM, the survey team provided the Administrator and DON with a copy of the CMS IJ Template and informed the facility the IJ existed as of 06/19/24. The IJ was related to 483.15 Admission, Transfer, and Discharge. On 06/20/24 the facility provided an acceptable IJ Removal Plan. On 06/20/24 at 12:23 PM, the survey team validated the facility's corrective action and removed the IJ as of 06/20/24 at 12:23 PM. The facility remained out of compliance at F624 at a lower scope and severity of D. Findings include: Review of the facility policy titled Discharge Planning with a reviewed date of 01/11/24, documented, Discharge planning will begin with each patient/resident and patient/resident's representative upon admission. The process is coordinated by Social Services/Nurse Navigator or designee. The patient/resident representative and Interdisciplinary Team (IDT) are involved in the planning process. The post-discharge plan of care is developed with the participation of the patient/resident and/or patient/resident's representative . Procedure: 3. Community resources should be determined based on input from the patient/resident, patient resident representative to include consideration of caregiver/support person availability and the patient/resident's or caregiver's/support person(s) capacity and capability to perform required care . 6. The Nurse Navigator, SSD, or Administrators designee provides oversight for the completion of this process and reviews all aspects of care with the patient/resident and patient/resident representative. Review of R369's Face Sheet revealed R369 was admitted to the facility on [DATE], with diagnoses including but not limited to: dementia, psychotics disturbance, mood disturbance, anxiety, and age related cognitive decline. Review of R369's Care Plan last revised on 06/17/24, revealed, No caregiver or family support identified, concern for patient readiness/family readiness (may need home modifications). Concern for risk of hospital readmission, patient cannot afford medications, no home health services in community. Patient cannot afford durable medical equipment, program take a while. Interventions include, involve patient/resident representative and interdisciplinary team. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R369's Care Plan with a start date of 06/17/24 documented, Behavioral Symptoms Presence of Behavioral Symptoms: Wanders; Wander guard in place as evidenced by: wandering about facility looking for family to take home. Further review of the Care Plan revealed the following approach, redirect as needed/indicated, check wander guard for function daily, observe for increased wandering/exit seeking, check wander guard for placement q shift, provide diversional activities per resident preference. Review of R369's Physician Order with a start date of 06/17/24 documented, behavior monitoring, monitor placement of wander guard to right ankle every shift, and monitor wander guard for function daily. Review of a Nurses Note dated 06/19/24 at 12:38 PM, revealed, Discharge planning meeting was held with [R369] Resident Representatives in person and via phone. Administrator and Nurse Consultant was present during this meeting, the family discusses that they would like to discharge the resident home. Staff educated family on importance of safety for the resident when she returns back home. SW has setup home health and other community services that will make a smoother transition back home. SW also sent referral to a sister facility (105 miles away according to Apple Maps) for a Memory Support Unit (MSU) bed to give family another option if family can't provide care for resident once returned home. Review of a Nurses Note dated 06/19/24 at 4:00 PM, revealed, Spoke with MD and made him aware of family request for discharge home. See new orders for discharge home with home health. Resident was assessed per MD on 06/18/24 during MD rounds. During an observation on 06/18/24 at 10:30 AM, revealed R369 sitting on a bench by the front door of the facility, appropriately dressed, with an Electronic Monitoring Device (EMD) on her right ankle. Licensed Practical Nurse (LPN)1 was close to the resident and encouraging her to come back inside of the facility. During a phone interview on 06/18/24 at 2:11 PM, R369's Resident Representative (RR)1 revealed that R369 needed to be admitted to the facility because the resident was no longer able to take care of herself and was becoming forgetful. R369's other family members were also unable to care for the resident, so the family began to look for Long Term Care (LTC) in August of 2023 and was approved for LTC in February. The resident is physically fine but mentally she is unable to make her own decisions. While at home she often sat outside and knew my vehicle and would often wait for me outside. RR1 stated, I am planning to come to the facility on ,d+[DATE] around lunch because the staff asked me to come due to her exit seeking behaviors. During an observation on 06/19/24 at 12:58 PM, R369 was with her RR1 eating lunch and appropriately dressed with an EMD in place on her right ankle. During an observation on 06/19/24 at 1:54 PM, revealed R369 and her resident representatives walking to their vehicle with R369's belongings and being discharged home with the resident representatives. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/19/24 at 3:07 PM, the Social Worker (SW) revealed that R369 was admitted to the facility for LTC. Due to the resident having exit seeking behaviors and the potential of elopement. The SW further stated the facility along with R369's resident representatives, in person and over the phone, suggest an alternative placement in LTC on a memory care unit. The SW stated R369's family was not in agreement with R369 being discharged to a memory care unit at another facility, and decided to care for the resident at home which is nearby. The SW further stated that the facility does not have any other residents that exit seek at the facility. During an interview on 06/19/24 at 3:40 PM, LPN2 revealed that R369 had been exit seeking since being admitted to the facility on [DATE], which is why she decided to place the resident on a 1:1 intervention and place an EMD on the resident. LPN2 stated that she notified the Medical Director (MD)1 of the resident's behaviors. LPN2 further stated they were unaware that the resident was being discharged from the facility until around 11:00 AM or 11:30 AM and was notified by the SW. LPN2 stated that she did not complete discharge paperwork or speak with R369's resident representatives related to her being discharged from the facility. LPN2 stated that she was instructed by the SW to complete an order for R369 to receive home health services and to be discharged from the facility. LPN2 finally stated that she has never discharged a resident from the facility in this manner and normally discharges are completed days in advance to coordinate with family and gather resources for the resident to go home. During an interview on 06/19/24 at 4:14 PM, R369's RR1 revealed that he had a meeting with the SW and other facility staff due to the resident's exit seeking behaviors and the facility was unable to handle her need of care. The facility suggested that the resident be discharged to a locked unit about two hours away (105 miles according Apple Maps) and that would not be feasible for family to visit the resident. RR1 stated that they currently don't have any medication for R369 and they are trying to schedule an appointment at a local doctor's office near their home to get the resident some medication. RR1 finally stated that the SW completed the discharge paperwork with them, and they did not speak with the resident's nurse during the discharge process. During an interview on 06/19/24 at 4:51 PM, MD1 stated I work the South side and [MD2] works the North side. MD1 stated I think that was her family's decision to take her home. MD1 stated I saw her earlier in the week. It surprised me. She doesn't look like she would be demented. She is incontinent of urine. I was trying to get more information from her. She initially came to us with no medications. She isn't on any meds. MD1 further stated, It doesn't seem like she needs to be admitted to a nursing home. Her agitation was a wanting to leave behaviors. MD1 stated while I was seeing other patients, I heard the door go off of her trying to leave. MD1 concluded, I do not make preparation for discharges. This occurs prior to and I sign off. I only see the residents once a month. (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/19/24 at 6:39 PM, RR2 revealed that they are unsure why RR1 agreed to take the resident home because they know how difficult it is to care for someone with dementia and specifically a person with dementia that exit seeks. RR2 stated that she hopes that her family will be able to care for R369 but believed that it would have been best for R369 to remain at the facility under LTC. RR2 further stated that during the meeting this morning, they attended via phone, that the resident being discharged from the facility was not planned by R369's family. The facility stated that due to the resident's exit seeking behaviors the facility was unable to provide care for high level of needs and they suggested that she be transferred to a memory care unit (105 miles away). RR2 stated that was unfeasible due to her family not being able to travel that far, along with the family not feeling comfortable with the resident being on a locked unit, both resident representatives agreed to bring R369 home due to having no other choices. RR2 further stated that they and RR1 are in the process of becoming Power of Attorney (POA)'s for R369 and are hoping to find another LTC closer to RR1. During an interview on 06/19/24 at 6:00 PM, the Director of Nursing (DON) stated, When a resident is about to be discharged from the facility, we talk to the families to see what they need to be functional at home. We usually coordinate with the MD's office for home health and medical devices to setup in the home. Mostly Social Services conducts discharge meetings with residents and their representatives. I did not attend the meeting with the family of [R369] and the Administrator. The discharge today with [R369] consisted of the Social Worker and Administrator. We coordinate services and have the Social Worker follow the services up. The DON further stated, she was unable to follow up procedures today because this was an isolated incident. The facility was trying to coordinate something different so they can follow up with R369's case, because it is more isolated. No one knew she was going home today. The DON concluded, Today, the Nurse Consultant, Administrator and Social Worker assisted [R369's] family with discharge planning. During an interview on 06/19/24 at 6:09 PM, the Administrator stated, When a person is admitted we schedule a meeting with the resident and or representatives which occurs within 48 to 72 hours. We clarify if they have concerns and goals. Sometimes we clarify it on admission if they are planning on staying short term or long term. Discharge planning occurs with the family who decides what is needed such as supplies, durable medical equipment. This is coordinated with their insurance, the durable medical services, home health agency of their choice to get them set up at home. The Administrator further stated that herself, the SW, and a Nurse Consultant spoke with R369 RR's because R369 was calling them and saying that she wanted to go home. The facility wanted to discuss with the family about her exit seeking behaviors and high level of care. The Administrator stated, During the conversation staff offered another appropriate place for placement in a MSU but the family was not in agreement with that option. The family then suggested that they wanted to discharge the resident home and care for her there which was a surprise because we were unaware that wanted to take [R369] home. During the meeting we also suggested that the family do a Leave of Absence (LOA) to ensure that they will be equipped to care for her high level of needs, but they also refused that option as well. The Social Worker then provided [R369's] family with resources in the area closes to [R369's RR1]. The Administrator also stated that she will be following up with R369 RR's and potentially Adult Protective Services to ensure that the resident had a safe discharge and an appropriate placement and educated RR's about the importance of keeping R369 on a schedule to adjust back to being home to reduce the potential of her eloping. The Administrator finally stated that she was unaware of how/why the SW gave an order to the nursing staff to put a discharge order and home health order for R369. On 06/20/24 the facility provided an acceptable IJ Removal Plan, which included the following: (continued on next page)

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F 0624 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Implementation of the removal plan for F624 includes: R369 Resident Representative (RR)1 verbalized R369 would discharge home on 06/19/24 during a post admission care conference meeting. This meeting occurs with residents to discuss the resident's needs, review the resident's plan of care and discuss discharging planning. While the meeting was being held, further discussion regarding the potential need for transfer to a facility with supporting memory support unit was discussed due to the resident verbalizing and displaying the desire to go home. RR1 then verbalized that would not be optional for the family and the resident would be discharged home. The facility Administrator further discussed the resident's safety concerns and suggested to the resident's RR1 that the facility would place the resident on leave of absence, giving them the opportunity to bring R369 back to the facility if the transition back home was not feasible. The family proceeded with the decision to take R369 home despite facility efforts to allow appropriate planning for alternate discharge needs. Our date of achieving substantial compliance is 06/20/24. Methods to identify any other residents who might be affected include: all residents who discharge without appropriate planning of discharge, have the potential to be affected by the alleged deficient practice. Systemic changes include: The facility's regional team Area [NAME] President ([NAME]) and/or Senior Nurse Consultant (SNC) will initiate education on 06/19/24, to the facility Administrator, Social Worker, and Director of Health Services/ DON on the facility discharge process, to include but not limited to needs at time of discharge such as: medications, discharge instructions, home health and/or medical device needs. The facility Administrator, DHS, or appointed designee will educate the same process to the facility clinical partners and interdisciplinary team (IDT) starting on 06/19/24 and all education will be completed by 06/20/24 prior to the partners starting their next scheduled work assignment. The facility Administrator will review residents who discharge to ensure proper discharge process is followed. Any discharge that is determined to be potentially unsafe, the Administrator will notify the appropriate agencies such as Adult Protective Services (APS),the Ombudsman, and/or local law enforcement agencies if appropriate. Monitoring includes: the Administrator will present results of reviews to the QAPI Committee monthly for three months and or until substantial compliance is achieved.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42424 Based on interview, record review, and review of facility policy, the facility failed to implement care plan interventions for Resident (R)55 for oxygen use, for 1 of 3 residents reviewed for care plans. Findings include: Review of the facility policy titled Care Plans last revised on 07/21/21, revealed, It is policy of the health care center for each patient/residents to have a person centered baseline care plan followed by a comprehensive care plan developed following the completion of the Minimum Data Set (MDS) and Care Area Assessment (CAA) portions of the comprehensive assessment according to the Resident Assessment Instrument (RAI) Manual and the patient/resident choice. Comprehensive care plans should be reviewed not less than quarterly according to the MDS schedule, following the completion of the assessment. Care plans updates/reviews will be performed within seven days of each quarterly assessment, each acute change in condition, and as needed following each hospital stay. Care plans will be updated by Nurses, Case Mix Directors (CMD), or any other interdisciplinary team member so that the care plan will reflect the patient/resident's needs at any given moment. Review of R55's Face Sheet revealed R55 was admitted to the facility on [DATE], with diagnoses including but not limited to: respiratory syncytial pneumonia, sleep apnea, type 2 diabetes, and muscle weakness. Review of R55's Quarterly MDS with an Assessment Reference Date (ARD) of 06/05/24, revealed R55 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates that R55 is cognitively intact. Further review of the Quarterly MDS revealed that R55 utilizes oxygen as a special treatment. Review of R55's Physician Order Report dated 05/21/24 - 06/21/24, revealed R55 had an order for oxygen with a start date of 05/16/24, at 2 liters/minute via nasal cannula as needed. Review of R55's Care Plan revealed R55 no care plan or interventions related to oxygen or oxygen usage. During an interview on 06/18/24 at 11:30 AM, R55 revealed they were unsure of the last time the facility spoke with her about her plan of care/care plan meetings. During an interview on 06/21/24 at 10:36 AM, Licensed Practical Nurse (LPN)4 verified that R55 had not been care planned and has no intervention for oxygen use in her Electronic Medical Record (EMR) at this time. LPN4 stated that according to the EMR, R55's last care plan conference occurred on 03/04/24 and a quarterly care plan should have taken place on 06/02/24, but was unable to verify that it occurred. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/21/24 at 11:24 AM, the Director of Nursing (DON) revealed R55 should have a care plan and interventions related to her oxygen use and they were also not able to verify if a care plan meeting took place on 06/02/24 for R55 and their resident representative.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47075 Based on review of facility policy, observation, interview, and record review, the facility failed to ensure a resident who was dependent on staff for Activities of Daily Living (ADLs) received the necessary services to maintain personal hygiene, specifically nail care, bed baths and showers, for 1 of 7 sampled residents (Resident (R) 2). Findings include: Review of the facility policy titled, Charting Activities of Daily Living (ADLs) with a date of 2014, revealed, Definitions: Activities of Daily Living (ADLS's): The task of everyday life. The ability or inability to perform ADL's is a measurement of the functional status of a person. Review of R2's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/19/24, indicated R2 was admitted to the facility from the hospital on 03/17/23, with diagnoses including but not limited to: chronic obstructive pulmonary disease with (acute) exacerbation, chronic diastolic (congestive) heart failure, malignant neoplasm of upper lobe, left bronchus or lung, syndrome of inappropriate secretion of antidiuretic hormone, and dementia. Further review of the MDS revealed R2 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which revealed the resident was moderately cognitively impaired. During an observation on 06/18/24 at 2:04 PM, R2 was lying in bed, hair disheveled, nails dirty, face and clothing had dried on food. During an observation on 06/19/24 at 11:20 AM, R2's hair was unkept, she was wearing a black shirt with a bright pink emblem. R2's nails were dirty. R2's face, clothing, and sheets contained dried food. During an observation on 06/20/24 at 11:03 AM, R2 was lying in bed with the same black and pink shirt that she wore on the previous day. R2's nails were dirty, hair unkept, and dried food was on her clothes, face, and sheets. During an observation on 06/20/24 at 4:34 PM, R2 was lying in bed with the same black and pink shirt that she wore previously. R2's nails were dirty, hair unkept, and dried food was on her clothes, face, and sheets. During an interview on 06/20/24 at approximately 7:03 PM, Certified Nursing Assistant (CNA)4 revealed she was not assigned to R2. CNA4 stated, It is never acceptable for residents not to get assistance daily with ADL care. During an interview on 06/20/24 at approximately 7:18 PM, CNA1 revealed she was assigned to R2 and is familiar with the resident. CNA1 stated R2 requires extensive care and follows R2's shower schedules that are in the system. R2 gets bed baths on the days that she does not get showers. CNA1 further stated nail care and hair care is included when she provides ADL care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425113	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Dillon	413 Lakeside Court Dillon, SC 29536

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47075 Based on review of facility policy, observation, interview, and record review, the facility failed to ensure: accurate labeling and dating of foods and removal of expired foods from 1 of 1 main kitchen. Findings include: Review of the facility policy title Labeling, Dating, and Storage dated 2014, revealed, Policy Statement: It is the policy of PruittHealth for all partners who assist in handling, preparing, serving, and storing food and beverage items to follow the proper procedures for labeling, dating, and storage to ensure proper food safety. During an observation on [DATE] at 10:47 AM, with the Dietary Manager (DM), revealed the cooler contained the following: 2 rotten heads of cabbage, dated [DATE], 3 cucumbers undated in a box that contained potatoes, 1 jar of reliance Italian dressing, opened [DATE] with an expiration date of [DATE], 1 large container of Apple Sauce dated [DATE], no expiration date. During an interview on [DATE] at 12:48 PM, the Kitchen Manager-Dietary Manager (DM) revealed labeling, storing, discarding of expired items are done by all staff and all staff received training. The items are always first in first out in all storage areas. It is the DM's expectation that staff always label, date, and discard of expired items.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42424 Based on interview, record review, and review of facility policy, the facility failed to maintain complete and accurate medical records for Resident (R)55, in accordance with accepted professional standards and practices, for 1 of 5 residents reviewed. Findings include: Review of the facility policy titled Maintenance of Medical Records last revised on 12/06/22 revealed, It is the policy of the facility to maintain a medical record for each patient/resident in the healthcare center/agency that is to be accurate, complete, and systematically organized. Review of R55's Face Sheet revealed R55 was admitted to the facility on [DATE], with the diagnoses including but not limited to: respiratory syncytial pneumonia, sleep apnea, type 2 diabetes, and muscle weakness. Review of R55's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 06/05/24, revealed R55 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that she is cognitively intact. Further review of the Quarterly MDS revealed that R55 utilizes oxygen as a special treatment. Review of R55's Physician Order Report dated 05/21/24 - 06/21/24, revealed R55 had an order for oxygen with a start date of 05/16/24 at 2 liters/minute via nasal cannula as needed. Review of R55's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for June 2024, revealed that R55 has an order for O2 (oxygen) at 2 Liters per min via nasal cannula as needed. Further review of the MAR and TAR revealed nursing staff did not document times oxygen were administered, reason for administering, and follow result from being administered from 06/01/24 - 06/20/24. Review of R55's MAR and TAR for May 2024, revealed R55 had an order for oxygen at two liters a minute via nasal cannula as needed. Further review of the MAR and TAR revealed nursing staff did not document times oxygen were administered, reason for administering, and follow results from being administered from 05/16/24 - 5/31/24. Review of R55's Nursing Notes revealed several different nursing staff incorrectly charting the oxygen that was administered to R55 as 3 liters/minute instead of the Physician Ordered 2 liters/minute, on the following dates: 05/05/24, 05/06/24, 05/08/24, 05/27/24, and 06/02/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/21/24 at 10:36 AM, Licensed Practical Nurse (LPN)4 revealed that the resident is on PRN (as needed) oxygen use, nursing staff don't always document in the MAR when a resident is on PRN oxygen use, only for continuous usage. LPN4 further stated that R55 will take off her oxygen throughout the day at times and will mostly use her oxygen while laying in bed, she discontinues when attending therapy. LPN4 reviewed R55's Physician Orders and verified that oxygen is at 2 liters. LPN4 reviewed R55's nursing notes and verified that nursing documentation has been incorrectly charted at 3 liters by several nursing staff. During an interview on 06/21/24 at 11:24 AM, the Director of Nursing (DON) expects nursing staff to document in the MAR when a resident is on oxygen even if the order is as needed/prn. The DON also stated that her expectation is for nursing staff to document accurately in the EMR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47075 Based on review of the facility policy, observations, interviews, recorded reviews, the facility failed to utilize appropriate hand hygiene during serving of meals on 1 of 3 units. Findings include: Review of the facility policy titled Infection Prevention - Hand Hygiene dated 2014, revealed, D. Indication Requiring Hand Wash or Hand Rub: 9. Passing meal trays to residents. During an observation on 06/19/24 at 8:18 AM, revealed on the Northside, staff not sanitizing their hands while passing out breakfast trays to residents. During an observation on 06/19/24 at approximately 12:37 PM, Certified Nursing Assistant (CNA)3 was not sanitizing her hands while passing out lunch meal trays. During an observation on 06/20/24 at 5:37 PM, CNA4 was not sanitizing her hands while passing out dinner meal trays. During an interview on 06/19/24 at approximately 2:37 PM, CNA3 revealed the policy and procedure for sanitizing hands while passing out meal trays is to always sanitize hand before going in the room and coming out of the residents' room, no exceptions. During an interview on 06/20/24 at approximately 7:03 PM, CNA4 stated, You always wash hands before passing out the trays and after wash them passing out the meal trays. During an interview on 06/21/24 at 8:43 AM, the Director of Nursing (DON) revealed all staff are required to sanitize their hands before passing out meal trays and after passing out meal trays, any time the staff hands become soiled.