STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425140	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Moncks Corner	505 South Live Oak Drive Moncks Corner, SC 29461

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51028 Based on review of facility policy, record review, observations, and interviews, the facility failed to maintain the dignity of Resident (R)40, for 1 of 2 residents reviewed for dignity. Specifically, R40's nose hairs failed to be trimmed. Findings include: Review of the facility's Certified Nursing Assistant (CNA) Position Description with a modified date of September 2016 indicated, the job's purpose is that it, Provides each of the assigned patients with routine daily nursing care and services in accordance with the patient's assessment and care plan, and as directed by the nurse supervisor. Further review of the description under Key Responsibilities indicates that CNAs Assists patients in dressing, or undressing, and personal grooming e.g., oral/denture care, brushing hair, trimming fingernails and toenails, skin care and shaving. Review of the facility's policy titled Documentation: Charting Activities of Daily Living (ADLs) dated for 01/11/24 under Policy Statement revealed, It is required for Activities of Daily Living (ADL) care given by Certified Nursing Assistants and Nurses to be documented under Care Assist in patient's/resident's Electronic Healthcare Record (EHR). For the healthcare centers not utilizing EHR, all documentation will be completed using the CNA ADL Flow Sheet Form. Further review of the policy under Procedure the monthly ADL tracking tool is utilized to code self-performance and for coding all ADL's when support is provided. When the Care Assist is unavailable, the ADL documentation should be completed using the CNA/ADL Flowsheet form. CNAs are required to enter documentation at the point of care. Review of R40's Face Sheet revealed R40 was admitted to the facility on [DATE], with diagnoses including but not limited to: unspecified dementia, altered mental status, and other lack of coordination. Review of R40's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/13/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating R40 was severely cognitively impaired. The MDS also indicated the resident is dependent on staff for oral hygiene, toileting hygiene, personal hygiene, and toilet transfer tasks. (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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R40's Care Plan, with a start date of 11/08/18, identified the resident as dependent upon staff to anticipate and provide extensive to total assist with all his Activities of Daily Living (ADL)'s, including his feeding. Interventions included that the resident will be clean, dry, odor free and appropriately dressed through the next review. Review of R40's Point of Care History dated 6/17/24 - 6/20/24, revealed R40's maintained personal hygiene: 06/18/24 2nd Shift [unanswered] 06/18/24 2:35pm 1st Shift Total Dependence care 06/18/24 1:13am 3rd Shift Activity did not occur 06/19/24 1:39am 3rd Shift Total Dependence 06/19/24 3:02pm 1st Shift Total Dependence 06/19/24 5:40pm 2nd Shift Total Dependence 06/20/24 6:22am 3rd Shift Total Dependence 06/20/24 1st Shift [unanswered] 06/20/24 2nd Shift [unanswered] Staff support provided for personal hygiene as follows: 06/18/24 2:35pm 1st Shift 1-person physical assist 06/19/24 5:40pm 2nd Shift 1-person physical assist 06/19/24 3:02pm 1st Shift 1-person physical assist 06/19/24 1:39am 3rd Shift 1-person physical assist 06/20/24 6:22am 3rd Shift 1-person physical assist During an observation on 06/18/24 at approximately 2:31 PM, R40 was observed in his room on the 200-hall lying awake on his back with nose hairs extending beyond his nostrils. During an interview on 06/19/24 at 9:36 AM, Registered Nurse (RN)2 stated that the CNAs provide ADL care for shaving at least 1 to 3 times a week. During an interview on 06/20/24 at 9:43 AM, CNA2 stated that she's not sure how to address his (R40) nose hair care but can find out. CNA2 further stated that she's only required to shave his beard and mustache. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/24 at 2:25 PM, the Director of Nursing (DON) stated the expectation is that the CNAs would groom residents daily, and that the CNAs would shave the residents as needed using a razor. The DON stated that she considers that ADLs are what a person does to get themselves out and about in the morning.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 31846 Based on record review and interview, the facility failed to ensure Resident (R)8, with a diagnoses of post traumatic stress disorder and bipolar disorder, was referred and screened for possible needed services, utilizing the PASARR Level II screening and evaluation tool for 1 of 3 residents reviewed for PASARR Level II. Findings include: Review of R8's Face Sheet revealed the facility admitted R8 on 06/14/18, with diagnoses including, but not limited to: cerebral vascular accident, anxiety, pain disorder, morbid obesity, and panic disorder. Review of R8's PASARR Level I Screening was completed on 06/28/17, prior to admission and did not include the diagnoses of bipolar disorder and the post traumatic stress disorder (PTSD), panic disorder nor anxiety disorder. The PASARR Level I did state under recommendation, No further evaluation recommended, but indicators are present. State reasons below. No reasons were provided on the PASARR Level I. Review R8's Medical Record on 06/19/24 at 2:54 PM, revealed diagnosis of PTSD dated 01/28/20 and 05/03/23, bipolar disorder, anxiety disorder and panic disorder. Further review of R8's Medical Record revealed, revealed no documentation of a PASARR Level II screening or evaluation, after R8 was diagnosed with PTSD, bipolar disorder, panic disorder, and anxiety disorder. During an interview on 06/20/24 at 12:20 PM, the Social Services Director stated that R8 was screened on admission and R8 did not have the diagnoses of PTSD and Bipolar Disorder. The Social Services Director stated that the facility is in the process of completing an audit to submit the paperwork for screening residents for the PASARR Level II.

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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** 48834 Based on observations, interviews, and record review, the facility failed to update Resident (R)677's Care Plan related to oxygen use and pain management for 1 of 5 residents reviewed. Furthermore, the facility failed to accurately reflect R31's advance directives in the Care Plan for 1 of 3 residents reviewed for Advance Directives. Findings include: Review of the facility policy titled Care Plans with a revised date of [DATE], documented, It is the policy of the health care center for each patient/resident to have a person - centered baseline care plan followed by a comprehensive care plan developed . The baseline care plan should be updated to reflect changes since base line care plan implementation. 3. The comprehensive person-centered care plan is developed to include measurable goals and timeframes to meet a patient/resident's medical, nursing and psychosocial needs . Review of the facility policy titled Advance Directives: South Carolina with a reviewed date of [DATE], documented, This healthcare center recognizes the right of patients/residents to control decisions related to their medical care. Review of R677's Face Sheet revealed R677 was admitted to the facility with diagnoses including but not limited to: paroxysmal atrial fibrillation, shortness of breath, and chronic pain. Review of R677's Physician Order indicated an order for hydromorphone, a Schedule II pain medication, dated [DATE]. Review of R677's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], indicated the use of oxygen therapy. Review of R677's Nursing Progress Notes for the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], revealed R677 complained of pain presence. Review of R677's Physician Progress Note dated [DATE], indicated R677 received oxygen therapy via nasal cannula at 2 liters, and at 3 liters on [DATE], [DATE], [DATE], [DATE]. Review of R677's [DATE] and [DATE] Treatment Administration Record (TAR) indicated that a referral was made to pain management on [DATE]. The TAR also indicated that R677 reported pain at a level 10 (pain scale of 1 - 10, 10 being severe) on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Review of R677's Care Plan did not indicate goals and approaches for pain management or oxygen therapy. During an observation on [DATE] at 9:30 AM and [DATE] at 8:37 AM, revealed R677 grimaced and grabbed their shoulder when moving their right arm and right shoulder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:52 PM, R677 stated the presence of pain occurs twenty-four seven. During an interview on [DATE] at 11:32 AM, R677 stated, I'm hurting so bad that I can hardly move my arm. During an interview on [DATE] at 8:37 AM, R677 stated, My shoulder hurts so bad and revealed that they received their pain medicine already. During a combined interview on [DATE] at 10:35 AM, with the Director of Nursing (DON) and the Consultant. The Consultant revealed they are aware of R677's pain concerns. The Consultant further stated they believe that R677's current pain regimen works, and the hope is that the regimen will continue to work once R677 is discharged . During an interview with the Administrator on [DATE] at 2:30 PM, revealed that if a resident is on oxygen, then it should be care-planned. The Administrator stated that management often reviews orders and updates the care plan during morning meetings. The administrator confirmed that oxygen use was not indicated on the care plan. Review of R31's Face Sheet revealed R31 was admitted to the facility on [DATE], with diagnoses including but not limited to: seizures, peripheral vascular disease, heart failure, and dementia. Further review of the Face Sheet, under the Advance Directive section, revealed R31 was Do Not Resuscitate (DNR) and on Hospice. Review of R31's DNR Authorization Form for Patient/Resident Without Decision-Making Capacity dated [DATE] and [DATE], revealed, As the attending physician of [R31], I hearby authorize the entry of an order in the medical record instructing this healthcare center not to provide Cardiopulmonary Resuscitation (CPR) . Further review revealed, The patient/resident has a medical condition which can be expected to result in the imminent death of the resident/patient. Review of R31's Physician Order revealed, Code Status: DNR with a start date of [DATE]. Review of R31's Care Plan with a start date of [DATE], indicated a problem under the category Advance Directives, Attempt Resuscitation Full Code the goal with a target date of [DATE], indicated, Patient/Resident's Advance Directives are in effect, and their wishes and directions will be carried out in accordance with their advance directives on an ongoing basis. During an interview on [DATE] at 10:44 AM, Licensed Practical Nurse (LPN)3, who is also the Case Mix Coordinator, stated, I didn't make that update. There are 3 other staff under me that can update the care plan. All the nurses can too. If there is a change in advance directives it should be updated with the change. During an interview on [DATE] at 2:25 PM, the DON revealed there are multiple ways to make sure things don't fall through the cracks. The DON stated, My expectation is that the order/care plan is updated to reflect what the resident wants.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 31846 Based on review of the facility policy, observation, record review, and interviews, the facility failed to ensure proper hand washing during wound care for Resident (R)13. Furthermore the facility failed to properly clean the wounds and additionally failed to ensure resident privacy before providing wound care for 1 of 1 resident observed for wound care. Findings include: Review of the undated facility policy titled, Guidelines for Cleansing and Observing a Wound, states as the Procedure: 1. Identify resident. 3. Explain procedure to resident. 4. Perform hand hygiene according to facility/protocol. 5. Don personal protective equipment as appropriate for procedure. 6. Apply cleansing solution to the sponge, then squeeze it so it is not dripping. 7. Gently clean the wound with the ordered cleanser or normal saline. 9. To cleanse an injury or pressure ulcer, work in half circles or full circles, beginning in the center of the wound and working outward. Cleanse the skin at least one inch beyond the edge of the dressing. Use a new sponge for each circle. 10. Avoid rubbing back and forth. Rinse using the same technique. 11. Use each gauze sponge once, then discard it. 14. As soon as you have finished removing the soiled dressing and cleansing the wound , remove and discard your gloves. Otherwise, everything you touch will be contaminated with the microorganisms on your gloves. 16. Wash your hand (or use an alcohol cleanser) after removing and discarding the existing dressing. 17. Put on clean gloves before applying a new dressing. 19. Perform hand hygiene according to facility policy/protocol. Review of R13's Face Sheet revealed the facility admitted R13 with diagnoses including, but not limited to: anoxic brain damage, muscle contractures, osteomyelitis, and contracture of the left and right ankles and the right foot. During an observation of wound care on 06/19/24 at 11:55 AM the following was observed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13 is on Enhanced Barrier Precautions due to multiple wounds, pressure ulcers, a Foley catheter, feeding tube, colostomy and a J tube. Registered Nurse (RN)1 cleaned the scissors and her hands with hand sanitizer outside the residents room before donning a gown, and 3 pairs of gloves. RN1 knocked on the residents door and the roommate asked us in. This surveyor asked permission to observe wound care, even though R13 is non verbal. RN1 explained the procedure to the resident, but she did not shut the room door, did not pull the privacy curtain, and did not close the blinds as R13's bed is beside an outside window facing the front parking lot. RN1 removed the bed covers from the residents feet and raised the bed. She then removed one pair of the gloves applied before entering the room. RN1 opened a drape and placed it onto the over bed table that had been cleaned by a Certified Nursing Assistant (CNA). The supplies were left inside a wash basin brought into the room upon entering and placed on the drape. RN1 removed the socks from the resident's feet and then removed the second pair of gloves. RN1 used the scissors to remove the Kerlix from both feet and removed the soiled dressing from the right ankle. RN1 then removed the third pair of gloves. RN1 donned clean gloves, but did not wash or clean her hands. She opened the normal saline (NS) and squeezed it onto a 4 x 4 and blotted the right ankle wounds x2, removed gloves and applied gloves, and opened the another plastic tube of NS and applied it to the gauze and blotted the ankle a second time. RN1 removed her gloves and applied gloves and took a piece of Prisma Matrix, cut a small piece with the scissors x2 and placed it on the 2 small wound beds. She then removed her gloves cleaned her hands with hand sanitizer and took a marker from her pocket and wrapped it in gauze and wrote the date and her initials on the border foam and placed it over the right ankle. RN1 applied gloves and removed the soiled dressing from the right great toe area, removed her gloves and applied gloves, RN1 did not clean her hands, took the saline and squeezed it onto a 4x4 gauze and cleaned the area x2 wiping over the raw area of her right great toe and it did have some bloody drainage. RN1 removed her gloves, did not clean her hands, applied new gloves and opened another plastic tube of NS and applied it to a 4x4 gauze and cleaned between the resident's toes. RN1 removed her gloves and applied gloves, RN1 did not wash or clean her hands prior to donning clean gloves. RN1 then took another 4x4, applied NS and cleaned under her toes on her right foot, wiping over and over them. RN1 then removed her gloves and opened another plastic tube of NS and squeezed it on a 4x4 gauze and wiped the toe area a second time. She removed her gloves and applied gloves, she took a piece of Prisma Matrix and cut it and applied it to her right great toe area and then opened the foam dressing and took the marker and wrote the date and her initials onto the outer dressing and applied it to the toe wound and removed her gloves and applied gloves, RN1 did not wash or clean her hands after removing her gloves. Left foot - heel only - With gloved hands after finishing with the right foot, RN1 applied normal saline to a 4x4 gauze, removed the soiled dressing to her left heel, and then wiped the heel wound and blotted it several times, removed her gloves and cut a piece of Prisma Matrix, applied gloves, placed it onto the heel wound, opened the opti foam dressing and wrote the date and her initials in the dressing and placed it over the heel wound. RN1 then went to the residents closet and took out a pair of socks and placed them on the residents feet. Took the pillow from under her feet and place it under her left arm, and applied the heel protecting boots to her bilateral feet and covered the resident. RN1 lowered the bed and made the resident comfortable. RN1 removed her gloves, applied gloves, moved the trash can, removed her gloves, applied gloves, gathered the supplies, clean the pen and the scissors, and removed her gloves. RN1 did not wash her hands after care. RN1 then gathered the soiled linen and the trash and carried it to the soiled utility room. During an interview on 06/19/24 at 12:35 PM, RN1 did not comment regarding the residents privacy during wound care. RN1 confirmed that she cleaned her hands only one time during wound care. RN1 concluded that she had not provided privacy during wound care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 31846 Based on review of the facility policy, observation, and interview, the facility failed to follow a procedure during catheter care to prevent infections for Resident (R)13, for 1 of 1 residents reviewed for catheter care. Finding include: Review of the undated facility policy tiled Catheter Care states for a female resident, 1. Wet washcloth and sparingly apply soap or perineal cleanser. 2. Separate inner labia with nondominant hand. Wash down the center, wiping downward from front to back and stopping at the base of the labia. Continue washing, wiping from front to back, alternating from side to side moving outward to the thighs. Turn the wash cloth or use a new washcloth for each area. 3. Rinse and dry the urethral and perineal area, working in the same direction until the entire area is clean, soap free, and dry. 4. Hold catheter tubing to one side and support against leg to avoid traction or unnecessary of the catheter while washing perineum. Keep drainage bag below level of the bladder. 5. When washing, rinsing, and drying the urethral area: a. Gently wash, rinse and dry around the juncture of the catheter and meatus. b. Wash the catheter from the meatus down the tube about 3 inches. 11. Position the bed linen and the resident. 12. Perform hand hygiene according to facility policy/protocol. 13. Document procedure per facility policy/protocol. 14. Take appropriate actions for abnormal findings or observations. Review of R13's Face Sheet revealed the facility admitted R13 with diagnoses including, but not limited to: anoxic brain damage, history of urinary tract infections, chronic pain, and osteomyelitis. During an observation on 06/20/24 at 11:00 AM, of Foley catheter care was performed as follows: Certified Nursing Assistant (CNA)1 applied a gown, gloves and a mask outside the resident room due to the resident being on enhanced precautions. CNA1 knocked on the door, R13 was non verbal, we entered the room, and CNA1 provided privacy, and explained the procedure to the resident. This surveyor asked permission to observe CNA1 performing the catheter care, the resident is non verbal, so she did not answer. CNA1 went into the bathroom, took the bath basin, added warm water, and a hand towel and a washcloth. CNA1 placed a towel over the resident's private area prior to catheter care. CNA1 then removed her gloves, cleaned her hands, applied gloves, and wet a wash cloth. CNA1 did not use soap or any type of cleaner, and took her left hand and held the catheter tubing, with the wet cloth wiped down the tubing, folding the wet wash cloth each time she wiped down the tubing x5. Then CNA1 dried the tubing using a hand towel, holding the tubing with her left hand and wiping down the tubing x4 with her right hand. CNA1 then took the soiled linen and placed it in a plastic bag, poured out the water, rinsed out the basin, and then dried it with paper towels. CNA1 removed her gloves, cleaned her hands, applied gloves, emptied the Foley bag of 350 milliliters of clear concentrate urine, poured out the urine, rinsed out the cylinder used to measure the urine, and placed it on back of the commode. CNA1 removed her gloves, cleaned her hands, applied gloves, and made the resident comfortable. CNA1 then cleaned the resident's mouth and wiped the dried secretions from the left side of her lower face. CNA1 removed her gloves, raised the head of the bed, and exited the room. CNA1 exited with the mask and the soiled gown, and removed them in the hallway, then placed them in the plastic bag and then carried the bag of soiled linen to the soiled utility room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/24 at 11:20 AM, CNA1 stated, I was taught in school to only clean the tubing. CNA1 further stated, The nurses do the rest.

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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. 48834 Based on review of facility policy, observations, interviews, and record review, the facility failed to establish a physician order related to oxygen use for Resident (R)677, for 1 of 5 residents reviewed. Findings include: Review of the facility policy titled Oxygen Administration revised on 08/02/23, indicated, Oxygen will be administered by licensed personal only when ordered by the physician, PA, or NP. Review of R677's Face Sheet revealed R677 was admitted to the facility with diagnoses including but not limited to: shortness of breath and paroxysmal atrial fibrillation. Review of R677's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/28/24, indicated the use of oxygen therapy. Review of R677's Physician Orders did not indicate an order for the use of oxygen therapy. Review of R677's Care Plan did not include a Care Plan for oxygen therapy. Review of a Physician Progress Note dated 05/24/24, indicated R677 received oxygen therapy via nasal cannula at 2 liters on 05/24/24, and at 3 liters on 05/27/24, 05/28/24, 05/29/24, 06/05/24. During an observation on 06/18/24 at 1:52 PM, 06/19/24 at 11:32 AM, and 06/20/24, revealed R677 was receiving oxygen via nasal cannula. During an interview on 06/20/24 at 10:30 AM, the Director of Nursing (DON) revealed there should be a physician order present if a resident receives oxygen. The DON further stated the only instance where a resident should use oxygen without a current physician order is if there is an emergency where oxygen is being used as 911 is called. The DON verified that there was no oxygen order for R677.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 31846 Based on record reviews and interviews, the facility failed to have a system in place to ensure every employed nurse aide had a completed performance review every 12 months. The facility further failed to ensure each nurse aide received the required 12 hours of inservice based on the outcome of the performance reviews. Findings include: Review of the Annual Skills Fair, dated 08/18/23, did not include the content, the total hours, and did not include the required 12 hours of inservice, based on performance reviews for Certified Nursing Assistants (CNA)s. The Annual Skills Fair included all staff, nurses, certified nursing assistants, maintenance, and housekeeping. Review of a document on 06/20/24 at 2:45 PM, titled, Course Completion History listed a total of 20 CNAs. Further review revealed 13 of the 20 CNAs had not completed the required 12 hours of inservice. The CNAs that completed at least 12 hours of training, did not mention receiving a performance review. During an interview on 06/20/24 at 3:00 PM, the Administrator confirmed that each employee had attended the annual skills fair on 08/18/23, but did not provide documentation for all CNAs performance reviews and the 12 hours of required in services based on the performance reviews.

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	425140	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Moncks Corner	505 South Live Oak Drive Moncks Corner, SC 29461

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 31846 Based on record reviews and interviews, the facility failed to designate a licensed nurse to serve as a charge nurse on each tour of duty. Findings include: Review on 06/20/24 at 2:06 PM, of the daily staffing sheets, as worked, posted for each shift from January 1, 2024 through June 16, 2024, did not include a designated licensed nurse to serve as a charge nurse for each shift. Review of the Daily Staffing Sheets revealed a line which indicated, Shift Supervisor. Each sheet revealed a blank where it had not been completed. During an interview on 06/20/24 at 3:25 PM, the Director of Nursing (DON) stated that each nurse working on each unit should be the charge nurse and confirmed that no one nurse is designated on each shift to be in charge. When asked if something occurs and no one is available, how does staff know who to contact, the DON did not respond.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25335 Based on observation, record review, and interview, the facility failed to assure that a medication prescribed to Resident (R)38 for a fecal impaction, was being administered according to physician orders for 1 of 3 residents reviewed for hospitalization . Findings include: Review of R38's Face Sheet revealed R38 was admitted to the facility on [DATE], with diagnoses including but not limited to constipation. On 06/20/24 at approximately 1:09 PM, a review of R38's Medical Record revealed that he had been hospitalized on [DATE], due to projectile vomiting with a subsequent hospital diagnosis of small bowel obstruction. Further review of the Medical Record revealed R38 was discharged back to the facility on [DATE] with a physician order for Senokot Plus 8.6 mg (milligram) - 50 mg 2 tablets twice daily at 9:00 AM and 9:00 PM daily for fecal impaction. Review of R38's Medication Administration Record (MAR) for May 2024 and June 2024, revealed the 9:00 PM doses of Senokot Plus 8.6 mg-50 mg were not being administered as prescribed, after R38 returned to the facility from the hospital on 05/09/24. The 9:00 PM doses were not documented as having been administered on 05/10/24, 05/24/24, 06/10/24, 06/15/24, and 06/16/24. During an interview on 06/20/24 at approximately 12:39 PM, the Interim Director of Nursing acknowledged multiple doses of medications were not being administered to R38 as ordered by the physician on the evening shift, including Senokot 8.6 mg-500mg.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 25335 Based on observation, record review, interview, review of facility policy, and manufacturer labeling, the facility failed to assure that medications were properly stored for 1 of 20 residents, 1 of 2 medication rooms and 2 of 2 treatment carts. Findings include: During an initial tour on 06/18/24 at approximately 10:36 AM, an opened bottle of esomeprazole magnesium 20 mg (milligram) (a proton pump inhibitor used to treat GERD (gastroesophageal reflux disease)) was observed sitting on the bedside table belonging to Resident (R) 66, R66 was not in the room. During an observation, from the entrance to R66's room, on 06/18/24 at approximately 11:41 AM, the opened bottle of esmoprazole magnesium was still sitting on R66's bedside table and the resident was still not in the room. Licensed Practical Nurse (LPN)1 was walking on the unit and was asked to come to the room. During an interview on 06/18/24 at approximately 11:41 AM, LPN1 acknowledged the finding and stated she would discard the medication and did not know how it got there. During an interview on 06/18/24 at approximately 12:15 PM, R66 denied having esmoprozole magnesium in her possession. During observation on 06/20/24 at approximately 1:49 PM, of the 100 Hall Treatment Cart revealed the following: three tubes of MediHoney 1.5 oz. (ounce) by Derma Sciences labeled with resident names. The manufacturer's labeling on each tube states: Single Use Only . Tube sterility guaranteed in unopened, undamaged package. During an interview on 06/20/24 at approximately 2:03 PM, LPN2 acknowledged the manufacturer labeling and that each of the three containers had been opened and were in use. During an observation on 06/20/24 at approximately 1:55 PM, of the 200 Hall Treatment Cart revealed the following: two opened MediHoney 1.5 oz. (one tube without a cap and contents exposed) labeled with resident names. During an interview on 06/20/24 at approximately 2:20 PM, LPN2 acknowledged the manufacturer labeling and that each of the two tubes had been opened with one tube not having been secured with the manufacturer supplied screw cap. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at approximately 2:08 PM inspection of the Hall 200 Medication Room Refrigerator revealed a thermometer which read 28 degrees F (Fahrenheit) with this finding being verified by Registered Nurse (RN) RN1 who was present at the time. The facility had placed a label on the front of the refrigerator which stated: REMEMBER! .Fridge Temp: 36 degrees to 46 degrees. On 6/20/24 at approximately 2:15 PM the Maintenance Director was called to bring to bring his thermometer and while waiting RN1 obtained another refrigerator thermometer and placed inside the refrigerator closing the door. Approximately 5 minutes later this thermometer read approximately 33 degrees F. On 6/20/24 at approximately 2:25 PM the Maintenance Director brought an infrared thermometer and R1 used his thermometer with varying results around 32 degrees F. On 6/20/24 at approximately 2:32 PM, the Surveyor used his calibrated thermometer leaving in the refrigerator for approximately 5 minutes and got a reading of 32 degrees F. The refrigerator contained insulins (Basalgar, Lantus, Humalog, Levemir, Novolin N, Novolin R and Novolog), Aplisol Injection, Ozempic 2 mg (milligram)/3 ml (milliliter), Acetaminophen 650 mg Suppositories and Promethazine 25mg Suppository. Manufacturer recommendations for these medications are 36-46 degrees F. The temperature log affixed to the refrigerator door stated the AM (morning) temperature on 6/20/24 was 39 degrees. On 06/20/24 at approximately 2:47 PM the Director of Nursing was informed of the investigative results and advised that refrigerator temperature is highly problematic for being approximately 32 degrees F or below. She stated she would immediately investigate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 25335 Based on observation, interview, facility policy review, and glucometer manufacturer recommendations, the facility failed to assure that proper infection control practices were being followed regarding glucometer cleaning for 1 of 3 residents, (Resident (R)42) observed for finger stick blood sugar testing during medication pass administration. Findings include: Review of the facility policy and procedure titled Glucometer Cleaning and Disinfecting revised on 06/27/23 and reviewed on 06/18/24 states, If one device must be used to monitor several residents, it must be cleaned and disinfected after every use following the manufacturer's instructions to prevent carryover of blood and infectious agent. Review of the Medline EvenCare G3 Blood Glucose Monitoring System (glucometer) User's Guide dated 2016, under Cleaning and Disinfecting Procedure for the Meter states, The EVENCARE G3 Meter should be cleaned and disinfected between each patient. The following products have been approved for cleaning and disinfecting the EVENCARE G3 Meter: Dispatch Hospital Cleaner Disinfectant Towels with Bleach, Medline Micro-Kill+ Disinfecting, Deodorizing Cleansing Wipes with Alcohol, Clorox Healthcare Bleach Germicidal and Disinfectant Wipes and Medline Micro-Kill Germicidal Bleach Wipes. During medication pass observation on 06/18/24 at approximately 4:29 PM, Licensed Practical Nurse (LPN)1 wiped an EvenCare G3 glucometer with an alcohol prep pad prior to performing a finger stick blood sugar test on R42. During an observation and interview on 06/18/24 at approximately 4:32 PM, LPN1 returned to the medication cart, wiped the EvenCare G3 glucometer with an alcohol prep pad and placed it in a basket designated for the glucometer. When asked if the glucometer was used for other residents, LPN1 responded Yes and I usually use an alcohol prep pad to clean . Is that okay? LPN1 went on to find a container of MicroKill Bleach in the treatment cart and showed it to the Surveyor, but did not use the MicroKill Bleach to clean the glucometer. During an interview on 06/19/24 at approximately 9:19 AM, LPN1 revealed that she had talked with the Director of Nursing and that she had made a mistake cleaning the glucometer for R42 yeserday, and had been in-serviced.