STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425121	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak View Health and Rehabilitation	3300 4th Avenue Conway, SC 29527

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, record review and interview, the facility failed to ensure Resident (R)5, R98 and R23, were afforded an ongoing program of activities, based on their personal preferences and interests for 3 of 3 residents reviewed for activities. Findings include: Review of the facility policy titled, Activities Program, states, as the policy, It is the policy of this facility to implement an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence. It is also the policy of this facility to create opportunities for each resident to have meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy, and meaning). Procedures: Activities are planned according to the resident's preferences, needs, and abilities. Every resident will be interviewed for preferences. Equipment and supplies are available and accessible to accommodate each resident who chooses to participate in an activity. 4. Daily newspapers, current magazines, and a variety of reading materials are available and accessible to all residents. 5. Socialization activities will be made available through: group discussion, conversation, recreation, visiting, arts and crafts, and music. 6. Physical activities will also be made available such as games, sports, and exercises which develop and maintain strength, coordination, and range of motion. Review of R98's Face Sheet revealed R98 was admitted to the facility on [DATE], with diagnoses which included, but was not limited to, encephalopathy, major depressive disorder, and psychosis. Review of the Activity Care Plan initiated on 04/01/2026, states R98 enjoys the following activities: board games, cards, bingo, word searches, exercise, sermons, reading, his religion, trips, shopping, being outdoors, watching tv, gardening, parties, dogs, and keeping up with the news. Interventions/Tasks on the care plan were as follows: invite to scheduled activities, needs assistance/escort to activity functions, offer leisure materials, and provide activities calendar monthly. Review of the Activity Tracker for April 2026 listed TV/Radio/Movies every day. R98 had coffee, salon, and snack/beverage one time each in the month of April 2026. Review of the Activity Tracker for May 2026 listed TV/Radio/Movies every day. No other activities of interest listed on the care plan was offered. During an interview with the Activity Director on 05/28/2026 at 1:15 PM, the Activity Director stated employment with the facility had been almost a year. The Activity Director further stated the priority (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was to start with the group activities, then Memory Care, and then room visits. The Activity Director stated we are working towards this and confirmed R98 was up in his/her chair watching TV daily. Review of R23's Face Sheet revealed R23's admission date was 11/02/2022, with diagnoses including, but not limited to, alcohol use unspecified, with alcohol induced persisting amnestic disorder, mood disorder due to known physiological condition with depressive features, and depression. Review of R23's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 04/29/2026, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating R23's cognition was moderately impaired. Review of R23's Activity Care Plan with a start date of 05/19/2026, and a target completion date of 08/10/2026, revealed R23 enjoys biking, enjoys keeping his room very tidy, and he also enjoys drinking ginger ale, hard pretzel sticks, and Hershey's chocolate kisses. He enjoys the Grateful Dead band. Most of the time, he prefers to have the blinds in his room closed. During an observation on 05/26/2026 at 11:39 AM, R23 was observed lying in bed in the dark with the blinds and door closed. During an observation on 05/27/2026 at approximately 11:03 AM, R23 was observed in the room with the door and blinds closed. With no lights on in the room facing the window. During an observation on 05/28/2026 at approximately 11:57 AM R23 was observed lying in bed, in the dark, with blinds closed, asleep. During an interview on 05/26/26 at 11:39 AM, R23 states, This place is a joke. R23 states he does not participate in activities by choice because they do not offer anything he wants to do. R23 further stated, I do not want to draw circles and color. During an interview on 05/28/2026 at 8:37 AM, the Activity Director (AD) states she has been the AD in the facility for approximately 1 year. The AD states R23 does not like group activities; sometimes she does 1:1 activities in his room. The AD confirmed the activity sheets for April and May 2026 reflected R23 was in his room watching TV independently for the majority of the months and did not participate in activities on the locked unit. The AD further stated there is a fenced courtyard that the residents could use if he wants to go outside. The AD states she will get with the locked unit manager to see if R23 can utilize the courtyard sometimes. During an interview on 05/28/2026 at 11:33 AM, Licensed Practical Nurse (LPN)2 states R23 sometimes refuses to get out of bed when asked. LPN2 states the resident does not like to be around a lot of people but prefers to do things with staff 1:1. During an interview on 05/28/2026 at approximately 11:40, R23 states he would love to have activities other than what he sees the other residents have on the locked unit. I would like to do something different, maybe go outside and get off this floor and out of this bed sometimes. During an interview on 05/28/2026 at approximately 2:01 PM, the Director of Nursing (DON) states that activity expectations are to know what the resident likes and tailor activities around the resident. For residents on the locked unit, her expectations are for a 1:1 activity visit with activities on the unit. The DON states that R23 is taken on walks with the unit manager, where R23 is walked through the facility. The DON revealed that staff do not document the walks with R23. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R5's Face Sheet revealed the facility admitted R5 with diagnoses including, but not limited to muscle weakness, dysphagia and stroke. Review R5's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/15/2026, revealed a Brief Interview for Mental Status score of 5 out of 15, which indicated R5 had severe cognitive deficit. Review of R5's comprehensive plan of care revealed a focus area of activities. The focus area states, Resident enjoys the following activities: bingo, country music, reading, praying and being outdoors. He also enjoys watching tv, parties, dogs/pets and keeping up with the news. Review of the activity attendance sheets provided by the Activity Director, revealed R5 participated in daily TV independently. R5 was not afforded any of the activities related to his preferences. During an interview on 05/28/2026 at 8:04 AM, the Activities Director (AD) confirmed that R5 had only received the television on in his room as an activity and was not offered any of the care planned activities of his preference. The AD also stated that she was in the process of initiating a one on one activity program for residents that did not want to attend out of room activities. At this time the AD confirmed that R5 had not been included in any of his activity preferences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy, observation and interview, the facility failed to ensure outdated/expired medications and biologicals were removed from 1 of 4 treatment carts. The facility additionally failed to ensure 1 of 1 medication carts and 1 of 1 treatment carts on Unit 400 was locked while unattended. The facility further failed to ensure one vial of insulin was labeled with an open date and discard date in 1 of 2 medication rooms.Findings include: Review of the facility policy titled, Medication Access and Storage, states as the policy, It is the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures:2. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. 12. Outdated or discontinued medications are removed from stock upon discovery and disposed of according to procedures for medication destruction. Outdated medications are reordered from the pharmacy, if a current order exists. During an observation on 05/26/2026 at 12:39 PM, of medication cart 700 center, revealed the medication cart was unlocked and unattended. There was no nurse in the vicinity of the cart. During an observation on 05/26/2026 at 12:41 PM, of a treatment cart on 700 center, revealed the treatment cart unlocked and unattended. During an interview on 05/26/2026 at 12:44 PM, Registered Nurse (RN)3 confirmed that the 2 carts were unlocked and she stated she had just stepped away to the restroom. During an observation on 05/27/2026 at 9:45 AM, of the Treatment Cart on 4th Hall, revealed 5 individual pads of XLTA Hydro Capillary 5 cm x 5 cm (2x 2) Sterile, with lot #202103 was expired on 03/2026. XLTA Hydro Capillary, 6 pads, 10 x 10 (4 x 4) with Lot# 202103 was expired on 03/2026. One bottle of Ready Prep, manufactured by Medline, Providone - Iodine 10% Solution with Lot #23DJA062 was expired on 03/2025. The above medications and biologicals were verified by RN5 and removed from storage. During an observation on 05/28/2026 at 8:25 AM, of the 4th Hall Medication room, revealed one vial of Insulin Lispro 100u/ml opened with Lot #D766068C with expiration date of 07/21/2027, with no opened date and no expiration date.During an interview on 05/28/2026 at 8:27 AM, Licensed Practical Nurse (LPN)3 Unit Manager, confirmed the findings and stated, when a medication is opened, it should be dated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, the facility failed to provide Resident (R)119 dignity during respiratory care, for 1 of 4 residents reviewed for dignity. Findings include: Review of the facility policy titled Policy/ Procedure - Nursing Administration Resident Right, Dignity and Privacy last revised November 2023, revealed, It is policy of this facility that all residents be treated with kindness, dignity, and respect. Procedures include that the staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. Residents shall be examined and treated in a manner that maintains privacy of their bodies. A closed door or drawn curtain shields the resident from passers-by; people not involved in the care of the resident shall not be present without the resident's consent while they are being examined or treated. Review of R119's Face Sheet revealed R119 was admitted to the facility on [DATE], with diagnoses including but not limited to, persistent vegetative state, tracheostomy status, bed confinement status, and aphasia. Review of R119's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/29/26, revealed that R119 was unable to complete a Brief Interview for Mental Status (BIMS) due to his vegetative state. Further review of the MDS revealed that R119 is dependent on staff for all Activities of Daily Living (ADLS). During an observation on 05/26/26 at 3:01 PM, revealed two staff members, Registered Nurse (RN)1 and RN2, providing tracheostomy care to R119 without the privacy curtain pulled or the door closed in his room. R119's care could be observed from the hallway and was visible to anyone who walked past his room at this time. During an interview on 05/26/26, with RN1 and RN2 after they finished providing tracheostomy care to R119, revealed that they should have provided R119 with dignity by closing the door or pulling the privacy curtain. During an interview on 05/28/26 at 5:35 PM, the Director of Nursing (DON) and Administrator revealed that their expectation is that all facility staff provide residents with dignity during care.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident (R)155 and R139 was allowed the right to self-determination. Specifically, the facilitation of preferences related to attending activities and Activities of Daily Living (ADL) schedule, for 1 of 5 residents reviewed for choices.Findings include: Review of R155's Face Sheet revealed R155 was admitted to the facility on [DATE], with diagnoses including but not limited to muscle weakness, anxiety disorder, mood disorder due to known physiological condition with mixed features, and chronic respiratory failure. Review of R155's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/09/26, revealed R155 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated that R155 had moderate cognitive impairment. Further review of the MDS revealed that it is very important to R155 to attend/do activities with groups of people. R155 requires set up or clean up assistance with upper and lower body dressing and needs supervision/touching assistance with personal hygiene. Review of R155's Care Plan, last revised on 04/20/26, revealed R155 has a self-care deficit related to weakness, chronic obstructive pulmonary disease (COPD), respiratory failure, depression, anxiety, mood disorder, and incontinence. Interventions include, promote dignity and privacy, encourage to discuss feeling about self-care deficit, requires supervision/touching assistance with personal hygiene and upper/lower body dressing. Review of R139's Face Sheet revealed R139 was admitted to the facility on [DATE], with diagnoses including but not limited to, anxiety disorder, dementia with anxiety, chronic pain, and essential tremor. Review of R139's MDS with an ARD of 03/10/26, revealed that R139 had a BIMS score of 14 out of 15, which indicates that she is cognitively intact. Further review of the MDS revealed that R139 is dependent on staff for upper/lower body dressing, personal hygiene, and for toileting hygiene. Review of R139's Care Plan, last revised on 01/19/26, revealed, R139 has self-care deficit related to right femur fracture, weakness, she is incontinent and has dementia, essential tremors, diabetes mellitus, bipolar disorder, depression, and anxiety. Interventions include, bed mobility, dressing (assistance of one staff for dressing), transfer (one assist), encouragement to participate to the fullest extent possible with interaction and requires partial/moderate assistance with personal hygiene care. Review of R139's Care Plan last revised on 09/29/25, revealed, R139 enjoys bingo, arts and crafts, outdoor patio and special events. R139 prefers independent leisure time acts such as playing games on her personal phone, intervention include encourage R139 to take rest breaks between activities and treatments, inviting and encourage to join groups of her interest, offering leisure materials, and providing a monthly calendar. Review of the May 2026 Activity Calendar revealed the following activities for 05/26/26; Coffee Social at 10:30 AM, Trivia at 11:00 AM, May Birthday Bash at 2:00 PM, and Family Feud at 3:00 PM. During an observation and interview on 05/26/26 at 11:09 AM, revealed R155 in bed waiting for staff to assist her with personal hygiene and ADL care. During the interview with R155, questions were asked related to choices of schedules and call light response times. R155 and her roommate, R139, both stated that staff answer the call light but don't actually come back to assist residents with care. R155 stated that she, at times, does like to attend activities, but today preferred not to attend any, but was just waiting on her CNA so she could get dressed for the day and had been waiting since after breakfast for someone to come back to help her. During an observation and interview on 05/26/26 at 11:14 AM, R139 revealed that she prefers to have staff assist her with ADL care before 10:00 AM, so she can attend activities. During the interview with R139, she stated that for the past few weeks, staff have not been adhering to her preference related to her ADL schedule, because of this she has been late attending several activities or missed the opportunity to attend activities in the morning altogether. R139 stated, This past Sunday, [05/24/26] I was late attending the church service that we have here at the facility. I hate to be late to things, but especially church. I (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was late because I had a difficult time finding a Certified Nursing Assistant (CNA) who could assist me with dressing. Today [05/26/26] I wanted to attend the coffee social in the dining room, but it's probably almost over because it started at 10:30 AM and I've been waiting for about an hour. Staff come into the room and say they are going to come back, but don't and turn off my call light. During the interview with R139 this surveyor requested that the resident press her call light again because it was currently not on. Shortly after pressing the call light (approximately 1 minute), CNA1 entered the room and told R139 that she was not her current CNA but would go and find the resident's assigned CNA. During an observation on 05/26/26 at 11:22 AM, revealed CNA1 and CNA2 entered the resident's room. CNA2 stated that she was unsure of who the resident's aid was for the day and had entered the room looking for another staff member and is currently working on a different unit of the facility. CNA1 explained to R139 that her assigned aid was assisting another resident at this time. During this observation, no staff member attempted to assist the resident with ADL care. During an observation and interview on 05/26/26 at 11:42 AM, R139 revealed a second request for the resident to press her call light for assistance. During an observation and interview on 05/26/26 at 11:44 AM, revealed that the Administrator entered the room, stating that he saw the resident's call light was on and that all staff are expected to respond to the resident's call lights. During this observation, R139 became upset with the Administrator and stated that she had been waiting over an hour for assistance with dressing so she could attend activities that began at 10:30 AM. During the interview the Administrator apologized to the resident and stated that he would be back shortly with staff so that the resident could get dressed for the day. During an observation and interview on 05/26/26 at 11:48 AM, revealed that the Administrator, Unit Manager, and a Licensed Practical Nurse (LPN) entered the room to provide ADL care to R139 and her roommate, who had also been waiting for assistance with ADL care. During an interview on 05/28/26 at 5:25 PM, the Director of Nursing (DON) and Administrator revealed that their expectation is for staff to adhere to residents' preferences with their schedule's related to ADL care, the Administrator further stated that he expects staff to respond to residents' call lights within 15 minutes.

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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** Based on review of facility policy, observation, record review and interview, the facility failed to implement the Comprehensive Plan of Care related to providing a program of activity preferences for Resident (R)5 and R98, for 2 of 3 residents reviewed for activities. Findings include: Review of the undated facility policy titled, Activities Program, states, as the policy, It is the policy of this facility to implement an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence. It is also the policy of this facility to create opportunities for each resident to have meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy, and meaning). Procedures: Activities are planned according to the resident's preferences, needs, and abilities. Every resident will be interviewed for preferences. Equipment and supplies are available and accessible to accommodate each resident who chooses to participate in an activity. 4. Daily newspapers, current magazines, and a variety of reading materials are available and accessible to all residents. 5. Socialization activities will be made available through: group discussion, conversation, recreation, visiting, arts and crafts, and music. 6. Physical activities will also be made available such as games, sports, and exercises which develop and maintain strength, coordination, and range of motion. Review of R5's Face Sheet revealed the facility admitted R5 with diagnoses including, but not limited to muscle weakness, dysphagia and stroke. Review of R5's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/15/2026, revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated a severe cognitive deficit. Review of R5's comprehensive plan of care revealed a focus area of activities. The focus area states, Resident enjoys the following activities: bingo, country music, reading, praying and being outdoors. He also enjoys watching tv, parties, dogs/pets and keeping up with the news. Review of the activity attendance sheets provided by the Activity Director, only contained daily TV independently. R5 was not afforded any of the activities related to his preferences. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/26 at 8:04 AM, the Activity Director confirmed that R5 had only received tv as an activity and was not offered any of the care planned activities of his preference. The Activity Director also stated that she was in the process of initiating a one on one activity program for residents that did not want to attend out of room activities. At this time the Activity Director confirmed that R5 had not been included in any of his activity preferences. Review of R98's Face Sheet revealed R98 was admitted to the facility on [DATE], with diagnoses which included, but was not limited to, encephalopathy, major depressive disorder, and Psychosis. Review of the Activity Care Plan initiated on 04/01/2026, states R98 enjoys the following activities: board games, cards, bingo, word searches, exercise, sermons, reading, his religion, trips, shopping, being outdoors, watching tv, gardening, parties, dogs, and keeping up with the news. Interventions/Tasks on the care plan were as follows: invite to scheduled activities, needs assistance/escort to activity functions, offer leisure materials, and provide activities calendar monthly. Review of the Activity Tracker for April 2026 listed TV/Radio/Movies every day. R98 had coffee, salon, and snack/beverage one time each in the month of April 2026. Review of the Activity Tracker for May 2026 listed TV/Radio/Movies every day. No other activities of interest listed on the care plan was offered. During an interview with the Activity Director on 05/28/2026 at 1:15 PM, the Activity Director stated employment with the facility had been almost a year. The Activity Director further stated the priority was to start with the group activities, then Memory Care, and then room visits. The Activity Director further stated we are working towards this. The Activity Director confirmed the resident is up in their chair watching TV daily.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on review of facility policy, manufacturer's recommendation, observation, and interview, the facility failed to ensure Resident (R)126 was free from significant medication errors. Specifically, Registered Nurse (RN)4 failed to correctly prime an insulin pen prior to administering a physician ordered dose of insulin. RN4 additionally failed to properly administer the insulin via an insulin pen for 1 of 1 residents observed receiving insulin.Findings include: Review of the facility policy titled, Insulin Pen Medication Administration, states as the policy, It is the policy of this facility that insulin will be administered based on manufacturer recommendations and best practice guidelines. Procedures:3. Apply disposable pen needle onto pen. Prime the pen needle with 2 units of insulin (or per manufacturer guidelines) before each injection.4. Dial the correct dose in the dose window.5. Select appropriate injection site and clean with alcohol wipe. Hold pen at 90-degree angle to skin and insert pen needle into the subcutaneous tissue.6. Once injected, continue to depress the button until the dial has returned to 0 and for an additional 5-10 seconds (or per manufacturer guidelines). Review of the manufacturer's guidelines titled, How to use your Lantus Solostar Pen, states:Step 1. Remove the pen cap with clean hands.Step 2. Wipe the pen tip (rubber seal) with an alcohol swab. Remove the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on. Do not make the needle too tight. After you have attached the needle, take off the outer needle cap.Step 3. Dial a test of 2 units. Hold the pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times, if there is still no insulin coming out, use a new needle and do the safety test again.Step 4. Select the dose. Make sure the window shows 0 and then select the dose. Otherwise you will inject more insulin than you need.Step 5. Clean the site with an alcohol swab. Keep the pen straight, insert the needle into the skin. Use your thumb to press the injection button all the way down . When the number in the dose window returns to 0 as you inject, slowly count to 10 before removing. (Counting to 10 will make sure you get the full insulin dose.) Review of R126's Face Sheet revealed the facility admitted R126, with a diagnosis including but not limited to Diabetes Mellitus Type 2. Review of R126 electronic medical record revealed R126 was to receive 35 units of Lantus Insulin via a kwik pen each am. During an observation on 05/27/2026 at 8:30 AM, RN4 took the insulin pen from the medication cart and removed the outer cap. RN4 then, holding the insulin pen horizontally, dialed 2 units and pressed the injection button. RN4 then wiped the hub and placed the needle and laid the pen on the top of the medication cart. Before going into R126's room, this surveyor said, I did not see you prime the pen. At that time RN4 stated, I primed the pen with the 2 units before I ever put the needle on. During the observation on 05/27/2026 at 8:30 AM, RN4, went into R126's room, and took the insulin pen in hand and gave the resident the injection and failed to hold the pen in place after pressing the injection button all the way down, for the recommended 7 to 10 seconds. During an interview on 05/27/2026 at 8:34 AM, RN4 confirmed that she had not primed the pen correctly and had not held the needle in place at the injection site for the recommended 7 to 10 seconds, to ensure R126 received the required physician ordered dose of Lantus Insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425121	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak View Health and Rehabilitation	3300 4th Avenue Conway, SC 29527

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation and interview, the facility failed to follow safe infection control practices related to transporting soiled linen on 1 of 4 nursing units. Specifically, Certified Nursing Assistant (CNA)3 failed to bag soiled linen at point of use and was observed carrying the soiled linen down the hallway utilizing only a pair of gloves during one of one observation of a CNA transporting soiled linen unbagged. Review of the facility policy titled, Laundry Policy, states under Regulatory Basis and Guidance, Soiled linen must be stored and transported in enclosed or covered nonabsorbent containers or washable laundry bags, with no sorting or rinsing outside the laundry service area.Staff must handle, store, wash, and transport linens in a way that prevents the spread of infection. Contaminated laundry must be handled as [NAME] as possible, with minimum shaking, and bagged or placed in a container at the location where it is used.Roles and Responsibility:Nursing and care staff: Bag or secure soiled linen and resident clothes at the point of use and route them to the soiled linen rooms for pickup. Follow standard precautions.Soiled Linen Handling and TransportNurse and caregivers should always place all soiled linen and resident clothes into a tied bag or coveed nonabsorbent container or washable laundry bag at the point of use before taking it to the soiled linen rooms for pickup.Transport soiled linen in a way that prevents leakage, exposure, and spread of contamination. A random observation on 05/28/2026 at 10:36 AM, Certified Nursing Assistant #3, CNA3 was observed bringing soiled linen from a resident room. CNA3 was wearing gloves and walking down the hall holding her gloved hands away from her body. CNA3 was trying to get to a soiled laundry bin that was being pushed down the hall by another CNA before it was transported to the laundry. During a interview on 05/28/2026 at 10:37 AM CNA3 stated, I work for Hospice and not this facility. This surveyor reminded the CNA, that it is still an infection control issue to just carry soiled linen down the hallway and unbagged. During the interview with CNA3, she did not agree that it was an infection control concern carry soiled linen down the hallway by other residents sitting in wheel chairs and propelling themselves down the hallway. During an interview with the Administrator, he provided an inservice document for CNA3, and signed by CNA3 and states, Infection Control whne transporting clean/dirty linen must always be in a plastic bag for transport. Soiled linen bust be in a bag prior to putting it in a [NAME].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425121	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on review of facility policy, observation and interview, the facility failed to ensure an excessive amount of lint was removed from 2 of 2 clothes dryers.Findings include: Review of the undated facility policy titled, Dryer Lint Removal and Laundry Room Safety, states, Laundry staff must clean lint from the dryer lint screen after each load has been dried and remove lint from under and around dryers according to the posted deep-clean schedule. During an observation on 05/28/2026 at 8:33 AM, of the laundry room dryers revealed 2 of 2 clothes dryers with an excessive build up of lint. The lint was hanging from the baskets and all around the wiring above the baskets. During an interview on 05/28/2026 at 8:35 AM, the Housekeeping Supervisor confirmed the findings and provided a lint removal log that was checked as if the 2 dryers were lint free. During an interview on 05/28/2026 at 8:50 AM, the Maintenance Director also confirmed the excessive build up of lint in the 2 of 2 clothes dryers.