STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425131	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks Healthcare	151 Lovely Drive Orangeburg, SC 29115

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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 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** 42424 Based on interview, record review, and review of facility policy, the facility failed to develop a Care Plan for Resident (R)163, related to Advance Directives, for 1 of 2 residents reviewed. Findings include: Review of the facility policy titled Care Plan, Comprehensive Person Centered last revised on March 2022, documented, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . 7. The comprehensice, person-centered care plan: a. includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident excersing his or her rights, including the righ to refuse treatment; Review of R163's Face Sheet revealed R163 was admitted to the facility on [DATE], with diagnoses including but not limited to: encounter for orthopedic aftercare, dementia with psychotic disturbance, muscle weakness, hypertension, major depressive disorder, and anemia. Review of R163's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/11/24, revealed R163 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated that R163 had severe cognitive impairment. Review of R163's Care Plan, last revised on 11/04/24, revealed that R163 was not care planned for Advanced Directives. An interview on 11/04/24 at 3:20 PM with Licesned Practical Nurse (LPN)2 revealed that they were unable to locate interventions in R163 Electronic Medical Record (EMR) related to Advanced Directives. An interview on 11/05/24 at 6:03 PM with the Administrator and Director of Nursing (DON) revealed that R163 was not care planned for Advanced Directives while a resident in the facility.

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 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 facility policy the facility failed to ensure Resident (R)163 had Care Plan interventions for Advanced Directives. 1 of 2 reviewed for Advanced Directives Care Planning. Findings include: Record review of facility policy titled Care Plan, Comprehensive Person Centered last revised March 2022 revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care. R163 was admitted to the facility on [DATE] with diagnoses including but not limited to encounter for orthopedic aftercare, dementia with psychotic disturbance, muscle weakness, hypertension, major depressive disorder, and anemia. Review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/11/24 revealed, R163 had the Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicates that R163 has severe cognitive impairment. Record review on 11/04/24 11:37 AM, of R163 Care Plan last revised 11/04/24 revealed that R163 was not care-planned for Advanced Directives. An interview on 11/04/24 at 3:20 PM with Licesned Practical Nurse (LPN)2 revealed that they were unable to locate interventions in R163 Electronic Medical Record (EMR) related to Advanced Directives. An interview on 11/05/24 at 6:03 PM with the Administrator and Director of Nursing (DON) revealed that R163 was not care planned for Advanced Directives while a resident in the facility.

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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. **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 Resident (R)52, who was dependent on staff for activities of daily living (ADLs), received the necessary services to maintain personal hygiene, for 1 of 6 residents reviewed. Findings include: Review of the facility policy titled, Activities of Daily Living (ADL), Supporting with a date of 2001, documented, Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support with assistance with: a. hygiene (bathing, dressing, grooming, and oral care) . Review of R52's Admission Record revealed R52 was admitted to the facility on [DATE], with diagnoses including but not limited to: Parkinson's Disease, chronic kidney disease, muscle weakness, acquired absence of right leg above knee, and acquired absence of left leg above knee. Review of R52's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/23/24, indicated R52 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R52 had intact cognition. Review of R52's Task Documentation revealed no showers were documented for the months of June through November 2024, indicating R52 did not receive showers during that time frame. During an observation on 11/03/24 at 12:46 PM, R52 was observed laying in bed, with no shirt and laying underneath a sheet. R52's face was unshaven, and a crusty discharge was in the corners of both eyes. During an observation on 11/04/24 at approximately 12:20 PM, R52 was observed laying in bed without a shirt, face still unshaven. During an interview on 11/03/24 at 12:46 PM, R52 stated he has not had a shower since his admission into the facility in June 2024. R52 further stated he does not know his shower days and he is dependent on staff to take him for his showers. R52 concluded that he does not refuse showers. During an interview on 11/04/24 at approximately 12:20 PM, R52 stated he had not received a shower or bed bath today. During a follow up interview on 11/05/24 at 10:52 AM, R52 stated staff provided him with a bed bath earlier, but he still was not offered a shower or received one. R52 verified that he does not refuse showers, and he has not had a shower since he has been in the facility. (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 11/05/24 at 11:19 AM, Certified Nursing Aide (CNA)2 revealed she is familiar with R52. CNA2 stated, To be honest I had never put him in the shower. [R52] usually received a bed bath by staff on the previous shift. CNA2 further stated that most of the time he has already had a bed bath on the previous shift. CNA2 concluded that she has never offered R52 a shower. During an interview on 11/05/24 at 3:28 PM, Unit Manager Licensed Practical Nurse (LPN)4 revealed she is the unit manager for [NAME]-100 wing where R52 resides. LPN4 stated R52's shower days are Monday, Wednesday and Friday. Residents shower schedules are charted, and refusals are documented in the system. LPN4 further stated, it is the expectation that staff will offer residents showers on their scheduled days. The days that are not shower days; residents receive bed baths. If residents refuse showers, the CNA notifies the nurse, and the nurse will reapproach residents.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42424 Based on interview, record review, and facility policy the facility failed to ensure that Resident (R)163, a resident with an Advanced Directive as Full Code received Cardiopulmonary Resuscitation (CPR) after being found unresponsive on [DATE]. 1 of 1 reviewed for CPR. On [DATE] at 7:15 PM the Administrator and Director of Nursing (DON) were notified that the failure to initiate CPR on R163 on [DATE] after being found unresponsive constituted an Immediate Jeopardy (IJ). The IJ was determined to first exist on [DATE] at approximately 4:10 PM (time of death according to County Coroner's Office/ Electronic Medical Record). The facility presented a removal plan on [DATE] at 5:52 PM, the deficient practice remained at F678 at a lower scope and severity of D, the facilities failure constituted substandard quality of care at F678. The facilities removal plan for F678 included Audit completed by the Social Services Director (SSD) on all residents to ensure that all advanced directive paperwork is present and correct Physician's Order is in the Electronic Medical Record (EMR) and Care Plan is correct. Education initiated immediately on [DATE] for all licensed by the DON and designees to include what to if you find someone unresponsive and initiated CPR immediately. All newly hired nurses, agency nurses, or facility staff not reached by phone will receive the education prior to their next scheduled shift at the facility. Mock Code Blue drills be conducted monthly by the DON/ designee and alternate shifts to ensure all shifts receive training. Audit/review of all deaths in the facility will be reviewed on the following business day by the Nursing Administration team to ensure that CPR initiated when needed for full code status and documentation complete. SSD will do random audit of five residents per week to ensure that code status paperwork is correct and order matches and correlating Care Plan in place as well. Audits will be weekly for four weeks then monthly for two months then random thereafter. Results will be reported to the Quality Assurance committee to determine need for further monitoring. Findings include: Record review of facility policy titled, Emergency Procedure - Cardiopulmonary Resuscitation revealed Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. 1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: A. Instruct a staff member to activate emergency response system (code) and call 911. C. Verify or instruct a staff member to verify the DNR or code status of the individual. D. Initiate the basic life support (BLS) sequence of events. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a facility policy titled, Advanced Directive, with a last revised [DATE], revealed The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Additionally, the policy also reveals: Refusing or Requesting Treatment 1. The resident has the right to refuse medical or surgical treatment, whether or not he or she has an advance directive. a. A resident will not be treated against his or her own wishes. b. Residents who refuse treatment will not be transferred to another facility unless all other criteria for transfer are met. c. The residents refusal does not absolve facility staff from providing other care that allows him/her to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. R163 was admitted to the facility on [DATE] with diagnoses including but not limited to encounter for orthopedic aftercare, dementia with psychotic disturbance, muscle weakness, hypertension, major depressive disorder, and anemia. Review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed, R163 had the Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicates that R163 has severe cognitive impairment. Record review on [DATE] at 11:30 AM, of R163's Discontinued Physician Orders revealed R163 had an order for Full Code that was discontinued on [DATE]. Record review on [DATE] at 11:35 AM, of an Electronic Medication Administration Record (EMAR) Note dated [DATE] at 8:56 PM, revealed Resident was nonresponsive to verbal or touch, no pulse or blood pressure was not detected the Nurse Practitioner was in the room to check the resident and stated she had passed. Resident Representative notified. Record review of a Nurses Note dated [DATE] at 5:03 PM revealed Received a call back from Coroner's office, resident's information given to county coroner. The time of the resident's death was 4:10 pm. Family at the facility and aware. The funeral home of choice is [NAME] Funeral Home. Record review on [DATE] 11:37 AM, of R163 Care Plan last revised [DATE] revealed that R163 was not care-planned for Advanced Directives. Record review on [DATE] 11:44 AM, of R163 Advanced Directive dated [DATE], revealed I, the resident or authorized party understand the nature of illness involved, prognosis, and the treatment available, as explained in full and I understand the consequences of either providing or withholding this measure. I also understand this request may be revised upon consultation with said parties. I fully understand the consequences of refusing cardiopulmonary resuscitation. I do want Cardiopulmonary Resuscitation. Record review on [DATE] at 5:21PM, of R163 vital signs. No documented vital signs seen on resident electronic health records during the time of resident death. Record review on [DATE] at 5:59 PM of R163 EMR revealed no documentation of the resident's decisional making capacity. Record review on [DATE] at 6:54 PM of a Physican Progress Note dated [DATE] revealed R163 seen today at the facility for weakness, per nursing staff, resident has not eaten or drank much since this morning. Minimally interactive, she had an orthopedic appointment today at 9:30 AM, since being back, she has still declined food and drink. Per nursing staff there has been an overall decline since arriving at the facility. Assessment included will discuss transition to palliative care with family members, (unable to reach at the time of this writing). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An attempted telephone interview on [DATE] at 11:54 AM, to R163's Resident Representative was unsuccessful, a voicemail message was left with contact/call back information. An attempted telephone interview on [DATE] at 11:57 AM, to Licensed Practical Nurse (LPN)1 was unsuccessful, a voicemail message was left with contact/call back information. A second attempted telephone interview on [DATE] at 1:26 PM with LPN1 was unsuccessful. A third attempted telephone interview on [DATE] at 2:43 PM with LPN1 was unsuccessful. A fourth attempted telephone interview on [DATE] at 3:14 PM with LPN1 was unsuccessful. An interview on [DATE] at 3:20 PM, with LPN2 revealed the expectation for nursing staff when a resident has an advanced directive of full code is to immediately begin CPR and notify the Unit Manager and Physician and call 911. After CPR initiated and the resident is stable/EMS has arrived nursing staff are expected to notify the Resident Representative of the incident and other appropriate parties. Nursing staff are to document every step that was taken from when the resident was found unresponsive, when CPR was initiated and for how long/who was involved or notified/ and if the resident passes during the notification to the coroner's office and resident representative. During interview with LPN2 they stated that they were also unable to find documentation in R163 Electronic Medical Record (EMR) if CPR was initiated when the resident was found unresponsive. An interview with the Nurse Practitioner (NP) on [DATE] at 4:07 PM, revealed that their expectation when a resident is full code and is found non responsive for staff is to immediately initiate CPR and at minimum of two cycles and to notify the Physician and contact EMS. Further interview revealed that the Nurse Practitioner was on site on [DATE] but was not on his case load. The NP reveals that the staff nurse only informed him that the resident had passed away because he was inside the facility during the time of the resident's transition. NP further stated that he was notified by nursing staff (unsure of whom) that the resident was a Do Not Resuscitate and that he did not witness nursing staff complete CPR on the resident. NP finally stated when he went to see, the resident appeared to be deceased for about 30 minutes or longer. An interview with the Director of Nursing (DON) on [DATE] at 4:42 pm, revealed that their expectation when a resident is full code and unresponsive is to call the code, someone would grab the crash-cart, and all CPR Certified staff will participate in the process. The DON further revealed she was told that the patient was a DNR. An interview with the Administrator on [DATE] at 4:42 pm, revealed the resident returned from an appointment in transition. A call was made to the family, and the decision was made to Do Not Resuscitated. A telephone attempt was made on [DATE] at 05:23 PM to reach the Resident Representative, no answer at this time. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow up interview with the NP on [DATE] at 5:56 pm, revealed that the signature on the Physician's telephone order dated [DATE] for DNR for R163 is his signature. It was further revealed that two nurses took the verbal order form the family member to change the resident from full code to DNR on the day of the resident's death. NP stated, when I entered the room of the resident the nurse advised the resident was DNR. I was not notified of the code changing form Full Code to DNR, on that day, until I returned to my office after the resident was pronounced died and I was told the order needed to be signed. An interview on [DATE] at 06:12 PM with the Medical Doctor revealed My staff, RN, LPNs and, myself will discuss code status. It will be me who will write an order after the ok with the family. This lady's family did not want her to be an DNR. She was never a DNR. She was never switch over to a DNR. My expectation is for anyone who is a full code it is my expectation for staff to start CPR. R136 was found cold and obviously dead for quite a while. I was not aware of the DNR order. This family stated they wanted everything done for their mother even though she was declining. She has had conversations with staff about her being a full code. Because of the nature of our relationship with the OAKs they can order labs and etc. All of their orders come through me. At some times orders do get written by Oaks Practitioners and Physicians.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49800 Resident #47 Oaks of Orangeburg- R47 483.25 Quality of Care F689 - Free of Accident Hazards/Supervision/Devices Based on observation, interviews, and record review the facility failed to provide assistive device of bed pad alarm for R47 as outlined on care plan post-accident/fall as needed for 1of 9 residents reviewed for accidents in the facility. The census was 117. Findings include: Review of facility policy titled, Falls, and Fall Risk, Managing revised March 2018 revealed, Position -change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Review of a Face Sheet revealed R47 had a diagnosis of but not limited to encounter for other orthopedic aftercare, muscle weakness, unspecified abnormalities of gait and mobility, anxiety disorder, hallucinations unspecified, and delusional disorders. Review of a Minimum Data Set (MDS) dated [DATE] revealed R47 scored 13 on a Brief Interview for Mental Status (BIM S), indicated R47 was cognitively intact. Review of R47 Care Plan initiated 08/14/24 and target date of 10/22/24 Will minimize risk for falls to extent possible. Safety devices as ordered; 10/04/24-Pressure Pad Alarm while in bed. Date Initiated: 10/04/2024 Revision on: 10/14/2024 CNA LPN RN. During an interview on 11/04/24 @ approximately 8:10AM with Certified Nursing Assistant, CNA3, on Unit 300, reports interventions for fall prevention for R47 included bed in the lowest position, call light and bed control placed on resident chest so R47 does not have to reach far for either. CNA3 reports she never leaves resident bed in high position. CNA3 reports after she returned from having 3 days off, she noticed R47 was having difficulty moving her left leg and when she touched R47's left leg it felt hard. CNA3 states she reported her findings to the nurse and the nurse assessed R47. CNA3 reports a mobile x-ray was ordered for R47. CNA3 stated she did not know what triggered R47 fall, resident stated she was reaching for call light. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 11/04/24@ approximately 9:26AM with Licensed Practical Nurse, LPN8, reports CNA called her into R47 room. LPN8 reported that R47 was leaning against bed with her knees on the floor. LPN 8 reported she assessed R47 range of motion and R47 denied pain, or injuries. LPN 8 reports she and CAN transferred R47 back to bed using Hoyer lift. LPN8 stated she reassessed resident again, R47 denied pain or injuries again. LPN8 reported resident was cleaned and dried her up. LPN stated interventions for fall prevention was the bed placed in lowest position; resident given her call light. LPN reported that R47 asked for a coke, and she gave her a coke. LPN8 reports she notified the doctor and resident responsible party. LPN8 reports R47 's bed was in the lowest position however LPN8 states R47 was out of bed in wheelchair earlier in the shift and was yelling out. Observation in room [ROOM NUMBER], on11/04/24 @ approximately observed no bed alarm pad, fall mat beside bed or bed rails noted on/beside bed for R47. Observation in room [ROOM NUMBER], on 11/05/24 @ approximately 8:45AM observed no bed alarm on bed, fall mat beside bed or bed rails on R47 bed. During an interview on 11/05/24 in room [ROOM NUMBER] @ approximately 8:49AM with Licensed Practical Nurse, LPN6 reviewed resident care plan and admitted R47 was to have bed pad alarm, bed lowered in lowest position, call light within reach. However, when LPN6 checked R47 bed for bed pad alarm and searched closets and drawers LPN6 attested she did not see bed pad alarm. LPN6 stated she would ensure bed pad alarm would be in place and should have alerted Unit manager that bed pad alarm was not in place. During an interview on 11/05/24 in an empty office beside the Social Workers office @ approximately 9:55AM with LPN7 states R47 bed pad alarm was beeping all night as reported by the night nurse. LPN7 reported bed pad alarm was taken to supply clerk to be checked for malfunctioning. LPN 7 reports bed pad alarm was placed on R47 bed after she returned from hospital in October. Observation in room [ROOM NUMBER], on 11/05/24 @ approximately 10:00AM observed CNA3 and PTA placing bed alarm on R47 bed, room [ROOM NUMBER]. A clear bag was in noted on bed, that alarm was in. During an interview on 11/05/24 in room [ROOM NUMBER] @ approximately 10:00AM CNA3 reports there had not been a bed alarm on R47 bed until today. CNA3 states she is R47usual CAN and works 7AM - 7PM. CAN reports bed alarm was placed on bed for the first time per therapy today. During an interview on 11/05/24 in the hallway approximately 10:23AM with Physical Therapist Assistant, PTA reported she was assisting CNA3 with placing bed pad alarm on R47 bed. PTA reports she normally does not do this task.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42424 Based on observation, interview, record review, and facility policy the facility failed to provide Resident (R)68 with adequate hydration daily. 1 of 3 reviewed for hydration Findings include: Record review of facility policy titled Resident Hydration and Prevention of Dehydration last revised October 2017 revealed This facility will strive to provide hydration and to prevent and treat dehydration. The dietitian will assess residents for hydration as part of the comprehensive assessment, at least quarterly, and more as necessary per resident need. Nurses' aids will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. Intake will be documented in the medical records; aids will report intake of less than 1200 ml/day to nursing staff. R68 was admitted to the facility on [DATE] with the diagnosis including but not limited to seizures, overactive bladder, hypertension, chronic pain, and paraplegia. According to the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/01/24 R68 has the Brief Interview of Mental Status (BIMS) score of 12 out of 15 which indicates R68 has a moderate cognitive impairment. Further review of the Admission MDS revealed R68 has no difficulty with swallowing or chewing and had no nutritional approaches during the assessment period. An observation and interview on 11/03/24 at 12:32 PM revealed the resident in bed in his bedtime clothing, observation of resident's bedside table revealed two empty cups. Interview with R68 revealed that staff do not offer/provide him with hydration in-between mealtimes. R68 further stated that the two empty cups came from the nurse earlier that morning when he received his morning medications. A follow-up observation on 11/03/24 at 2:45 PM revealed R68 in bed in his bedtime wear without hydration present. R68 stated that no one had offer him anything to drink since lunchtime. Record review on 11/05/24 08:16 AM of R68 Fluid Intake Documentation revealed on 11/03/24 resident received 840 milliliters of fluid for the day at 6:16 PM. Record review 11/05/24 08:21 AM of R68 Fluid Intake Documentation from 10/07/24 - 11/04/24 revealed the following dates with no documentation of hydration being provided to the resident: 10/08/24 10/09/24 10/12/24 10/13/24 10/17/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425131	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks Healthcare	151 Lovely Drive Orangeburg, SC 29115

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/21/24 10/22/24 10/26/24 Record review of R68 Care Plan last revised 10/17/24 revealed Resident has history of stroke and has actual or potential complications as manifested by stroke. Interventions include observe document and notify physician of adverse side effects. Observe for dteriorations such as changes in behavior, cognition, swallowing, range of motion, sensation or vision and report changes to physician. Interview on 11/05/24 at 5:54 PM with the Administrator and DON revealed staff are expected to provide hydration throughout the day in-between meals as guided in the facility policy, and they expect staff to document appropriately hydration that is provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49918 Based on review of the facility policy, observations and interviews, the facility failed to ensure biologicals were stored appropriately in 3 of 3 Medication Treatment Carts. Findings include: Review of the facility policy, copyright 2001 Med-Pass, Inc, titled, Medication Labeling and Storage documents, the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Medication Storage 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. During an observation on [DATE] at 12:23 PM, of the [NAME] Treatment Cart revealed the following: -Gentell rolled gauze bandage (4.5 x 4.1 YDS (11cm x 3.7m) Lot # 240217 exp 2027 02 16 Sterile and opened. -Silvercel Non-adherent antimicrobial Alginate Dressing with Easy Lift ,d+[DATE] ,d+[DATE] in x 4 ,d+[DATE] in (11cm x 11cm) Manufacturer Sustagenix Lot # 55760V001 Expired 2024 09 30 Manufacturer Sustagenix X6 was expired. During an interview on [DATE] at 12:51 PM, Licensed Practical Nurse (LPN)5 stated, The wound nurse and unit managers check the expiration dates. The wound nurse changes the dressings except on the weekends and nights. All the nurses are responsible for changing dressings. LPN5 discarded the items. During an observation on [DATE] at 1:07 PM, of the Riverside Treatment Cart revealed the following: -Medline Extra Absorbent Abd Pad single use Sterile Ref # PRM 21453 Lot # 6052406001 Sterile and opened. -Xeroform Gauze Dressing 5 in x 9in (13cm x 23 m) Manufactured for HealQu LLC exp 2026 08 24 Sterile and opened. -Wound Closure Strip ,d+[DATE] x 3 Manufacturer [NAME] Skin Closure Strips non reinforced sterile MRF # 3000 AirLife Ref Al4109k Lot T22N32 exp 2024 12 01 Sterile and opened. During an interview on [DATE] at 1:25 PM, LPN2 stated, We usually check the treatment carts. LPN2 discarded the open items into the trash. During an observation on [DATE] at 1:59 PM, of the Palmetto [NAME] Treatment Cart revealed, Nystatin Cream USP (1000, 000 USP) Nystatin units Manufacturer Padagis R 34321766 exp ,d+[DATE] and was opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 2:08 PM, LPN6 stated the wound nurse checks the treatment cart. During an interview on [DATE] at 3:25 PM, the Director of Nursing (DON) stated, Both wound nurse and floor nurse should check the treatment cart for expirations.

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	425131	A. Building B. Wing	11/05/2024

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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. 48215 Based on observations and interviews the facility failed to ensure that the ice machine in 1 of 1 kitchen was kept clean and sanitized. Findings include: A facility policy regarding the ice machine was requested on 11/05/24 at 3:22 PM. At 5:15 PM, the Administer advised that a policy was not available. During the initial tour of the Kitchen on 11/03/24 at 9:55 AM, the ice machine was observed, in the presence of the Kitchen Manager (KM), to have a black moldlike substance around the ice dispenser. During an interview on 11/03/24 at 9:55 AM, the KM verified the the black moldlike substance in the ice machine and stated that it is her expectation that the ice machine is cleaned daily, at the end of the day. Attempted review of the kitchens cleaning logs, revealed there were no cleaning logs of the ice machine available. During an interview on 11/05/24 at 3:22 PM, the Administrator stated that it is expected that all equipment is maintained in a clean and sanitized manner.