

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER Heartland Health Care Center - Union		STREET ADDRESS, CITY, STATE, ZIP CODE 709 Rice Avenue Union, SC 29379	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>39714</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure 1 (Resident (R)16) of 19 sampled residents was assessed to determine whether the resident could safely self-administer medications prior to keeping the medication at the resident's bedside.</p> <p>Findings included:</p> <p>A facility policy titled, Self-Administration of Medications, revised February 2021, revealed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The policy revealed, 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The policy revealed, 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan.</p> <p>An Admission Record revealed the facility admitted R16 on 08/29/2023. According to the Admission Record, the resident had a medical history that included diagnoses of chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), acute on chronic diastolic (congestive) heart failure (CHF), and a need for assistance with personal care.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed R16 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had shortness of breath or trouble breathing with exertion and when lying flat.</p> <p>R16's Care Plan, included a focus area revised on 11/26/2024, that indicated the resident was at risk for altered respiratory status/difficulty breathing related to diagnoses of COPD, chronic respiratory failure, CHF, and pleural effusion. Interventions directed staff to administer medications/puffers (inhalers) as ordered and to monitor for effectiveness and side effects (initiated 01/12/2024). The Care Plan also indicated that the resident May have inhaler on person (initiated 05/09/2024). The Care Plan did not address whether the IDT had assessed to determine whether self-administration of the inhaler had been deemed safe and clinically appropriate for R16.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R16's Order Summary Report for active orders as of 01/15/2025, contained an order dated 08/29/2023 for albuterol sulfate HFA (hydrofluoroalkane) inhalation aerosol solution, inhale two puffs every six hours as needed for shortness of breath/wheezing. The Order Summary Report revealed R16 did not have an order to self-administer any medication.</p> <p>An observation on 01/14/2025 at 11:26 AM revealed an albuterol inhaler lying on R16's bedside table. During a concurrent interview R16 stated that they kept the inhaler on their table and used the inhaler every six hours. R16 further stated the staff left the inhaler with the resident and picked it up when the resident was done.</p> <p>During an interview on 01/16/2025 at 2:20 PM, Certified Nursing Assistant (CNA)20 stated the nursing staff gave R16 their inhaler and left it with the resident to self-administer the medication. CNA20 stated staff picked up the inhaler during their next medication pass.</p> <p>During an interview on 01/16/2025 at 3:54 PM, Licensed Practical Nurse (LPN)21 stated she was aware that R16 had an inhaler in their possession but was not certain whether any resident had been assessed for self-administration of medication.</p> <p>During an interview on 01/16/2025 at 3:58 PM, LPN4 stated she was not aware R16 had albuterol at the bedside until the previous day when R16 mentioned the medication. LPN4 stated she asked the resident where the albuterol came from, and the resident stated they needed it for their breathing but did not tell her where they got the medication. LPN4 stated the resident had not been assessed for self-administration of the medication.</p> <p>During an interview on 01/16/2025 at 4:20 PM, the Director of Nursing (DON) stated that no resident of the facility had been assessed for self-administration of medications.</p> <p>During a follow-up interview on 01/17/2025 at 3:14 PM, the DON stated R16 should not have been self-administering medication without being assessed and having a physician's order to self-administer.</p> <p>The Administrator was interviewed on 01/17/2025 at 3:55 PM. The Administrator stated he expected residents to be evaluated or assessed prior to self-administering medication. The Administrator stated R16 should not have self-administered medication without first being assessed.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>22445</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive person-centered care plan to address contractures, which affected 1 (R29) of 1 resident reviewed for limited range of motion (ROM) concerns.</p> <p>Findings included:</p> <p>A facility policy titled, Care Plans, Comprehensive Person-Centered, revised 03/2022, indicated, 7. The comprehensive, person-centered care plan: included b. 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 exercising his or her rights, including the right to refuse treatment and (3) which professional services are responsible for each element of care. The policy revealed the comprehensive, person-centered care plan also e. reflects currently recognized standards of practice for problem areas and conditions.</p> <p>A facility policy titled, Resident Mobility and Range of Motion, revised 07/2017, revealed the Policy Statement included, 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. The Policy Interpretation and Implementation revealed, 4. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment, and will be revised as needed. 5. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. 6. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. 7. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives.</p> <p>An Admission Record revealed the facility admitted R29 on 05/08/2019. According to the Admission Record, R29 had a medical history that included a diagnosis of unspecified Alzheimer's disease.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed R29 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS revealed R29 was dependent upon staff for eating, oral hygiene, toileting hygiene, showers/baths, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated the resident was dependent on staff for rolling to the left and right, chair/bed-to-chair transfers, and with tub/shower transfers.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R29's care plan included a focus area revised on 11/13/2023, that indicated the resident was at risk for general pain evidenced by verbal and nonverbal expressions due to decreased mobility and osteoarthritis. Interventions directed staff to encourage and assist the resident with repositioning frequently to achieve comfort (initiated 08/21/2022). The care plan revealed no documentation that revealed R29 had contractures.</p> <p>An observation on 01/14/2025 at 11:25 AM revealed R29's left hand was contracted. There was nothing observed in the resident's palm to protect their palm from their long fingernails. The resident's legs were observed to be drawn up under sheets.</p> <p>Restorative Nursing Assistant (RNA)3 was interviewed on 01/16/2025 at 10:20 AM. RNA3 stated R29 was on the restorative nursing caseload for feeding. She stated R29's legs and arms were contracted and stated she provided ROM for the resident's legs and arms.</p> <p>Certified Nursing Assistant (CNA)5 was interviewed on 01/16/2025 at 4:50 PM. CNA5 stated she provided care to R29 on the 3:00 PM to 11:00 PM shift. She stated R29 had contractures in their left leg and arms and stated their hands were contracted a little as well. She stated the resident's contractures started within the past year. She stated she was not sure if the resident received any therapy services but stated that at one time restorative aides worked with the resident. CNA5 stated she did not use any devices in the resident's hands to protect the resident's palms but did place pillows between the resident's legs.</p> <p>CNA6 was interviewed on 01/16/2025 at 5:15 PM. CNA6 stated she had worked at the facility for a year and R29 had contractures when she started. CNA6 stated R29's legs and hands were contracted. She stated the resident had a wedge, but the wedge had been lost, so she used pillows to place between the resident's legs. CNA6 stated that when she was assigned to provide care to R29, she placed a folded cloth in the resident's hands.</p> <p>Licensed Practical Nurse (LPN)2 was interviewed on 01/16/2025 at 3:16 PM. LPN2 stated R29 had contractures in their left leg. During a concurrent observation LPN2 went to the resident's room and was unable to open the resident's right hand and was able to open their left hand slightly. LPN2 stated the expectation was for the certified nursing assistants (CNAs) to place a washcloth in the resident's hands to keep the nails from touching the resident's palms. LPN2 stated she was not aware of R29 receiving therapy services or restorative services for their contractures.</p> <p>The MDS Coordinator was interviewed on 01/17/2025 at 10:54 AM. The MDS Coordinator stated she was responsible for addressing nursing issues on the care plan and stated the Director of Nursing (DON) and the Assistant DON (ADON) also added to the care plan. She stated she reviewed orders daily and received verbal reports from staff regarding issues that required care planning. The MDS Coordinator stated contractures were care planned. The MDS Coordinator reviewed R29's care plan and stated the resident's care plan had not included the resident's contractures until the day prior, when she updated it, but stated that she had not added interventions yet. She stated the lack of addressing the contractures in the care plan was an oversight.</p> <p>The DON was interviewed on 01/17/2025 at 3:19 PM. The DON stated she expected contractures, contracture management, and interventions to provide comfort to be addressed in the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Administrator was interviewed on 01/17/2025 at 4:01 PM. The Administrator stated he expected contractures and any interventions for the resident to be addressed in the care plan.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>22445</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure a quarterly care plan meeting was held for 1 (Resident (R)37) of 19 sampled residents.</p> <p>Findings included:</p> <p>A facility policy titled, Care Planning- Interdisciplinary Team, revised 03/2022, indicated, 1. Resident care plans are developed according to the timeframes and criteria established by S483.21 [public health code of federal regulations for comprehensive person-centered care planning] The policy revealed, 5. Care Plan meetings are scheduled at the best time of the day for the resident and family when possible.</p> <p>An Admission Record revealed the facility admitted R37 on 06/24/2024. According to the Admission Record, the resident had a medical history that included diagnoses of myotonic muscular dystrophy, unspecified anxiety disorder, unspecified depression, chronic congestive heart failure, and presence of a cardiac pacemaker and automatic cardiac defibrillator.</p> <p>R37's IDT [Interdisciplinary Team] Conference Notes, dated 07/11/2024, revealed an admission conference was held. According to the notes, the resident, the resident's guardian, and a family member attended the conference.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/19/2024, revealed R37 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>A quarterly MDS, with an ARD of 12/19/2024, revealed R37 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>R37's Care Plan, initiated 06/25/2024 revealed the Last Care Plan Review Completed was 12/27/2024.</p> <p>R37's electronic medical record line listing for IDT conference notes revealed there was no documented evidence a quarterly care plan meeting had been held since 07/11/2024.</p> <p>During an interview on 01/14/2025 at 9:45 AM, R37 stated they had not been invited to discuss their care and was unaware there was anything like that (care plan meetings) in place.</p> <p>The Social Services Director (SSD) was interviewed on 01/17/2025 at 7:20 AM. The SSD stated she was responsible for inviting residents to care plan meetings. The SSD stated she kept a log that included the month that each resident's care plan meeting was due. She stated that at the end of the month, she set up a schedule for the following month and sent a list of the residents who were due for a care plan meeting to the receptionist. The SSD stated the receptionist mailed meeting information and delivered a card with care plan meeting information to each resident who was alert and oriented. The SSD reviewed the IDT notes for R37 and revealed the resident did not have a quarterly care plan meeting in 10/2024. The SSD stated it was an oversight.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON was interviewed on 01/17/2025 at 3:31 PM. The DON stated care plan meetings were held quarterly and as needed. The DON stated she expected residents to be notified of care plan revisions and meetings. The DON stated she was unaware R37's quarterly care plan meeting was missed in 10/2024.</p> <p>The Administrator was interviewed on 01/17/2025 at 4:06 PM. The Administrator stated care plan meetings were expected to be held quarterly, and he expected residents to be invited.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>22445</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to provide interventions to prevent the development or worsening of contractures for 1 (Resident (R)29) of 1 resident reviewed for limited range of motion concerns.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Mobility and Range of Motion, revised 07/2017, indicated, 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.</p> <p>An Admission Record revealed the facility admitted R29 on 05/08/2019. According to the Admission Record, R29 had a medical history that included a diagnosis of unspecified Alzheimer's disease.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed R29 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS revealed R29 was dependent upon staff for eating, oral hygiene, toileting hygiene, showers/baths, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated the resident was dependent on staff for rolling to the left and right, chair/bed-to-chair transfers, and with tub/shower transfers.</p> <p>R29's care plan included a focus area revised on 11/13/2023, that indicated the resident was at risk for general pain evidenced by verbal and nonverbal expressions due to decreased mobility and osteoarthritis. Interventions directed staff to encourage and assist the resident with repositioning frequently to achieve comfort (initiated 08/21/2022). The care plan revealed no documentation that revealed R29 had contractures.</p> <p>An Admission/Readmission Evaluation, dated 01/24/2023, indicated R29 could move all their extremities and indicated the resident had no impairment in ROM of their upper extremities or their lower extremities. The evaluation also indicated R29 was independent with transferring from a sitting position to a standing position. The Care planning decision indicated the resident was to be transferred with a gait belt.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A PT [Physical Therapy] Plan of Care, dated 01/24/2023, indicated R29 had difficulty walking and had generalized muscle weakness. The PT Plan of Care indicated the resident's prognosis was Fair and indicated the resident had impaired balance and impaired mobility. The PT Plan of Care indicated the resident's lower extremities were weak, and R29 received assistance with bed mobility, transfers, and gait [walking style]. The PT Plan of Care revealed the Plan included Gait training and PT was to be provided six times a week for an Expected Treatment Duration of four weeks. Per the PT Plan of Care, R29's prior level of functioning indicated the resident required minimum to moderate assistance from one staff member with their gait, was able to maintain balance when sitting, required moderate assistance from one staff member for transfers, and used a rolling walker and required assistance from one staff member to walk.</p> <p>A hospice Visit Note Report, dated 12/20/2023, revealed R29 had a recent functional decline and was in bed most of the time. The record revealed that previously, the resident had been in a wheelchair most of the day. The note indicated R29 no longer had balance when sitting. The note indicated the resident was unable to walk, was unable to sit up, and was bedbound.</p> <p>An observation on 01/14/2025 at 11:25 AM revealed R29's left hand was contracted. There was nothing observed in the resident's palm to protect their palm from their long fingernails. The resident's legs were observed to be drawn up under sheets.</p> <p>Restorative Nursing Assistant (RNA) #3 was interviewed on 01/16/2025 at 10:20 AM. RNA #3 stated R29 was on the restorative nursing caseload for feeding. She stated R29's legs and arms were contracted and stated she provided ROM for the resident's legs and arms. RNA3 stated she was part-time, and the full-time RNA was on vacation, so there was no one providing restorative services that day.</p> <p>Licensed Practical Nurse (LPN)2 was interviewed on 01/16/2025 at 3:16 PM. LPN2 stated R29 had contractures in their left leg. During a concurrent observation LPN2 went to the resident's room and was unable to open the resident's right hand and was able to open their left hand slightly. LPN2 stated the expectation was for the certified nursing assistants (CNAs) to place a washcloth in the resident's hands to keep the nails from touching the resident's palms. LPN2 stated she was not aware of R29 receiving therapy services or restorative services for their contractures. She stated when the resident was admitted, they were able to stand and get out of their wheelchair.</p> <p>LPN4 was interviewed on 01/16/2025 at 3:37 PM. LPN4 stated that at one time, R29 was up in a wheelchair, walking with the use of handrails, and propelling independently in their wheelchair. LPN4 stated the resident had declined. She stated that at one time the resident received therapy services, but the services were discontinued because the resident had met their potential. LPN4 stated now that R29 was on hospice services and therapy staff would not provide treatment.</p> <p>CNA5 was interviewed on 01/16/2025 at 4:50 PM. CNA5 stated she provided care to R29 on the 3:00 PM to 11:00 PM shift. She stated R29 had contractures in their left leg and arms and stated their hands were contracted a little as well. CNA5 stated R29 had not always had contractures. She stated that at the time of the resident's admission, the resident was able to walk to the bathroom with assistance. She stated the resident's contractures started within the past year. She stated she was not sure if the resident received any therapy services but stated that at one time restorative aides worked with the resident. CNA5 stated she did not use any devices in the resident's hands to protect the resident's palms but did place pillows between the resident's legs.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA6 was interviewed on 01/16/2025 at 5:15 PM. CNA6 stated she had worked at the facility for a year and R29 had contractures when she started. She stated R29's legs and hands were contracted. CNA6 stated the resident had a wedge, but the wedge had been lost, so she used pillows to place between the resident's legs. CNA6 stated that when she was assigned to provide care to R29, she placed a folded cloth in the resident's hands.</p> <p>The Director of Rehabilitation (DOR) was interviewed on 01/17/2025 at 9:20 AM. The DOR stated residents were screened for services annually and quarterly dependent upon MDS information. She stated the annual screening included contracture management. The DOR stated even if a resident were not receiving therapy services or restorative services, the expectation was for the nursing staff to place something in the resident's hands to prevent the nails from touching the palm, protect the palm, and to help reduce the risk of the contracture worsening. The DOR stated R29 had not had any recent therapy screenings due to the resident being on hospice. The DOR stated therapy staff were unable to screen residents who were on hospice unless permission was given by the hospice company. She stated it had been a year and a half or more since R29 had been screened for any type of therapy services. The DOR stated the nursing staff had not mentioned that R29 had contractures. During a concurrent observation the DOR observed R29 and stated the resident's legs and hands were contracted. She stated that prior to receiving hospice services, R29 had been out of bed more and sat in the wheelchair and was not as contracted as they were currently. The DOR stated that when R29 was admitted , the resident had been able to walk with assistance.</p> <p>Hospice Registered Nurse (HRN)7 was interviewed by telephone on 01/17/2025 at 9:46 AM. HRN7 stated the primary objective of hospice was to assure comfort and safety. HRN7 stated she first started seeing R29 in August 2024. She stated that both of the resident's legs, their right arm, and both hands were contracted. She stated there had been no change in the resident's contractures since she had first seen the resident. She stated the resident started receiving hospice services on 12/22/2023 and stated that if the resident's contractures had worsened since admission to hospice, she would have expected the facility staff to notify her. She stated she expected the facility staff to make sure the resident was comfortable by keeping the areas padded, assessing for pain, and expected a washcloth to be used in the resident's hands. HRN7 stated she had not seen any interventions used for R29's contractures, such as using a rolled cloth in their palms or pillows for positioning. HRN7 stated it was reasonable for nursing staff to ask the hospice provider for a therapy screen/evaluation for contracture management and stated that she had not received any requests for the hospice provider to provide orders for a therapy evaluation.</p> <p>The Director of Nursing (DON) was interviewed on 01/17/2025 at 3:19 PM. The DON stated that when a resident had contractures, she expected staff to be aware of positioning and pain management and to provide passive ROM. She stated she expected nurses or CNAs to use rolled washcloths or some device to prevent any damage to the palms of the hands. The DON stated for R29, the rolled washcloths in their hands would be a comfort measure. She stated the resident declined after they had a stroke and returned to the facility after being hospitalized .</p> <p>The Administrator was interviewed on 01/17/2025 at 4:01 PM. The Administrator stated he expected any interventions implemented to address contractures to be the decision of the hospice staff, therapy staff, the physician, and nursing staff. He stated therapy staff did not usually make recommendations when a resident was on hospice.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>22445</p> <p>Based on interview, record review, and facility policy review, the facility failed to accurately monitor and document the amount of fluid consumed by a resident with a physician ordered fluid restriction. The deficiency affected 1 (Resident (R)62) of 2 residents reviewed for nutrition.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Hydration and Prevention of Dehydration, revised 10/2017, indicated, 3. Physician orders to limit fluids will take priority over calculated fluid needs. The policy revealed, Fluid restrictions will be assessed by RD [Registered Dietician] and orders to include breakdown by dept [department] and shift. The policy revealed, 12. Nursing will monitor and document fluid intake and the dietitian will be kept informed of status.</p> <p>An Admission Record revealed the facility admitted R62 on 12/12/2023. According to the Admission Record, the resident had a medical history that included diagnoses of end stage renal disease, dependence on renal dialysis, kidney transplant status, and unspecified systolic congestive heart failure.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/05/2024, revealed R62 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident did not reject evaluation or care during the assessment timeframe. The MDS revealed R62 required set-up or clean-up assistance from staff with all activities of daily living (ADLs). The MDS revealed the resident received hemodialysis services while a resident at the facility.</p> <p>R62's care plan included a focus area initiated 12/27/2024, that indicated the resident was at risk of dehydration or electrolyte imbalance related to a fluid restriction. Interventions directed staff to provide the resident with a diet per the physician's order (initiated 12/27/2024) and monitor the resident's intake and output (initiated 12/27/2024). The care plan included a focus area initiated 12/14/2023 and revised 01/15/2025, that indicated the resident received dialysis. Interventions directed staff to promote the resident's fluid restriction as ordered (initiated 02/06/2024).</p> <p>R62's Order Summary Report, with active orders as of 01/15/2025, revealed an order dated 06/20/2024 for a renal diet, regular texture, thin liquids, with a 1,500 milliliters (mL) fluid restriction for Resident needs low potassium low phosphorus diet. The Order Summary Report revealed an order dated 01/07/2024 for a 1,500 mL fluid restriction every shift. The Order Summary Report revealed the orders did not include a breakdown of the amount to be provided by each department.</p> <p>R62's Progress Notes revealed a Nutrition Narrative Note, dated 09/06/2024, that indicated the resident received a renal diet and had a 1,500 mL fluid restriction. The note indicated staff should monitor for fluid gain/edema and continue the current nutrition plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R62's Medication Administration Record [MAR], for the timeframe from 01/01/2025 through 01/31/2025, revealed a transcription of an order for 1,500 mL fluid restriction every shift, with an order date of 01/07/2024 and a discontinued date of 01/16/2025. The MAR revealed it did not include a space for staff to record the resident's actual intake of fluids. The MAR revealed a transcription of an order dated 01/17/2025 for 1,500 mL fluid restriction, with instructions for nursing staff to provide 780 mL, and dietary staff to provide 720 mL every shift.</p> <p>R62's meal tray card, dated 01/17/2025, indicated the resident received a renal diet. The meal tray card revealed Alerts indicated a 1,500 mL fluid restriction.</p> <p>R62 was interviewed on 01/14/2025 at 1:50 PM. R62 stated staff gave them one large foam cup of ice water daily and added that they (R62) knew to limit their fluids.</p> <p>Restorative Nursing Assistant (RNA)3 was interviewed on 01/16/2025 at 10:20 AM. RNA3 stated any resident on a fluid restriction was listed on an assignment sheet. RNA3 pointed out R62's name on the sheet and stated the resident had fluid restriction of 1500 mL. She stated that when she passed ice water to residents, she gave R62 a 16-ounce (oz) foam cup of ice water that was filled with ice and about a half a cup of water. She stated she returned to ask the resident how much was consumed and documented that amount in the EMR. RNA3 stated the fluids documented in the EMR included fluids consumed at breakfast, lunch, and any additional fluids given to the resident by the CNAs.</p> <p>Licensed Practical Nurse (LPN)2 was interviewed on 01/16/2025 at 4:05 PM. LPN2 stated R62 had been ordered a fluid restriction. LPN2 stated a certain amount of fluid was provided by dietary staff, and the resident was given between 60 mL and 90 mL with medication administration. She stated there were two medication administrations on her shift, which meant the resident received between 120 mL and 180 mL from the medication administrations but stated that she did not document the amount given. LPN2 stated the nurses were responsible for adding the total fluid consumed by R62 in a 24-hour timeframe but stated that there was nowhere to document the amount.</p> <p>LPN #4 was interviewed on 01/16/2025 at 4:31 PM. LPN #4 stated that when a resident had an ordered fluid restriction, the order should indicate how much fluid was to be given by dietary staff and how much fluid was to be given by nursing staff. She stated that the amount of fluid given to a resident with medication administration was documented on the MAR. LPN #4 stated no staff had been assigned to total the 24-hour fluid intake for the resident.</p> <p>The Dietary Director (DD) was interviewed on 01/17/2025 at 7:53 AM. The DD stated that she documented the amount of fluid to be given to a resident on their meal tray ticket. She stated the staff knew to only give the amount of fluids listed on the meal tray ticket. The DD stated that when a resident was admitted on a fluid restriction, she notified the Registered Dietician (RD), and the RD entered the fluid restriction order into the EMR, which included how much would be given by the dietary staff and how much would be given by the nursing staff. The DD stated fluid overload could occur, which may require the resident to need more time on the dialysis machine.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Dialysis Registered Nurse (DRN) was interviewed by telephone on 01/17/2025 at 8:17 AM. The DRN stated the dialysis RD was not available, but she was familiar with R62 and was able to answer questions about the resident's diet, fluid restriction, and overall condition. The DRN stated it was important that R62 adhered to the ordered fluid restriction to limit the amount of extra fluid the resident retained. The DRN stated retaining too much fluid could cause the resident problems during dialysis and added it was hard to remove extra fluid, causing fluid overload and an increased blood pressure.</p> <p>The Physician's Assistant (PA) was interviewed on 01/17/2025 at 8:35 AM. The PA stated it was important for a resident receiving dialysis to adhere to a fluid restriction to avoid fluid overload and flushing out of electrolytes. The PA stated he expected the facility to maintain an accurate record of what fluids R62 consumed.</p> <p>The RD was interviewed by telephone on 01/17/2025 at 1:52 PM. The RD stated if a resident was on a fluid restriction, she used a fluid restriction guideline that was available to both the dietary department and the nursing department and stated the nursing department responsible for dividing their portion of the fluid restriction as they saw fit. The RD stated she expected the nurses to have documentation of the fluid consumed so nurses knew how much fluid the resident received.</p> <p>The Director of Nursing (DON) was interviewed on 01/17/2025 at 3:34 PM. She stated she expected the fluids to be divided between the dietary department and the nursing department. The DON stated there was a fluid cheat sheet that divided the amount of fluid nursing staff provided per shift. The DON stated she expected the nurses to document the amount of fluid consumed during medication administration and expected the CNAs to document what fluids were consumed during meals. The DON stated the 7:00 PM to 7:00 AM nurse was responsible to total the fluid intake for the 24-hour timeframe and document the amount of fluid consumed in the nurse's notes. She stated that she had not been aware the nurses were not documenting the amount of fluid consumed by R62.</p> <p>The Administrator was interviewed on 01/17/2025 at 4:09 PM. The Administrator stated he expected the amount of fluid given to a resident who had an ordered fluid restriction to be documented accurately, adding that otherwise there was no point in the fluid restriction.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46659</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to provide oxygen therapy in accordance with professional standards of practice and the comprehensive care plan for 2 (Resident (R)37 and R38) of 4 residents reviewed for respiratory care. Specifically, the facility failed to administer R38's supplemental oxygen per physician orders and failed to obtain a physician's order for supplemental oxygen for R37.</p> <p>Findings included:</p> <p>A facility policy titled, Oxygen Administration, revised 10/2010, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. The policy revealed, 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.</p> <p>1. An Admission Record indicated the facility admitted R38 on 12/24/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute and chronic respiratory failure and chronic obstructive pulmonary disease (COPD).</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/31/2024, revealed R38 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had received oxygen therapy within the last 14 days of the assessment look-back period.</p> <p>R38's Care Plan, included a focus area initiated 12/26/2024, that indicated the resident was at risk for altered respiratory status/difficulty breathing related to acute on chronic respiratory failure, COPD, and sleep apnea. Interventions directed staff to provide oxygen as ordered (initiated 12/26/2024).</p> <p>R38's Order Summary Report, for active orders as of 01/17/2025, contained an order dated 12/24/2024, for supplemental oxygen at two liters per minute (LPM) via nasal cannula every shift for low oxygen saturation.</p> <p>An observation on 01/14/2025 at 11:18 AM revealed R38's oxygen concentrator was set at 1.5 LPM. During a concurrent interview R38 stated their supplemental oxygen should be at 2 LPM.</p> <p>An observation on 01/14/2025 at 11:00 AM revealed R38 was out of the room. The observation revealed the resident's oxygen concentrator was on and their oxygen tubing was lying on the resident's bed.</p> <p>During an interview on 01/14/2025 at 11:18 AM, R38 stated they had just returned from the shower and was struggling to catch their breath. R38 stated they needed supplemental oxygen when they went to the shower; however, staff did not take any supplemental oxygen with them.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/14/2025 at 1:15 PM, Certified Nursing Assistant (CNA)13 revealed he was aware that R38 was dependent on supplemental oxygen. CNA13 stated he took R38 to the shower that morning but did not take supplemental oxygen for the resident. CNA13 stated the facility did not have portable oxygen tanks to use when transporting a resident.</p> <p>During an additional interview on 01/14/2025 at 1:33 PM, CNA13 stated he should have taken supplemental oxygen with R38 to the shower that morning to prevent anxiety or shortness of air.</p> <p>An observation on 01/16/2025 at 4:40 PM of the oxygen storage room revealed an ample supply of tanks along with oxygen haulers and concentrators.</p> <p>An observation on 01/16/2025 at 2:33 PM revealed R38's oxygen concentrator was set at 1.5 LPM.</p> <p>During an interview on 01/16/2025 at 4:40 PM, Licensed Practical Nurse (LPN)14 observed R38's oxygen concentrator and stated the oxygen concentrator was set at 1.75 LPM. LPN14 stated that the resident's supplemental oxygen should be set to 2 LPM.</p> <p>During an interview on 01/16/2025 at 3:21 PM, LPN14 stated she was told that R38 was dependent on supplemental oxygen and that it benefited the resident to take supplemental oxygen with them to the shower.</p> <p>During an interview on 01/17/2025 at 8:27 AM, the Physician Assistant (PA) stated he expected staff to follow the orders and to make sure supplemental oxygen was being delivered at the correct rate. The PA stated R38 should be provided supplemental oxygen when taken to the shower.</p> <p>During an interview on 01/17/2025 at 3:32 PM, the Director of Nursing (DON) stated she expected staff to administer supplemental oxygen at the correct rate.</p> <p>During an interview on 01/17/2025 at 4:14 PM, the Administrator stated he expected staff to follow physician orders for oxygen therapy and to make sure it was being delivered at the correct rate.</p> <p>22445</p> <p>2. An Admission Record revealed the facility admitted R37 on 12/05/2018 and most recently readmitted the resident on 06/24/2024. According to the Admission Record, the resident had a medical history that included diagnoses of myotonic muscular dystrophy, unspecified anxiety disorder, unspecified depression, and chronic congestive heart failure.</p> <p>A Transition of Care form dated 06/24/2024, the date of R37's most recent readmission from the hospital, indicated the resident received oxygen at two liters per minute by nasal cannula. The form indicated the resident's oxygenation decreased on room air. The form revealed no documented evidence related to which facility staff nurse completed the form.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed R37 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had an active diagnosis of pneumonia. According to the MDS, the resident did not receive oxygen therapy during the assessment look-back period.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R37's Care Plan, with a revision date of 07/09/2024, revealed the resident was at risk for an altered respiratory status/difficulty breathing related to pneumonia, dysphagia, and congestive heart failure. Interventions directed staff to administer medication/puffers (inhalers) as ordered, monitor for signs/symptoms of respiratory distress, and report to the physician as needed (initiated 06/25/2024).</p> <p>R37's Order Summary Report, with active orders as of 01/15/2025, revealed an active order started on 06/24/2024 to monitor the resident's oxygen saturation every shift and notify the medical doctor if the resident's oxygen saturation was less than 90 percent. The Order Summary Report revealed R37 had no active physician's order to administer oxygen to the resident.</p> <p>R37's Treatment Administration Record [TAR] for 01/2025 revealed a transcription of an order dated 06/24/2024 that instructed staff to monitor the resident's oxygen saturation every shift and notify the medical doctor if the resident's oxygen saturation was less than 90 percent. The TAR revealed that prior to 01/16/2025, there was no documentation that staff were administering supplemental oxygen to the resident.</p> <p>An observation on 01/14/2025 at 9:52 AM revealed R37 was receiving supplemental oxygen at two liters per minute via nasal cannula.</p> <p>Licensed Practical Nurse (LPN) #2 was interviewed on 01/16/2025 at 3:45 PM. LPN #2 stated a physician's order was required for the use of supplemental oxygen and should specify the amount of oxygen to be delivered. LPN #2 reviewed the physician's orders for R37 and stated the resident had no order for supplemental oxygen administration. LPN #2 stated R37 transferred to her unit from another unit within the facility and was wearing oxygen on arrival. LPN #2 stated someone should have noticed there was no order for supplemental oxygen for the resident.</p> <p>The Physician's Assistant (PA) was interviewed on 01/17/2025 at 8:33 AM. The PA stated that prior to administering supplemental oxygen an order for oxygen therapy was needed. He stated he expected the nurses to ask for supplemental oxygen orders.</p> <p>The Director of Nursing (DON) was interviewed on 01/17/2025 at 3:32 PM. The DON stated that prior to administering oxygen therapy, there had to be a physician's order.</p> <p>The Administrator was interviewed on 01/17/2025 at 4:07 PM. The Administrator stated he expected orders to be obtained prior to initiating oxygen therapy for a resident.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>22445</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure the attending physician documented a clinical rational when declining pharmacy recommendations, which affected 1 (Resident (R)29) of 6 residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>A facility policy titled, Antipsychotic Medication Use, revised 07/2022, indicated, Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject gradual dose reduction and re-review. The policy revealed, 9. Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others; AND: (1) the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or (2) behavioral interventions have been attempted and included in the plan of care, except in an emergency. The policy revealed, 19. The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.</p> <p>An Admission Record revealed the facility admitted R29 on 05/08/2019. According to the Admission Record, R29 had a medical history that included a diagnosis of unspecified Alzheimer's disease, dementia, bipolar disorder, generalized anxiety disorder, and major depressive disorder.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed R29 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS revealed R29 had no hallucinations or delusions, exhibited no physical or verbal behavioral symptoms towards others, did not reject evaluation or care, and did not exhibit behaviors of wandering during the assessment timeframe. The MDS revealed the resident received antianxiety medication, antidepressant medication, and antipsychotic medication during the assessment timeframe. The MDS revealed a physician documented that a gradual dose reduction was clinically contraindicated on 05/09/2024.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R29's care plan included a focus area revised on 05/23/2023, that indicated the resident was at risk for behavior symptoms related to Alzheimer's disease/dementia, anxiety disorder, bipolar disorder, and depression. Interventions directed staff to administer medications per physician orders (initiated 07/22/2019), observe the resident for mental status/behavior changes with new medications and changes in dosage (initiated 07/22/2019), provide non-pharmacological interventions for symptom management (revised 11/24/2023), and use consistent approaches when providing care (initiated 07/22/2019). The care plan also revealed a focus area initiated 05/14/2019, that indicated R29 exhibited verbal and physical aggression, including hitting at staff and resisting care. Interventions directed staff to administer medications as ordered (initiated 05/14/2019), provide diversional activity (initiated 05/14/2019), allow the resident time to respond to staff directions or requests (initiated 05/14/2019), and be aware of not invading the resident's personal space (initiated 05/14/2019). The care plan revealed a focus area initiated 05/14/2019 and revised 03/05/2023, that indicated the resident was at risk for adverse effects related to the use of antipsychotic medication, antidepressant medication, and antianxiety medication. Interventions directed staff to evaluate the effectiveness and side effects of medications for a possible decrease/discontinuation of psychotropic medications (initiated 05/14/2019).</p> <p>R29's Order Summary Report, with active orders as of 01/15/2025, revealed R29 was admitted to hospice services on 12/22/2023 related to a diagnosis of Alzheimer's disease. The Order Summary Report revealed the following medication orders:</p> <ul style="list-style-type: none"> - Citalopram hydrobromide (an antidepressant) tablet, 10 milligrams (mg) daily for depression, with a start date of 01/25/2023. - Clonazepam (a benzodiazepine) oral tablet, 0.5 mg twice a day for anxiety, with a start date of 08/28/2023. - Divalproex sodium (an anticonvulsant) delayed release sprinkle capsule 125 mg, one capsule twice a day for mood alteration, with a start date of 11/06/2023. - Lamotrigine (an anticonvulsant) oral tablet 25 mg, two tablets twice a day for bipolar disorder/seizure, with a start date of 11/27/2024. - Risperidone (an antipsychotic) oral tablet 0.5 mg, one tablet once a day for bipolar disorder/anxiety, with a start date of 06/24/2023. - Risperidone oral tablet 1 mg, one tablet once a day for bipolar disorder, with a start date of 12/17/2023. <p>A consultant pharmacist Consultation Report, with a Recommendation date of 11/04/2024, revealed a comment that the resident had several medications that were due for a gradual dose reduction (GDR) assessment. The report revealed that as of 11/04/2024, the resident was receiving the following medications:</p> <ul style="list-style-type: none"> - Risperidone 0.5 mg every morning and 1 mg every night for bipolar/dementia, noting that the medication was last increased on 06/24/2023. <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Lamotrigine 50 mg twice daily for bipolar/dementia, noting that it was last reduced on 03/25/2024. - Divalproex 125 mg twice daily for bipolar/dementia, noting that it was last reduced on 11/06/2023. - Clonazepam 0.5 mg twice daily for anxiety, noting that no changes in dosage had been made since starting the medication on 08/30/2023. - Citalopram 10 mg daily, noting that it was last reduced on 01/23/2020. <p>The Consultation Report revealed a recommendation to reevaluate the medications and consider attempting a GDR of any of the referenced medications and to consider discontinuing citalopram. The Consultation Report revealed the provider declined the recommendation, and revealed, Hospice NP [nurse practitioner] declined, was handwritten in the signature line and did not have a physician signature. The Consultation Report revealed the response was dated 11/06/2024. The report revealed no clinical rationale for rejecting the recommendation.</p> <p>The Physician's Assistant (PA) was interviewed on 01/17/2025 at 8:25 AM. The PA stated the psychotropic medications received by a resident was dependent upon the discharge medications from the hospital and then psychiatric services determined the routine. The PA stated diagnoses including anxiety disorder, bipolar disorder, and mood disorders supported the use of an antipsychotic medication. The PA stated if a GDR was needed on R29 the facility should reach out to the hospice provider, and the reason a GDR had not been attempted for R29 was due to the resident receiving hospice services.</p> <p>Hospice Registered Nurse (HRN)7 was interviewed by telephone on 01/17/2025 at 9:46 AM. HRN7 stated R29 had started hospice services on 12/22/2023. HRN7 stated that in November 2024 she and the hospice physician discussed R29's medication with the Director of Nursing (DON) to determine if the medications were still appropriate for the resident and to prevent destabilization. HRN7 stated that during the November discussion with the DON, the DON did not request a risk versus benefit statement or a reason from the hospice physician to support the declined GDR recommendation.</p> <p>The DON was interviewed on 01/17/2025 at 3:23 PM. The DON stated receiving hospice services did not support R29's use of an antipsychotic medication and stated the resident's primary physician declined a GDR. The DON stated she had made the hospice agency aware that they must follow rules and regulations for long-term care facilities.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>22445</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to maintain a medication error rate of less than 5 percent. Observation of medication administration revealed staff made two errors during 27 medication opportunities, resulting in a medication error rate of 7.41 percent.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised 04/2019, indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. The policy revealed, 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.</p> <p>An Admission Record revealed the facility admitted R3 on 01/26/2018. According to the Admission Record, the resident's medical history included an unspecified vitamin D deficiency and chronic idiopathic constipation.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/28/2024, revealed R3 had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition.</p> <p>R3's Care Plan, included a focus area initiated 01/30/2018, that indicated the resident had an alteration in bowel elimination and constipation related to anxiety, lack of exercise, and medications. Interventions directed staff to administer medications per the physician's orders and observe effectiveness (initiated 01/30/2018). The resident's Care Plan also included a focus area revised 12/06/2022, that indicated the resident was at nutritional risk. Interventions directed staff to administer medications (initiated 02/09/2021) and supplements (initiated 01/31/2018) as ordered.</p> <p>During an observation of medication administration on 01/15/2025 at 8:05 AM, Licensed Practical Nurse (LPN) #1 placed one capsule of docusate sodium, 100 milligrams (mg) into a medication cup. LPN1 removed one cholecalciferol tablet from a bottle that indicated the dosage of the cholecalciferol tablet was 400 international units (IU). LPN1 administered the medications to R3.</p> <p>R3's Order Summary Report for active orders as of 01/15/2025 revealed an order dated 04/12/2024, for cholecalciferol tablets 1000 units, with instructions to give one tablet one time per day for a vitamin D deficiency. The Order Summary Report revealed an order dated 12/02/2020 for docusate sodium 100 mg, with instructions to give 200 mg one time per day for constipation.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/15/2025 at 10:07 AM, LPN1 revealed she administered one docusate sodium and one cholecalciferol tablet to R3. During the interview, LPN1 reviewed R3's physician's orders and stated she needed to give the resident another capsule to equal 200 mg of docusate sodium the physician had ordered. LPN1 stated she also needed to give R3 another cholecalciferol to equal the amount the physician had ordered. When LPN1's attention was brought to the ordered cholecalciferol dosage, she stated she was not able to give half a tablet because the tablets were not scored and would have to check to see if the facility had the correct dosage available. LPN1 revealed she had made two medication errors because she did not check the medication labels and the medication orders carefully.</p> <p>The Director of Nursing (DON) was interviewed on 01/15/2025 at 10:54 AM. The DON stated LPN1 made medication errors when the correct dosage of docusate sodium and cholecalciferol were not given to R3. The DON stated she expected nurses to check dosages prior to giving medication to make sure the right dose was administered to the right resident. The DON stated if the right dosage of a medication was not available, she expected the nurse to contact the physician and follow the physician's directions. The DON stated medication errors were unacceptable.</p> <p>The Administrator was interviewed on 01/17/2025 at 4:12 PM. The Administrator stated that prior to giving medications, she expected nurses to check orders to make sure the medications administered to the resident matched the physician's orders.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39714</p> <p>Based on observation, interview, and facility policy review, the facility failed to store foods in accordance with professional food storage standards for labeling and dating for 1 of 1 resident refrigerator observed.</p> <p>Findings included:</p> <p>A facility policy titled, Food Receiving and Storage, revised November 2022, revealed, Refrigerated/ Frozen Storage. 1. All foods stored in the refrigerator or freezer are covered, labeled, and dated ('use by' date). The policy revealed, 7. Refrigerated foods are labeled, dated and monitored so they are used by their 'use-by' date, frozen, or discarded. The policy revealed the section titled Foods and Snacks Kept on Nursing Units indicated, 2. All foods belonging to residents are labeled with the resident's name, the item and the 'use by' date.</p> <p>A tour of the facility D-Wing Nursing Station was conducted with the Dietary Director (DD) on 01/15/2025 at 6:37 AM, revealed the following unlabeled, undated food items, were observed in the refrigerator designated for residents' food:</p> <ul style="list-style-type: none"> - Two transparent, plastic bowl containers of beef stew. - One gallon-sized bag of cheese slices. - Four brown paper bags containing hamburgers and French fries. - Two plastic bags of fresh fruit. - One transparent, plastic bowl container of chicken and pasta. - One opened carton of Egg Nogg. <p>During an interview on 01/15/2025 at 6:39 AM, the DD stated the food items noted in the refrigerators should have been dated and labeled and did not know why these food items were not disposed of.</p> <p>During an interview on 01/16/2025 at 3:33 PM, Certified Nursing Assistant (CNA)15 stated staff who put a food item in the refrigerator for a resident were to label the item with the resident's name, date, and resident room number. CNA15 further stated that it was everyone's responsibility to make sure it was done.</p> <p>During an interview on 01/16/2025 at 3:39 PM, CNA16 stated that all foods should be labeled with the resident name and the date and that it was everyone's responsibility. CNA16 further stated that she can admit it hasn't been getting done.</p> <p>During an interview on 01/16/2025 at 4:15 PM, Licensed Practical Nurse (LPN)16 stated that residents' personal food items were supposed to be labeled with the resident's name, date, and room number.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow-up interview on 01/16/2025 at 4:36 PM, the DD stated that prior to that week it was her understanding that the third shift nurse was responsible for cleaning out the resident refrigerator.</p> <p>During an interview on 01/17/2025 at 3:11 PM, the Director of Nursing (DON) stated that when food was brought in it should be labeled with the resident's name and date.</p> <p>The Administrator was interviewed on 01/17/2025 at 3:55 PM. The Administrator stated that he expected all food to be dated and labeled prior to being placed in the resident refrigerator.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46659</p> <p>Based on observation, interview, and record review, the facility failed to maintain and store oxygen equipment in a manner to prevent the development or spread of infection for 1 (Resident (R)37) of 4 residents reviewed for respiratory care.</p> <p>Findings included:</p> <p>A facility policy titled, Oxygen Administration, revised 10/2010, revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration. The policy did not address storage or changing oxygen tubing.</p> <p>On 01/17/2025 at 5:53 PM, the Regional Director of Clinical Services (RDCS) revealed the facility had no policy for the storage of oxygen tubing.</p> <p>The Director of Nursing (DON) was interviewed on 01/17/2025 at 3:32 PM. The DON stated oxygen tubing should be stored in a bag when not in use to decrease contamination. The DON stated third shift staff should change oxygen tubing weekly.</p> <p>An Admission Record revealed the facility admitted R37 on 06/24/2024. According to the Admission Record, the resident had a medical history that included diagnoses of myotonic muscular dystrophy, unspecified anxiety disorder, unspecified depression, chronic congestive heart failure, and presence of a cardiac pacemaker and automatic cardiac defibrillator.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed R37 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>A Transition of Care form dated 06/24/2024, indicated R37 received oxygen at two liters per minute by nasal cannula.</p> <p>R37's Care Plan, with a revision date of 07/09/2024, revealed the resident was at risk for an altered respiratory status/difficulty breathing related to pneumonia, dysphagia, and congestive heart failure.</p> <p>An observation on 01/14/2025 at 9:52 AM revealed R37's oxygen tubing, connected to a portable oxygen tank, was wrapped around the arms of a wheelchair and was dated 12/05/2024. There was no covering over the nasal cannula portion of the tubing. During a concurrent interview R37 stated staff did not cover the tubing, and the tubing was always hanging free and uncovered.</p> <p>Licensed Practical Nurse (LPN)2 was interviewed on 01/16/2025 at 3:45 PM. LPN2 stated tubing for oxygen was changed weekly and stored in a plastic bag between uses. LPN2 stated third shift staff were responsible for changing tubing, and any staff member could change the tubing when needed. LPN2 stated all nurses were responsible for making sure the tubing remained covered when not in use. LPN2 observed R37's oxygen tubing and stated the tubing was dated 12/30/2024 (not 12/05/2024), which had been more than one week and should have been changed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Physician's Assistant (PA) was interviewed on 01/17/2025 at 8:33 AM. The PA stated it was important to change oxygen tubing and to keep oxygen tubing covered when not in use to decrease the risk of germ transmission.</p> <p>The Administrator was interviewed on 01/17/2025 at 4:07 PM, and stated he expected oxygen tubing to be covered when not in use and expected for it to be changed per the facility policy.</p>