STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425122	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inman Operations	51 N Main St Inman, SC 29349

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on facility policy, record review and interviews the facility failed to provide written notices of hospitalization to the Responsible Party (RP) and/or the Resident (R) and failed to ensure that the Ombudsman was notified for (R)3 in a timely manner for 1 of 2 residents reviewed for hospitalization s. The findings include: The facility admitted R3 with diagnoses including but not limited to, cirrhosis of liver, dementia, and history of falling. Review of Nurses Notes for hospitalization s on 02/28/24 revealed documentation from 06/28/2023 at 6:24 PM, Resident stated she wanted to be sent to Emergency Department (ED). This nurse and [another] nurse assessed [patient] pt. Abnormal [vital signs] v/s. Resident states I don't feel good she also stated that her body was aching all over. Resident was slurring her speech and had periodic episodes of rolling her eyes back and screaming I want to go now. Showing [signs and symptoms] s/s of anxiety while waiting on [Emergency Medical Service] EMS. Resident have been experiencing [Nausea, Vomiting, Diarrhea] NVD the past few days. [Nurse Practitioner] NP notified. New order to send to ED. [Left Voicemail] LVM for [Responsible Party] RP. Documentation from nurse's note on 06/28/2023 at 6:41 PM, EMS arrival and departed @ 6:40 PM to transfer resident to [Spartanburg Regional Medical Center] SRMC. Documentation from nurse's note on 07/18/2023 at 12:00 PM, readmitted to room [ROOM NUMBER]-4 from hospital. Alert to name and place. Up in [wheelchair] w/c with assistance of [one] 1, ate 25% of lunch. Meds verified per [Nurse Practitioner] NP. Documentation from nurse's note on 7/23/2023 07:45 AM, Resident alert and oriented x 3, started screaming saying her legs hurt and she is going to hospital. Offered to contact on call to obtain pain medication, but resident said no she wants to go to SRMC. Therefore contacted all disciplines needed and transferred to SRMC via stretcher. (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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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation from nurse's note on 7/28/2023 at 8:30 PM, Resident returned from SRMC via stretcher and readmitted to room [ROOM NUMBER]-4 from hospital. Alert to name and place. Up ambulates with assistance of [one] 1. Meds verified per on call and NP to reassess Monday currently continue with all meds as ordered. Documentation from 10/12/2023 at 3:00 PM, Call light came on. [Certified nursing assistant] CNA went in, bad alarm was sounding. Resident on floor in front of wheelchair (w/c), hit knees when fell . I came in to check resident. Resident stated I was going to bathroom and fell . Hit my knees and they hurt. Neuro check [within normal limits] WNL. Check skin - intact. Moving all extremities. Lift used to put resident in bed. With CNA and me present. Call light in place, bad alarm in place and functioning. Resident told not to get [out of bed] OOB without calling for help . Vital signs are good. Alert and answering appropriately. Will monitor closely. Documentation from nurse's note on 10/15/2023 at 3:25 PM, Hospital. Documentation from nurse's note on 10/24/2023 at 4:29 PM Resident returned to facility via EMS from SRMC. Resident transferred to bed x2 assist. Condition stable. Call bell within reach, will continue to monitor. Documentation from nurse's note on 11/27/2023 at 2:18 PM, Resident weak, not eating slow to respond. NP in building and gave order to transport to SRMC for [Evaluation] eval and treat. Message left for RP to call facility. Documentation from 11/28/2023 at 12:23 PM, Call placed to SRMC, resident remains in [emergency room] ER at this time, has been admitted and is waiting on an available bed. Admit [Diagnosis] dx: elevated Ammonia level (176) and [Urinary Tract Infection] UTI. Documentation from 12/5/2023 at 3:33 PM, Resident returned from SRMC via stretcher. Resident transferred to w/c x2 [Medical Technician] med techs. Resident condition stable. Resident request to use resident phone to call nephew to bring her a hot dog. Will continue to monitor. During an interview on 03/06/24 at 1:44 PM the Social Worker (SW) provided the bed hold policy but reported that there was not one completed for the resident for the following hospitalization s: 11/27/23, 10/15/23, 7/23/23, and 06/28/23. She stated that family was notified but not informed about the bed hold. In reviewing documentation for notification of the Ombudsman in a binder, the SW reported that the resident did not show up on her report that was sent to the Ombudsman at the end of each month. During an interview on 03/06/24 at 2:03 PM the Director of Nursing (DON) reported the procedure for residents transferring or being discharged was to notify the family/representative and document using the Situation, Background, Assessment, and Recommendation (SBAR) or at least in a nurses note. The DON reported that the bed hold policy is signed on admission, the ombudsman is notified monthly and social services does this part. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/24 at 2:07 PM the Administrator reported the procedure for residents transferring or being discharged was to notify family/representative. She reported that the bed hold policy is signed on admission and social services sends a monthly report to the Ombudsman. When asked if this procedure was for all residents whether they were admitted to the hospital or transferred but then returned in short time frame, she stated she believed so but would check.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on facility policy, record review, and interviews, the facility failed to provide the bed hold document to Resident (R)3 and/or Resident Representative (RR) in a timely manner for 1 of 2 reviewed for hospitalization . Findings include: Review of the facility policy titled, Bed Hold and Therapeutic Leave Policy, undated, revealed Before the Center transfers a Resident to a hospital ., the Center must provide this written information to the Resident or the Resident Representative that specifies the Center's bed hold and therapeutic/temporary leave policy. The following applies to all residents. Medicaid Residents-Bed Hold: If the Resident leaves the Center for hospitalization , the Center will reserve or hold a bed available for the Resident for up to ten (10) consecutive calendar days per medically necessary hospital stay when the Resident is expected to return to the Center per South Carolina Medicaid. If the Resident is hospitalized for a period longer than ten (10) days, the Resident will be discharged . Bed holds for leaves of absence of more than 10 days are considered non-covered services and not paid by South Carolina Medicaid. The Resident may elect to pay the full Medicaid daily rate to continue the bed hold for up to thirty (30) calendar days. If the Resident does not elect to pay to hold the bed and the leave exceeds the bed hold period of 10 days, the Resident may return to the Center to their previous room, if available, or immediately upon the first availability of a bed in a semi-private room, if the Resident: a0 requires the services provided by the Center and b.) is eligible for Medicare or Medicaid nursing facility services. Review of R3's Electronic Medical Record (EMR) revealed R3 was admitted to the facility on [DATE] with diagnoses including but not limited to, cirrhosis of liver, dementia, delusional disorders, urinary tract infection, and history of falling. Review of R3's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/21/22 revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating R3 has moderate cognitive impairment. Review of R3's electronic medical record (EMR) revealed R3 was discharged to the hospital on 06/28/23, 07/23/23, 10/15/23, and 11/27/23. There was no documentation of a bed hold notification given to the resident and/or responsible party prior to R3's transfer to the hospital on any of the above dates. During an interview on 03/06/24 at 1:44 PM the Social Worker (SW) provided the bed hold policy but reported that there was not one completed for the resident for the following hospitalization s: 11/27/23, 10/15/23, 07/23/23, and 06/28/23. She stated that family was notified but not informed about the bed hold. In reviewing documentation for notification of the Ombudsman in a binder, the SW reported that the resident did not show up on her report that was sent to the Ombudsman at the end of each month. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/24 at 2:03 PM, the Director of Nursing (DON) reported the procedure for residents transferring or being discharged was to notify the family/representative and document using the Situation, Background, Assessment, and Recommendation (SBAR) or at least in a nurses note. The DON reported that the bed hold policy is signed on admission, the Ombudsman is notified monthly and Social Services does this part. During an interview on 03/06/24 at 2:07 PM, the Administrator reported the procedure for residents transferring or being discharged was to notify family/representative. She reported that the bed hold policy is signed on admission and social services sends a monthly report to the Ombudsman. When asked if this procedure was for all residents whether they were admitted to the hospital or transferred but then returned in short time frame, she stated she believed so but would check. During an interview on 03/06/24 at 2:10 PM, the Executive Director reported that on admission the bed hold policy is signed but once a resident is discharged /transferred a conversation takes place to discuss payment etc. on the day of the discharge/transfer or shortly thereafter in cases involving a weekend for example. She confirmed that the Ombudsman is notified at the end of the month.

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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. 49818 Based on observations, interviews, record review, and facility policy review, the facility failed to provide services to residents who were unable to carry out activities of daily living (ADL) necessary to maintain good grooming and personal hygiene for Resident (R)9; 1 of 4 reviewed for assistance with ADL care. Findings include: Reviewed the facility's undated policy titled, Activities of Daily Living (ADLs), revealed, Policy Explanation and Compliance Guidelines 3. a resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review the facility's undated policy, titled, Nail Care, revealed, Policy Explanation and Compliance Guidelines: 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises. Review of the face sheet revealed the facility admitted R9 on 01/02/2024 with diagnoses that included but were not limited to:hemiplegia, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, and major depressive disorder. Review of an Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date of 01/10/24 revealed R9 was coded for functional Limitation in Range of Motion with upper extremity on one side and lower extremity impairment on one side with wheelchair mobility. Review of R9's Care Plan revealed, The resident has an ADL self-care performance deficit Fatigue, Hemiplegia, Impaired balance, Limited Mobility. The goal was: the resident will maintain the current level of function through the review date. Interventions included: BATHING/SHOWERING: The resident requires extensive assistance by (1) staff with bathing/showering. PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assistance by (1) staff with personal hygiene and oral care. TOILET USE: The resident is totally dependent on (1) staff for toilet use. During an observation on 03/05/2024 at 01:02 PM, R9 was observed sitting in a chair beside her bed with the call light in reach. R9's hand were observed with brown debris underneath her nails on both hands. During an observation and interview on 03/06/2024 at 08:15 AM, R9 was observed lying in the bed in the supine position. R9 stated she was waiting for breakfast. Additional observation of R9's hands revealed her fingernails were dirty with brown debris underneath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/2024 at 11:34 AM, R9 ' s family member revealed R9's nails were dirty because staff did not cut up R9 ' s meat and when R9 feeds herself, she gets food underneath the fingernails. During an interview on 03/06/2024 at 01:36 PM, Certified Nursing Assistant (CNA)1 revealed R9 was scheduled to get showers on the 2nd shift. CNA1 revealed that hand hygiene was completed before and after each meal and nail care was completed randomly by the CNAs or the activity CNA . CNA1 accompanied the surveyor to R9 ' s room and observed R9 ' s hands with identified food debris between the fingers and brown debris underneath the fingernails on both of the resident ' s hands. CNA1 revealed R9 sometimes complains of pain in her hand, especially in left hand. CNA1 revealed R9 ' s hands were dirty because they had just finished lunch and used her hands to feed herself. CNA1 revealed she would use a warm washcloth to clean R9 ' s hands and get a tool to clean R9 ' s fingernails. During an interview on 03/03/2024 at 02:09 PM, the Director of Nursing (DON) revealed nail care was to be done daily during ADL care. The DON revealed staff were expected to check residents ' nails daily when washing their face and hands and clean nails as needed. During an interview on 03/07/2024 at 11:55 AM, the Administrator revealed nail care should be provided daily by the staff, or nurse. The Administrator also stated the unit manager is responsible for monitoring staff to ensure nail care was done.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on review of facility policy, observations, interviews, and record review, the facility failed to administer oxygen per physician's orders for 1 of 1 residents reviewed for respiratory care, Resident (R)17. Findings include: Review of the facility's policy titled, Oxygen Administration dated 2024 revealed, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and resident's goals and preferences. Definitions: 'Oxygen therapy' is the administration of oxygen at concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia. 'Hypoxia' means decreased perfusion of oxygen to the tissues. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician . 2. Personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists. 3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. Review of R17's Electronic Medical Record (EMR) revealed R17 was admitted to the facility on [DATE] with diagnoses including but not limited to; chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, anxiety disorder, chronic pain syndrome, paroxysmal atrial fibrillation, major depressive disorder. Review of R17's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 01/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R17 has cognition intact. Review of R17's Care Plan documented, the focus The resident has altered respiratory status/difficulty breathing. Further review of the Care Plan revealed the following goal, The resident will have no [signs and symptoms] s/sx of poor oxygen absorption through the review date. The care plan also documented intervention: OXYGEN SETTINGS: [Oxygen] O2 via nasal prongs @ 4 [Liters] L continuously. Humidified. Review of R17's Physician Order documented, Oxygen at 4 L/[minute] min [by] via [nasal cannula] n/c continuous [related to] R/T Chronic respiratory Failure with hypoxia. every shift. During an observation of R17's room on 03/05/24 at 11:00 AM, the oxygen concentrator was noted at 3 1/2 L/min via nasal cannula. Resident reported that the rate was supposed to be at 4 L/min. During an observation of R17's room on 03/06/24 at 8:25 AM, the oxygen concentrator was noted at 4 L/min. via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of R17's room on 03/07/24 at 8:18 AM the oxygen concentrator was noted at 4 L/min. via nasal cannula. During a staff interview on 03/07/24 at 10:35 AM, Licensed Practical Nurse (LPN)1 stated, R17's physician order for oxygen was for 4 L/min. She looked at R17's physician order in electronic medical record and confirmed the oxygen concentrator was to be set at 4 L/min. LPN1 then went to room and verified oxygen setting on concentrator and confirmed 4 L/min. During a staff interview on 03/07/24 at 10:42 AM, the Director of Nursing (DON) stated that her expectation for nurses is to verify orders and to check daily during their assessment to ensure that oxygen setting was at the correct setting.

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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. 49818 Based on observations, interviews, and review of the facility policy, the facility failed to ensure foods that are stored in the freezer, refrigerators and dry food storage were appropriately sealed, labeled, dated with a use by date and/or discarded after the manufacturer's expiration date. Findings include: Review of the facility's undated policy titled, Food Safety Requirements, showed that food will be stored, prepared, distributed and served in accordance with professional standards for food service safety. Policy Explanation and Compliance guidelines: Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage. Labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used by its use-by date, or frozen (where appl)/discarded. During an observation on 03/05/24 at 10:58 AM, the kitchen refrigerator revealed one 1-gallon jug of ranch dressing not fully closed and dressing on outside of lid; 1 package of 160 slices pasteurized process American yellow cheese slices (individual slices, not individually wrapped) opened and not properly sealed nor dated with an opened date or use by date; 2 large bags of salad mix with a use by date of 3/4/2024. The kitchen freezer revealed 1 open bag of frozen pancakes containing 9 pancakes that was not dated with no open or use by date; 1 bag of frozen potato wedges with a use by date of 12/5/2023. During an observation on 03/05/24 at 11:26 AM, 1 pan of Jello gelatin was observed in the freezer, undated and unlabeled, 1 bag of frozen biscuits- open, undated and unlabeled, 1 box dated 2/26 containing a 10 lb (pound) bag of chopped chicken, opened and not properly sealed. During an observation on 03/05/24 at 11:35 AM, the dry food storage revealed an 11.8 lb bag of basic American foods potato pearls, opened and not sealed, 1 24 oz (ounce) bag of AM fruit punch drink mix, opened and not sealed, 1 package of chicken flavored gravy mix, opened, wrapped in saran wrap, and undated, 1 5 lb bag of thick & easy instant rice, opened and not properly sealed with a date marked 1/29, 1 5 lb bag of curly, extra wide egg noodles, opened and undated, 1 5 lb bag of ziti cut, macaroni noodles, opened and undated. Observation of the small, refrigerated cooler on 03/05/24 at 11:57 AM revealed 1, 1 1/2 gallon jug of buttermilk with a use by date of 2/29/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/07/24 at 11:12 AM, Dietary Manager (DM) stated, All staff should check dates, but the cooks are responsible for checking the dates, as well as the manager. Food storage dates are routinely checked twice a week and sometimes more. The dietary manager revealed that it is her expectation that food be labeled and dated and prepared food only be held for three days. During an interview on 03/07/24 at 11:49 AM, the Director of Nursing (DON) revealed that dates on food should be checked daily by everyone but ultimately the DM is responsible. The DON stated that her expectation is that food should be sealed, labeled and dated in the kitchen, and the nursing staff ensure food items are safe at the nursing station. During an interview on 03/07/24 at 11:55 AM , the Administrator stated that her expectation of staff when it comes to food storage, is that the person responsible for opening an item is the person that should date and label the item. She revealed that the DM is responsible for monitoring the dates and food storage. The Administrator also revealed that she oversees that kitchen and performs checks monthly to ensure that the kitchen staff is following protocol.