

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  02/05/2025
NAME OF PROVIDER OR SUPPLIER  Pruithhealth- 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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48835</p> <p>Based on review of facility policy, observation, record review and interview, the facility failed to ensure Resident (R)1 was free from misappropriation of a narcotic medication for 1 of 1 residents reviewed for misappropriation.</p> <p>Findings include:</p> <p>Review of the facility policy last reviewed on 11/15/2024, titled, Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property documented, It is the policy of PruithHealth and its affiliated entities to actively preserve each patient's right to be free from . misappropriation of patient property . Definitions: Misappropriation of Patient Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent.</p> <p>Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses that included but was not limited to: cognitive communication deficit, anxiety disorder, and unspecified intellectual disabilities.</p> <p>Review of R1's Minimum Data Set (MDS) with an Assessment Reference Date of 01/06/25, revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating R1 was moderately cognitively impaired.</p> <p>Review of the Monthly Controlled Drug Report revealed on 01/09/25, R1's Ativan 1 milligram (mg) containing 45 tablets, was delivered to the facility</p> <p>Review of a Narcotic Refill Request Log revealed on 01/19/25, R1's Ativan was requested from the pharmacy.</p> <p>Review of the Controlled Drug Record documented, Ativan 0.5 mg tab three times a day (TID) dated 01/21/25, number of doses 3, retrieved from the Cubex (automatic electronic drug kit in the facility). Further review revealed, written on the form were three entries where each dose was signed as the medication was administered on 01/21/25 at 3:00 PM, 01/21/25 at 9:00 PM, and 01/22/25 at 2:00 AM.</p> <p>Review of page 3 of the Medication Administration Record (MAR) documented, Ativan (Lorazepam) 1 mg was reordered on 01/20/25 at 9:00 AM, reordered at 3:00 PM and Drug/Item unavailable at 9:00 PM. Additionally, on 01/21/25 at 3:00 PM the medication was requested.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's MAR dated 01/01/25, did not reveal an order for Ativan 0.5 mg to be given for 3 doses.</p> <p>During an interview with the Administrator on 02/05/25 at 4:25 PM, the Administrator stated, I think the control sheet and the card were missing, so we don't have a copy of the sheet. I'll get the Director of Nurses (DON) and she can review that with you.</p> <p>During an interview on 02/05/25 at 4:30 PM, the DON confirmed it was the 1 mg Ativan that went missing. The DON revealed we were alerted by our Physician Assistant (PA). It was a request from pharmacy that it was too soon to order the 1 mg Ativan. The PA gave an order for Ativan 0.5 mg to be given and pulled from the e-kit until the pharmacy could deliver a new card. The DON stated R1 went 2 doses without the Ativan, but he covered her with the Ativan 0.5 mg until pharmacy could replace the missing card.</p> <p>During an interview on 02/05/25 at 4:55 PM, Registered Nurse (RN)1, with the DON present, stated the PA called me, saying I am ok to pull 0.5 mg Ativan from the Cubex, until the card arrives. The 0.5 mg Ativan was given via a verbal order, that was [DATE]st. RN1 further stated, she called the pharmacy and requested the number to pull the Ativan. They approved it. The PA spoke to them first. R1 was not my resident. I was helping the other nurse by getting the medication from the Cubex, so I did not write the order.</p> <p>During an interview on 02/05/25 at 6:03 PM, the PA confirmed he did not put the order in the system. The PA stated he didn't remember the exact date, but he remembered speaking to RN1 about this. The PA further stated the Cubex had 0.5 mg of Ativan, not 1 mg tablets. He gave a verbal order for RN1 to pull the medication, 3 doses. The PA concluded that he put this order in as late even though it was already given.</p> <p>During a follow up interview on 02/05/25 at 6:15 PM, the DON revealed there was a card of 15 tablets and the Controlled Drug Sheet went missing. It was the 9th of January. The Pharmacy filled 45 tablets, in 2 medication cards. One was a card of 30 tablets and we confirmed those were given as ordered. The narcotic sheet confirms it was zeroed out. The DON stated we cannot account for the second medication card that contained 15 tablets, or the narcotic sheet that went with it. The second med card is what disappeared. It was 15 tablets. We started going through all the meds for the upcoming storm. The DON stated, the [PA] alerted me stating the pharmacy notified him, said it was too soon to reorder the Ativan. That's how I was alerted to it. When I looked at it, I realized the math didn't add up. The storm was on the 21st. We started looking right away for the missing card. My initial findings were the one resident. Because the [PA] or [RN1] wrote the order for Ativan that would go to the MAR, the 3 doses he ordered and [RN1] pulled from the Cubex, they weren't signed off as given on the MAR. The DON stated the Controlled Drug Record is the proof that they were administered twice on 01/21/25, and the missing dose on 01/22/25 at 3 PM, on 01/20/25 at 9:00 PM and on 01/21/25 at 9:00 AM, even though the MAR reveals Ativan 1 mg was given, it was not. R1 missed 2 doses related to the missing drug card and sheet.</p>		