STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425138	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Creek Post Acute	401 Chandler Rd Greer, SC 29651

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review and interview, the facility failed to report a significant medication error that resulted in serious bodily injury to the Administrator and the State Agency within 2 hours, for 1 of 2 residents reviewed, Resident (R)2. Specifically, on 12/04/25, Licensed Practical Nurse (LPN)1 administered medications prescribed for R3, to R2. Following the medication error, R2 was hospitalized . Findings Include: Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating last revised in September 2022, states, Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation: Reporting Allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/ licensing the facility . 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone. Review of R2's admission Record revealed the facility admitted R2 on 08/23/25, with diagnoses including but not limited to: cognitive communication deficit, dementia with mild anxiety, atrial fibrillation, dysphagia and major depressive disorder.Review of R2's Progress Notes revealed the following:12/4/2025 11:58 Nurse's Note: Note Text: contacted [Nurse Practitioner] NP and [Resident Representative] RR regarding recent med error incident. Esident [sic] stable in bed RR next to bedside.12/4/2025 15:10 Nurse's Note : Note Text: was checking [Blood Pressure] BP every 30 mints as ordered Blood pressure continues to be lower inspite [sic] of ordered midrodine 10mg one time. resdient [sic] drank about 4 [ounces] oz of fluids, residetn [sic] alert and responsive at time of transfer, BP 74/48 pulse 44 [Respirations] resp 8 [dangerously slow breathing] 02 sats [Oxygen Level] at 96% with 02 on via nonrebreather mask. notified RR of NP transfer to [Local Hospital] for furter [sic] Evaluation.Review of a witness statement dated 12/04/25 and written by LPN1 revealed, 0800 nurse labeled med cup with a [sic] residents name- then I poured meds into med cup I mixed whole pills in pudding to help resident swallow pills. I administered pills to room [ROOM NUMBER]D [R2]. Then I proceeded to look for room [ROOM NUMBER]w [R3] meds and instead found [R2's] med cup that's when I realized my error.Review of a witness statement dated 12/04/25 and written by Unit Manager (UM)1 revealed, I received a call from nurse [LPN1] at 8:14 AM. She (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she did a Med error on [R2] and gave her the following meds that weren't hers. Gabapentin 600 mg, Dofletilide 250 [sic] mg, Metoprolol ER 50 mg, Cozarr 50 mg and oxycodone 30 mg. She stated pt was stable. ADON and NP called right away. BP to be checked [every thirty minutes] Q30 min and Midodrine 10 ordered. Patient monitored closely. At 2:00 PM pressures were dropping and wouldn't go up even with midodrine and ordered fluids. EMS called.Review of a witness statement dated 12/04/25 and written by the Assistant Director of Nursing (ADON) revealed, [R2's] Medication Error: This nurse was informed by Unit Manager that nurse [LPN1] had a medication error. Resident [R2] was given another resident's medication. Medication given was Oxycodone 30mg, Amlodipine 5mg, Losartan 50mg, Dofetilide 520mcg, Gabapentin 600mg, Metoprolol 50mg, Metoprolol 50mg. This nurse contacted NP who went to see resident and ordered STAT Midodrine 5mg to be given and BP & Pulse to be checked every 30mins. Orders were placed by this nurse. [Nurse Practitioner] NP checked on resident throughout the day. Vitals were still low, and orders to send residents to ER were given.Review of the facility-provided reportable incident log for the past three months did not include the medication error involving R2 on 12/04/25. During an interview on 02/23/26 at 1:00 PM, LPN1 stated, I made an error. LPN1 reports that on the day of the incident during the morning medication pass, she pre-pulled medications for more than one resident at a time. She had already prepared R2's medications and R3's medications. While she was about to give R2's medications that's when R3 asked for pain medication. She then retrieved R3's Oxycodone and then went to give R2 her medications first but got distracted. She then administered medications to R2. Afterward, when she went to give R3's medications, she realized that R2's medications were still in the cup on the cart and that R2 had received R3's medications by mistake. LPN1 immediately reported the error to her supervisor.During an interview on 02/23/26 at 1:25 PM, the Director of Nursing (DON) stated that when a medication error occurs, the resident's condition should be assessed, vital signs checked, the Nurse Practitioner notified, and the incident reported to the State Agency. The DON stated she was on maternity leave at the time of the incident and confirmed that a report was not submitted. She stated that the ADON was unaware that the incident needed to be reported.During the same interview, the DON was asked if the facility had submitted a report since discovering the incident. She stated, Well I thought since y'all were here we didn't have to now. The surveyor informed the DON that the facility had a duty to self-report because this was a complaint received by the State Agency. The DON stated she would submit the report immediately.During interview on 02/23/26 at 1:36 PM, the ADON states that LPN1 notified her immediately after administering the medication. the ADON further stated she was unsure if the Administrator was notified of the incident. The ADON also noted that she was unaware she was required to report the incident to the State Agency.During an interview on 02/23/26 at 2:43 PM, the Facility Administrator (FA) stated that he was only made aware of the medication error recently, when he spoke with [R1]. The FA confirmed that a report was not sent to the State Agency. He also stated that the ADON discovered the incident and that he was not informed of it at the time.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident records, hospital records, and interviews, the facility failed to protect Resident (R)2 from a significant medication error for 1 of 2 residents reviewed. Specifically, on 12/04/25, Licensed Practical Nurse (LPN)1 administered medications prescribed for R3 to R2, including Oxycodone thirty milligrams (mg) (a pain medication), Amlodipine 5 mg (a blood pressure medication), Losartan 50 mg (a blood pressure and heart medication), Dofetilide 250 micrograms (mcg) (a heart rhythm medication), Gabapentin 600 mg (a nerve pain medication), and Metoprolol 50 mg (a heart rate and blood pressure medication). This failure resulted in R2 being sent out to the hospital.On 02/23/26 at 3:06 PM, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death.On 02/23/26 at 3:06 PM, the survey team provided the Director of Nursing with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 12/04/25. The IJ was related to 42 CFR S483.45(f)(2) Pharmacy Services.On 02/23/26, the facility provided an acceptable IJ Removal Plan. On 02/23/26 the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F760 at a lower scope and severity of D.An extended survey was conducted in conjunction with the Complaint Survey, for non-compliance at F760, constituting substandard quality of care.Findings Include: Review of the facility policy titled Administering Medications last revised in April 2019, states, Policy Statement: Medications are administered in a safe and timely manner and as prescribed. Policy Interpretation and Implementation: . 4. Medications are administered in accordance with prescriber orders, including any required time frame. 9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. Checking identification band; b. Checking photograph attached to medical record; and c. If necessary, verifying resident identification with other facility personnel. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 26. Medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nursing Services.Review of R2's admission Record revealed the facility admitted R2 on 08/23/25, with diagnoses including but not limited to: cognitive communication deficit, dementia with mild anxiety, atrial fibrillation, dysphagia and major depressive disorder.Review of R3's admission Record revealed the facility admitted R3 on 03/17/25, with diagnoses including but not limited to: heart failure, high blood pressure, chronic pain syndrome and lumbar spondylosis. Review of a witness statement dated 12/04/25 and written by LPN1 revealed, 0800 nurse labeled med cup with a [sic] residents name- then I poured meds into med cup I mixed whole pills in pudding to help resident swallow pills. I administered pills to room [ROOM NUMBER]D [R2]. Then I proceeded to look for room [ROOM NUMBER]w [R3] meds and instead found [R2's] med cup that's when I realized my error.Review of a witness statement dated 12/04/25 and written by Unit Manager (UM)1 revealed, I received a call from nurse [LPN1] at 8:14 AM. She stated she did a Med error on [R2] and gave her the following meds that weren't hers. Gabapentin 600 mg, Dofletilide 250 [sic] mg, Metoprolol ER 50 mg, Cozarr 50 mg and oxycodone 30 mg. She stated pt was stable. ADON and NP called right away. BP to be checked [every thirty minutes] Q30 min and Midodrine 10 ordered. Patient monitored closely. At 2:00 PM pressures were dropping and wouldn't go up even with midodrine and ordered fluids. EMS called.Review of a witness statement dated 12/04/25 and written by the Assistant Director of Nursing (ADON) (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed, [R2's] Medication Error: This nurse was informed by Unit Manager that nurse [LPN1] had a medication error. Resident [R2] was given another resident's medication. Medication given was Oxycodone 30mg, Amlodipine 5mg, Losartan 50mg, Dofetilide 520mcg, Gabapentin 600mg, Metoprolol 50mg, Metoprolol 50mg. This nurse contacted NP who went to see resident and ordered STAT Midodrine 5mg to be given and BP & Pulse to be checked every 30mins. Orders were placed by this nurse. [Nurse Practitioner] NP checked on resident throughout the day. Vitals were still low, and orders to send residents to ER were given.Review of R3's Active Physician Orders for the month of December 2025, revealed the following orders: Oxycodone 30 mg - Give 1 tablet by mouth three times daily, Amlodipine 5 mg - Give 2 tablets by mouth once daily, Losartan 50 mg - Give 1 tablet by mouth twice daily, Dofetilide 250 mcg - Give 1 capsule by mouth twice daily, Gabapentin 600 mg - Give 1 tablet by mouth four times daily, Metoprolol 50 mg - Give 1 tablet by mouth once daily.Review of R2's Active Physician Orders dated December 2025, revealed no documented physician orders for the medications administered on 12/04/25.Review of R2's Progress Notes revealed the following:12/4/2025 11:58 Nurse's Note: Note Text: contacted NP and [Resident Representative] RR regarding recent med error incident. Esident [sic] stable in bed RR next to bedside.12/4/2025 15:10 Nurse's Note : Note Text: was checking [Blood Pressure] BP every 30 mints as ordered Blood pressure continues to be lower inspite [sic] of ordered midrodine 10mg one time. resdient [sic] drank about 4 [ounces] oz of fluids, residetn [sic] alert and responsive at time of transfer, BP 74/48 pulse 44 [Respirations] resp 8 [dangerously slow breathing] 02 sats [Oxygen Level] at 96% with02 on via nonrebreather mask. notified RR of NP transfer to [Local Hospital] for furter [sic] Evaluation.Review of R2's Weights and Vitals Summary dated 12/04/25, revealed the following: 12:59 BP 77/48, HR 4711:50 BP 72/42 HR 5111:37 BP 86/44 HR 4511:09 HR 4110:47 BP 83/59 HR 63Review of a document titled Discharge Summary-Hospital Medicine dated 12/10/25, revealed, Chief Complaint: Patient presents with Medication Problem- Med error. [History of Present Illness] HPI obtained from admission [History and Physical] H&P: [R2] is an 82 y.o. with multiple chronic medical problems who presents with somnolence [excessive sleepiness], hypotension [critically low blood pressure], bradycardia [critically slow heart rate], and hypoxia [critically low oxygen levels] after medications incorrectly administered this morning while at her rehab facility. Per report, the staff at [NAME] Creek gave patient incorrect medications at about 8AM today: Oxycodone 30mg, Amlodipine 5mg, Losartan 50 mg, Dofetilide 250 mcg, Gabapentin 600mg, Metoprolol 50mg. BP 79/44, [Heart Rate] HR 44, 02 96% on 15 [Liters] L. Per EMS/ER triage note: Original 74% on [Room Air] RA, BP 60/palp [blood pressure critically low, measured by feeling the pulse only], [Blood Sugar] BGL 108. Given 700 NS [Normal Saline-a sterile saltwater solution given through an IV to provide fluids], 1mg Narcan [used to reverse overdoses of pain medications], 1mg atropine [used to treat low blood pressures]. BP increased to 100/60, Pulse 90. Hospital Course by Problem: Hypotension due to drugs/Bradycardia [slow heart rate]/Drug overdose: Initially admitted following unintentional receipt of multiple antihypertensives, antiarrhythmic, and opioid medications intended for another resident of her long-term care facility. Received atropine, naloxone in ED prior to admission at the recommendation of toxicology. Required initiation of vasoactive medications [given to support critically low blood pressure] due to persistent hypotension which persisted for several days. Acute Respiratory Failure with Hypoxia/Sepsis/[Pneumonia] PNA: Noted to have hypotension requiring vasopressor therapy for multiple days following hospital admission.Review of an After Visit Summary dated 12/10/25 revealed, Summary of Your Hospitalization: your primary diagnosis was: Hypotension Due to Drugs 12/04/25-12/10/25. Your diagnoses also included: Drug overdose, accidental or unintentional, confusion caused by a drug, bradycardia, respiratory insufficiency, sepsis with acute hypoxic respiratory failure without septic shock, and (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	pneumonia. During an interview on 02/23/25 at 12:38, LPN2 stated the process for administering medications starts with asking the resident their name and looking at medication card to confirm. LPN2 then stated she would ask the resident for their name and date of birth and if they are unable to communicate this information, they have pictures on the Medication Administration Record (MAR) the nurse can see. Some residents also wear bracelets with their information on it.During an interview on 02/23/25 at 1:00 PM, LPN1 stated, I made an error. LPN1 reports that during the morning medication pass, she pre-pulled medications for more than one resident at a time. She had already prepared R2's medications and R3's medications. While she was about to give R2's medications, that's when R3 asked for pain medication. She then retrieved R3's Oxycodone and then went to give R2 her medications first but got distracted. She then administered medications to R2. Afterward, when she went to give R3's medications, she realized that R2's medications were still in the cup on the cart and that R2 had received R3's medications by mistake. LPN1 immediately reported the error to her supervisor. She stated that at the time, R2 was arousable, but her breathing was slowing. LPN1 further stated, I was a little distressed and concerned that she wouldn't make it. The family was notified, and the resident was sent to the hospital. The NP administered Midodrine. Despite receiving medications and fluids, R2's blood pressure never improved. She had previously received training for medication administration, which included following the five or six rights, checking vitals, washing hands, and using sanitizer. Staff are aware that interruptions can happen, but they are instructed not to interrupt nurses during medication passes.During an interview on 02/23/25 at 1:36 PM, the ADON states that LPN1 notified her immediately after administering the medication. She stated that she initially assumed LPN1 had pre-pulled the medications and then realized the wrong resident had received the dose. The ADON notified the NP, who ordered Midodrine to raise the resident's blood pressure and instructed staff to check vital signs every 30 minutes. The resident was transferred to the emergency room a few hours after the error. The ADON recalled that the only medication she specifically remembered was Oxycodone 30 mg due to the high dosage. She explained that facility expectations are: only one resident's medications should be pulled at a time, nurses must verify the resident at least three times, and the five rights of medication administration must be followed. Medications should never be pre-pulled before administration. The ADON was unsure if the administrator was notified of the incident. She stated that after pre-pouring medications, the nurse was pulled into the office and disciplined.During an interview on 02/23/25 at 1:50 PM, the NP stated, I was made aware right after the medication error occurred. LPN1 called me on my cell phone. Upon notification, I came and assessed the resident, took her vitals, listened to her heart and lungs, and at this moment there was no acute distress noted. Within the hour of the medications being given, the resident started to become symptomatic. During the initial assessment, I ordered vital signs to be taken every 30 minutes. Midodrine was ordered and given to try to keep her blood pressure up, but it was not effective. The Medical Director was notified. It was less than four hours between the medication error and the resident being sent out. R2 was still alert and oriented, but her blood pressure was low.On 02/23/26, the facility provided an acceptable IJ Removal Plan, which included the following:The facility has taken the following steps to ensure the safety of our residents regarding significant medication error.1. On 2/23/2026, the Administrator notified the Medical Director of the Immediate Jeopardy.2. On 12/4/2025, [R2] was assessed by the Nurse Practitioner, and new orders were written for vital signs Q30 minutes and Midodrine stat.3. On 12/4/2025, [R2] was sent to the emergency department for a higher level of care.4. On 12/4/2025, the Assistant Director of Nursing began the investigation into the medication error.5. On 12/4/2025, the Assistant Director of Nursing counseled [LPN1] related to the medication error and (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	failure to follow the five rights of medication pass, prepulling medication that resulted in medication error. The licensed nurse was placed on a process improvement plan on 2/23/2026.6. On 12/4/2025, the Assistant Director of Nursing provided 1:1 education with the licensed nurse [LPN1] related to types of medication errors, causes, and prevention.7. On 12/5/2025, the Assistant Director of Nursing began a medication pass in-service related to the 5 rights of medication administration.8. On 2/19/2026, the Assistant Director of Nursing or designee began education with the licensed nurses on the 5 rights of medication pass and medication administration to be completed by 2/24/2026.9. On 2/23/2026, the Assistant Director of Nursing or designee began education on the medication administration policy to include how to verify the medications are correct. This will be completed by 2/24/2026 for all licensed nurses on or before the licensed nurses' next scheduled shift.10. On 2/23/2026, the Assistant Director of Nursing or designee began competency checks on medication pass on all licensed nurses. This will be completed by 2/24/2026 or before the licensed nurses' next scheduled shift.11. On 2/23/2026, the Administrator, the Director of Nursing, and the Assistant Director were re-educated on Medication Pass, including medication errors, by the Regional Assistant Director of Clinical Services.12. On 2/23/2026, the Director of Nursing completed a review of hospitalizations since 12/1/2025 to determine if any were related to medication error.13. On 2/23/2026, the Director of Nursing completed a 6-month medication error review to ensure proper documentation, appropriate corrective action, and reporting compliance.14. On 2/23/2026, nurse management will begin to randomly select each nurse daily to observe medication passes x 7 days, then weekly x 4 weeks, then monthly x 2 months.15. The nurse involved in the deficiency will have completed medication pass competency daily x 7 days, weekly x 4 weeks, monthly x 2 months, and quarterly x 2.DATE OF COMPLIANCE: 2/24/2026