STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425116	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edisto Post Acute	575 Stonewall Jackson Boulevard Orangeburg, SC 29115

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	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42072 Based on observation, interviews, and facility policy review, the facility failed to treat residents with respect and dignity for two sampled residents (Resident (R)28 and R64) as evidence by staff standing over the residents while assisting them with eating their meals. Findings include: Review of the facility's policy titled Assistance with Meals revealed: 2. Facility staff will serve resident trays and will help residents who require assistance with eating. 3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. Not standing over residents while assisting them with meals; b. keeping interactions with other staff to minimum while assisting residents with meals; c. avoiding the use of labels when referring to residents (e.g., feeders); and d. avoiding the use of bibs or clothing protectors instead of napkins, unless requested by the resident. Observation during lunch meal on 6/18/24 at 12:34 PM showed Certified Nurse Aide (CNA)1 was observed feeding R64, while she was standing over the resident. Further observations on 06/18/24 at 12:39 PM showed CNA1 was then observed feeding a second resident, R28, in addition to R64, and was standing up in between the residents, while feeding both of them. (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

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NAME OF PROVIDER OR SUPPLIER Edisto Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 575 Stonewall Jackson Boulevard Orangeburg, SC 29115	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 12:4 PM, during an interview with the Director of Nursing (DON), the DON stated, The protocol for just somebody that needs assistant with feeding, they have to feed the patient. They deliver the tray. They've used their hands; of course, they should have already used their hand sanitizer. They, you know, shouldn't touch the food. If they have to cut it up or anything like that after they're done, they need to wash their hands before they move on to the next person. They need to sit down when they're feeding the resident. On 6/20/24 at 12:51 PM, the DON further stated, Training? The last time was probably today, but I guess yesterday they did, but probably today. Now they know they need to wash their hands before and after helping a resident. The training probably didn't go in depth with not feeding two patients at the same time, but as far as standing while feeding the residents, they (the staff) know they need to sit down.

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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** 25619 Based on record review, interview with facility staff and review of facility policy, the facility failed to ensure the comprehensive assessment for one (1) of 21 residents reviewed was completed accurately (Resident (R)77). Findings include: Review of facility policy titled Electronic Transmission of the MDS revealed the Policy Interpretation and Implementation stated 8. The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking. Review of the medical record for R77 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, dementia and depression. Review of the Physician's Orders for R77 revealed Physician's Orders for Quetiapine Fumarate (Seroquel-an antipsychotic) 25 mg (milligrams) at bedtime, and Escitalopram Oxalate (Lexapro-an antidepressant) 10 mg by mouth daily. Review of the Medication Administration Record for R77 for the months of May 2024 and June 2024 revealed R77 received Seroquel and Lexapro from 5/28/24 through 6/18/24. Review of the Admission MDS assessment for R77, with an Assessment Reference Date of 6/4/24, revealed that R77 had not been coded for the use of antipsychotic and antidepressant medications. On 6/19/24 at 1:35 PM, during an interview with the MDS Coordinator 5, s/he stated s/he must have missed coding those medications and the MDS would need a modification.

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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** 25619 Based on record review and interview with facility staff the facility failed to ensure a comprehensive person-centered care plan for each resident identified services to be provided to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being by not initiating a care plan for the use of antipsychotic medications for one (1) of 21 residents whose care plans were reviewed (Resident (R)77). The findings include: Review of the medical record for R77 revealed an admitted [DATE]. Diagnoses included Metabolic Encephalopathy, Dementia and Depression. Review of the Physician's Orders for R77 revealed Physician's Orders for Quetiapine Fumarate (Seroquel-an antipsychotic) 25 mg (milligrams) at bedtime, and Escitalopram Oxalate (Lexapro-an antidepressant) 10 mg by mouth daily. Review of the Medication Administration Record for R77 for the months of May 2024 and June 2024 revealed R77 received Seroquel and Lexapro from 5/28/24 through 6/18/24. Review of the Admission Minimum Data Set (MDS) assessment for R77, with an Assessment Reference Date (ARD) of 6/4/24, revealed that R77 had not been coded for the use of antipsychotic and antidepressant medications. Review of the Care Plan for R77 revealed no Care Plan for the use of the antipsychotic medication, Seroquel. On 6/19/24 at 1:35 PM, during an interview with the MDS Coordinator 5, s/he stated s/he must have missed coding those medications and the MDS would need a modification. The MDS Coordinator 5 stated since R77 had not been coded on the Admission MDS for the use of antipsychotic medications, a Care Plan for the use of Seroquel had not been developed as it should have been.

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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. 42072 Based on observations, interviews, and facility policy review, the facility failed to ensure that food was served to residents in a manner that would ensure the prevention and spread of disease or potential infection for two (2) sampled residents (R28 and R64) during meals observation. The findings include: Review of the facility's policy titled Handwashing/Hand Hygiene revealed: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. The policy further revealed, Administrative Practices to Promote Hand Hygiene 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Observation during lunch meal on 6/18/24 at 12:34 PM showed Certified Nursing Assistant (CNA)1 was observed feeding R64. Observed CNA2 setting up R28 meal on the food tray while he/she was still feeding R64 without washing his/her hands. On 6/18/24 at 12:39 PM, CNA1 was observed to simultaneously feeding two residents, R28 and R64, without performing any hand hygiene in between assisting one to the other. On 6/18/24 at 3:15 PM, Licensed Practical Nurse (LPN)1, stated that the facility is definitely under staffing. LPN1 then stated, They have at least 15 Feeders (residents who need assistant with eating) and only three (3) CNAs to help. LPN1 then stated that the CNAs were doing the best they could to attend all of the residents. S/he stated, You know, now we have more residents and less staffing. On this wing right now, we have 2 CNAs I think, but we have several feeders. How can they attend all of them . On 6/20/24 at 12:49 PM, during an interview with the Director of Nursing (DON), the DON stated, Every delivery of trays, they have to wash their hands with hand sanitizer. Of course, they already wash their hands before delivery of trays. They can use hand sanitizer three times, and they have to wash their hands if they're going to feed a patient, you know. They should wash their hands after even before they go to the next person not hand sanitizer. No, not washing their hands and helping 2 patients at the same time, that will not be appropriate. They should wash their hands before they move to the next person . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 12:51 PM, the DON further stated, Training? The last time was probably today, but I guess yesterday they did but probably today. Now they know they need to wash their hands before and after helping a resident. The training probably didn't go in depth with not feeding two patients at the same time, but as far as standing while feeding the residents, they (the staff) know they need to sit down.