

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/20/2024
NAME OF PROVIDER OR SUPPLIER  Bennettsville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  710 15-401 Bypass, West Bennettsville, SC 29512	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835</b></p> <p>Based on review of facility policy, interview, and record review, the facility failed to ensure Resident (R)1 and R2 were free from misappropriation of a narcotic medication, for 2 of 2 residents.</p> <p>Findings include:</p> <p>Review of the undated facility policy titled, Abuse, Neglect, Exploitation, or Mistreatment documented, Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p> <p>Review of the facility policy titled, Controlled Substances with a revision date of 04/17/24, documented, All scheduled controlled medications removed from the storage for the purpose of administering doses to the resident will be entered onto the residents controlled drug receipt/record/disposition form. Additionally, the 8 rights for administering medication; #4. the right time, and Medications are administered no more than one hour before to one hour after the designated medication pass time.</p> <p>Review of R1's Facesheet revealed R1 was admitted to the facility on [DATE], with diagnoses that included but are not limited to: dementia, chronic pain, hypothyroid and atherosclerotic heart disease.</p> <p>Review of R1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/24, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severe cognitive impairment.</p> <p>Review of R1's Physician Orders revealed an order for hydrocodone/acetaminophen (narcotic pain medication) 10 milligrams (mg)/325 mgs, give 1 tablet 4 times a day, with a start date on 06/20/23.</p> <p>Review of R1's Medication Administration Record (MAR) dated 11/01/24 - 11/13/24, recorded R1's hydrocodone/acetaminophen is ordered to give at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM.</p> <p>Review of R1's Controlled Drug Receipt/Record/Disposition Form for hydrocodone/acetaminophen 10/325 (generic for Norco) revealed on 11/09/24 at 6:00 PM, Licensed Practical Nurse (LPN)1 signed the Norco medication from the narcotic box. There was an additional signature also dated 11/09/24 at 6:00 PM, by Registered Nurse (RN)1, that signed out the medication Norco for R1 from the narcotic box.</p> <p>(continued on next page)</p>

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:  425118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/20/2024
NAME OF PROVIDER OR SUPPLIER  Bennettsville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  710 15-401 Bypass, West Bennettsville, SC 29512	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R2's Facesheet revealed R2 was admitted to the facility on [DATE], with diagnoses that include but are not limited to: unspecified dementia, pain unspecified, Type 2 diabetes mellitus, hypertension and anemia.</p> <p>Review of R2's MDS with an ARD of 09/07/24, revealed R2 had a BIMS score of 14 out of 15, indicating R2 was cognitively intact.</p> <p>Review of R2's Physician Orders revealed an order for hydrocodone/acetaminophen 5mg/325mg, take 1 tablet twice a day for pain with a start date of 02/24/24.</p> <p>Review of R2's MAR dated 11/01/24 - 11/13/24, revealed hydrocodone/acetaminophen is ordered to give at 8:00 AM and 8:00 PM.</p> <p>Review of R2's Controlled Drug Receipt/Record/Disposition Form for hydrocodone/acetaminophen 5/325 (generic for Norco) revealed LPN1 recorded an incorrect date for 11/09/24. LPN1 signed the norco on 11/08/24 at 8:00 AM and 8:00 PM, although the previous date was also 11/08/24, which is consistent with the dates previously recorded in sequence of the dates the norco was ordered for. On 11/09/24 at 9:00 PM the norco was again signed as removed from the narcotic box by LPN2.</p> <p>Review of Drug Enforcement Administration (DEA) form 106, Report of Theft or Loss of Controlled Substances signed on 11/15/24 by the Director of Nurses (DON), to report 2 narcotic medications. Further review of this record revealed it reported 2 hydrocodone/acetaminophen, one a 10/325 mg replaced with a white oblong tablet scored with imprint M367 was replaced with oblong white tablet unscored and imprinted E. Additionally, 5/325 mg tablet replaced with a white oblong tablet scored with imprint M365 was replaced with oblong white tablet unscored and imprinted E.</p> <p>Review of a statement written by Registered Nurse (RN)1 revealed he was the assigned nurse on 11/09/24, 400 hall, from 2:00 PM until 7:00 PM. RN1 reported the narcotic count was correct when he counted the narcotics with LPN1, before she left. RN1 further stated, discovered a basket with pre-pulled medications with residents name in the medication cart. I informed the DON that these medications were prepulled and they were locked up in the DON office as directed. I was unaware that these prepulled medications were narcotics.</p> <p>Review of a statement dated 11/09/24, signed by Licensed Practical Nurse (LPN)2, revealed, When counting the narcotics prior to [RN1] leaving, the count was correct. I pulled all my medications for all residents as ordered, including narcotics. I was unaware of any prepulled medication of any kind. I did notice that the narcotic medication I was scheduled to administer was signed out by [LPN1] with the correct medication times, even though she was not present in the facility at any time during my shift.</p> <p>During an observation and interview on 11/20/2024 at 11:36 AM, R1 was up in a wheelchair and had no complaints of pain and showed no physical signs of pain.</p> <p>During an observation and interview on 11/20/2024 at 11:45 AM, R2 was laying in bed and had no complaints of pain and showed no physical signs of pain.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/20/2024
NAME OF PROVIDER OR SUPPLIER  Bennettsville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  710 15-401 Bypass, West Bennettsville, SC 29512	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/20/24 at 2:23 PM, LPN3 stated, I worked with [LPN1] on that date 11/09/24. Around 11 AM -12 PM, I noticed she was standing at the 400 cart. She was kind of swaying back and forth. Her eyes were closed. She appeared to be falling asleep. She looked wild eyed when she was awake with her eyes open. I notified my supervisor and DON. The on-call supervisor was [RN1]. He was on call that day. Somebody asked me, What's wrong with her? I can't remember who that was. Between 12-12:30 PM I notified them (supervisor and DON). It was about 20-30 minutes before they came in. They took [LPN1] privately off to speak to her. She left soon thereafter. She counted off with [RN1].</p> <p>During an interview on 11/20/24 at 3:14 PM, LPN1 stated, I worked that Saturday 11/09/24 and was scheduled to work 16 hours that day. My DON came in around 2-3 PM. She said someone had reported I was inebriated or something. I clocked out around 3 PM. Pre-pouring meds is normal if you are working that kind of schedule. The DON called a few days later to say she found pre-pulled meds and she also said 2 Norco's were replaced with Excedrin. I don't know where the Excedrin came from. I did pre-pour narcotics that were ordered along with the evening medications.</p> <p>During an interview on 11/20/24 at 3:25 PM, the DON stated, I sent [LPN1] home because of a call I got earlier from the nurse who works on the 500 unit. She reported something was wrong with [LPN1]. [LPN1] was scheduled to work 16 hours and [RN1] took over until 7:00 PM and [LPN2] took the cart after [RN1] left. It was not until Tuesday that I looked at those meds. When he went to do med pass, there was a basket of medications he found in the cart. [RN1] called me between 3:30 PM - 4:00 PM. I left around 2-2:30 PM. When he called me, he only said their were pre-pulled meds, no mention of narcotics. I didn't know there were narcotics at that time. When [RN1] left that day at 7:00 PM, he only signed out [R1's] Norco. He didn't realize [LPN1] had signed out for the med earlier, for the same time. It was [LPN2] who came in afterward to relieve [RN1]. She called me about 8 PM or so to tell me the narcotics she was scheduled to give were already signed out by [LPN1]. When I reviewed the meds, the Nurse Practitioner was with me. She was able to use her drug identifier to identify the medication, that the Norco was not a Norco but an Excedrin.</p> <p>During an interview on 11/20/24 at 5:27 PM, the Administrator stated, The employee was terminated. She pulled pills and narcotics too early. With the Excedrin replacing the narcotic, she was the obvious person, the only one with the narcotic keys.</p>		