

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Pruitthealth- Moncks Corner		STREET ADDRESS, CITY, STATE, ZIP CODE 505 South Live Oak Drive Moncks Corner, SC 29461	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>48835</p> <p>Based on review of facility policy, observation, record review, and interview, the facility failed to ensure 11 of 76 residents, Residents (R)4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14, received their physician ordered medications.</p> <p>On 08/27/24 at 5:40 PM, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations could cause serious harm.</p> <p>On 08/28/24 at 9:10 AM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 08/22/24. The IJ was related to 42 CFR 483.25 - Residents are free of Significant Medication Errors.</p> <p>On 08/28/24, the facility provided an acceptable IJ Removal Plan. On 08/28/24, the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. The SA is considering this IJ at Past Noncompliance as of 08/23/24.</p> <p>An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F760, constituting substandard quality of care.</p> <p>Findings include:</p> <p>Review of the facility policy dated 07/22/24, titled, Medication Administration: General Guidelines revealed under the policy, Medications are administered as prescribed . the authorized personnel will compare the Advantage bag to the MAR and will check off in ink on the bag the medications as they correspond to the MAR. Medications are administered within 60 minutes before or after scheduled time . which are administered precisely as ordered.</p> <p>During an observation on 08/27/24 and review of the Electronic Medication Administration Record (EMAR) dated 08/22/24, revealed the following:</p> <p>R4 had a pack of Oxybutynin ER 10 milligrams (mg), a pack of Duloxetine DR 60 mg, and a pack of Amlodipine 10 mg dated 08/22/24. The medications were scheduled to be given at 9:00 AM. The EMAR documented the medications as Not Administered.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R5 had a pack of Methocarbamol 750 mg scheduled to be administered at 3:00 PM, a pack of Gabapentin 800 mg scheduled to be administered at 1:00 PM, a pack of Valsartan 80 mg, Senna 8.6 mg, and Methocarbamol 750 mg scheduled to be administered at 9:00 AM and a pack of Gabapentin 800 mg scheduled to be administered at 9:00 AM. The EMAR documented the medication as late administration.</p> <p>R6 had a pack of Eliquis 5 mg 2 tablets, x2 packages (loading dose for new Deep Vein Thrombosis (DVT) to be administered at 9:00 AM and 5:00 PM, a pack of Venlafaxine ER 150 mg pack to be administered at 9:00 AM, a pack of Metoprolol 25 mg, Hydroxychoiraquine 200 mg, Amlodipine 10 mg to be administered at 9:00 AM and Zylpim 100 mg to be administered at 9:00 AM. The EMAR documented the medications as Not Administered.</p> <p>R7 had a pack of Carbid/Levod/Entaca 25 mg-100 mg-200 mg x2 packages, scheduled to be administered at 2:00 PM and 6:00 PM. The EMAR documented the medication as late administration.</p> <p>R8 had a pack of Prednisone 20 mg, scheduled to be administered at 9:00 AM. The EMAR documented the medication as late administration, however observation revealed the medication remained in the package.</p> <p>R9 had a pack Midodrine 5 mg to be administered at 1:00 PM, a pack Isoniazid 300 mg scheduled to be administered at 9:00 AM, a pack of Midodrine 5 mg, Escitalopram 10 mg, B6 Vitamin 50 mg to be administered at 9:00 AM. The EMAR documented the medications as Not Administered.</p> <p>R10 had a pack of Divalproex Sprinkle 125 mg scheduled to be administered at 9:00 AM, a pack of Olanzapine 10 mg, Metformin 1000 mg, and Januvia 25 mg scheduled to be administered at 9:00 AM. Also, a pack of Farxiga 10 mg scheduled to be administered at 9:00 am. The EMAR documented the medication as Not Administered.</p> <p>R11 had a pack of Carbidopa/Levodopa 25/100 mg x2 packs, one to be administered at 9:00 AM and the other to be administered at 1:00 PM. Also, a pack of Amlodipine 5 mg scheduled to be administered at 9:00 AM. The EMAR documented the medication as Not Administered.</p> <p>R12 had a pack of Eliquis 5 mg, a pack of Amlodipine 5 mg and a pack of Folic Acid 1 mg scheduled to be administered at 9:00 AM. The EMAR documented the medication as Not Administered.</p> <p>R13 had a pack of Metoprolol 25 mg, a pack of Finasteride 5 mg, a pack of Valsartan 160 mg, Metformin 500 mg, Levetiracetam, all scheduled to be administered at 9:00 AM. The EMAR documented the medication as Not Administered.</p> <p>R14 had a pack of Sulfamethoxazole/Trimethoprim 800 and a pack of Baclofen 5 mg, both scheduled to be administered at 9:00 AM. The EMAR documented the medication as Not Administered.</p> <p>During an interview on 08/27/24 at 1:35 PM, R5 stated, I heard about this last week. There was a day when I didn't get my medication. I need my medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/27/24 at 1:52 PM, R4 stated, I remember that day, the nurse said she was late passing medication, last week. She came in for my roommate. I asked her if she was going to give me my meds, she said she was late passing them. It only happened that one time. It was almost time for my evening meds, so I didn't take them. She said it was too close to give with my other medicine.</p> <p>During an interview on 08/27/24 at 9:53 AM, the Interim Director of Nurses (IDON) stated, On Friday morning, 08/23/24, I was reminded I was in charge for the next week. The Infection Preventionist (IP) Nurse told me after morning meeting, there were some medications documented as given, she had them (the actual pills) and gave them to the Administrator. She said the night shift nurse had given them to her. I went to the Administrator, and he gave me the pills. He asked me to pull the MAR and see what was going on. The nurse who did not administer the medication is [Licensed Practical Nurse Unit Manager [LPNUM]]. I opened the e-mar. I had the medications that were in the original packing and unopened. I compared them. She had notes in several of the meds on the MAR that said, not administered, but without an explanation. The Admin and I left her many messages, but she didn't return our calls. He finally left her a message on Friday that she was being suspended and she needed to call. I interviewed her yesterday. The [LPNUM] was scheduled on the med cart Thursday, 08/22/24 from 7a-7p, but the night [Registered Nurse [RN]] came in early to relieve her. She was the one who found the pills in the original package and reported it.</p> <p>During an interview on 08/27/24 at 11:26 AM, the Administrator stated, The IP nurse brought me the medications on Friday 08/23/24. She said they were found in the bin, the nurse who worked the night before had given them to her. She said she suspected the nurse before her didn't give them, [LPNUM]. I tried all day to contact her but couldn't reach her. She did finally text me after I left a message to suspend her. She text me on Saturday (08/24/24) morning. The interim DON was able to reach her yesterday to interview her.</p> <p>During a phone interview on 08/27/24 at 11:36 AM, the Director of Nursing (DON) stated, I was not made aware of [LPNUM] running late on her med pass. I would expect the nurse to come to me and report she was not passing medication. I would also expect the nurse to notify the doctor, that would be standard nursing practice.</p> <p>During an interview on 08/27/24 at 12:43 PM, the IP stated, I worked a med cart on Thursday evening from 4 PM-9:30 PM. I was wheeling myself to clock out. The night RN said, I need to show you something. I said ok. She showed me a box that was full of open med packets, but there were some that still had medications in them. She noticed them and looked at the dates and times. I was surprised and absolutely disappointed. I looked at them and said I cannot do anything about this now, put them away and I'll review first thing in the morning. The next morning, Friday 08/23/24, I went to the computer to check each residents' med orders. Unfortunately, most were active orders. The nurse who pulled the meds off the roll pulled 9 AM, 1 PM, 5 PM and 9 PM meds for the day. I then took the medications to the Administrator. Protocol is to place the empty packages into the little box which is kept in the med cart, empty it into the shredder box at the end of your shift, to be destroyed. Each shift completes that. The RN had relieved our LPNUM, on Thursday 08/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/27/24 at 1:03 PM, the LPNUM stated, On Thursday August 22, 2024, I arrived to work at 8:20 AM or so. My title is a Unit Manager. Often times I am assigned to work the cart. The night nurse RN didn't have relief. I got report from her. I started the back hall, cart 2. While on the cart I'm pulled away from the cart, concerning questions, therapy, etc. Around 11-12 noon I was in Matrix e-MAR. I saw some medications turn red. I realized I was not going to get through my med pass, I had 40 patients. I was behind in my med pass. I thought, let me tell my DHS. I locked my med cart. I marched to her office and said I need to get off the cart. I wasn't thinking clearly. I told her I am really slow today, I'm not in a mental state to tell myself to push through. I should have left the keys on her desk and said I need to leave now. I waited for her to call somebody in. I worked 4 more additional hours. I'm still on the cart going really slow. I was being pulled to the med room, etc. My relief came in, the same nurse that I relieved, around 4:35 PM. I made sure my patients who needed pain medication got it and other Hospice patients got theirs. I told one resident I didn't give her morning meds. I said it was too late to give them. I thought about calling the doctor, but I did not. I should have looked in Matrix for all who were in red, then report it. By this time, it's late and I did not give them, I was afraid of patient harm by then. I told the RN there were some people who didn't get their morning meds. I didn't know who got the same meds again, so I was afraid to give them so late.</p> <p>On 08/28/24, the facility provided an acceptable IJ Removal Plan, which included the following:</p> <p>IMMEDIATE CORRECTIVE ACTION: Residents (R) 4, 5, 6, 7, 8, 9 10, 11, 12, 13, and 14 were immediately assessed by licensed registered nurse, medical director/provider notified, resident responsible parties notified, nurse in question (UM LPN) immediately suspended, notification and reporting process initiated by Administrator on 08.23.2024. No residents sustained any negative outcome related to the isolated event. The licensed nurse in question (UM LPN) was suspended immediately pending investigation, and at conclusion of investigation, terminated related to medication administration discrepancies.</p> <p>METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED: All residing residents on the UP LPN assignment for 8.22.2024 had the potential to affected by the alleged deficient practice. The medication cart and disposal bin were thoroughly observed by the licensed nurse for any additional medications. All residents on assignment were observed by the license nurse and remained at baseline with no negative effects.</p> <p>SYSTEMIC CHANGES: All licensed nurses are to receive education on medication administration and the process when medications are not given timely and/or have the potential to not be given timely by the Clinical Competency Coordinator (CCC), Director of Health Services (DHS), and/or licensed designated charge nurse initiated on 08.23.2024. Any new hire licensed nurses will receive education in orientation. The CCC, DHS, and/or licensed charge nurse will observe/document licensed nurse(s) medication pass 3 x per week at random to validate the competency and timeliness of the medication administration. Any discrepancies observed will be reported to the DHS for further review and action.</p> <p>MONITORING: Monthly the CCC and/or DHS will present all reportable events to the QAPI committee x 3 months and/or until substantial compliance determined.</p>		