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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425145 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/23/2024 |
| NAME OF PROVIDER OR SUPPLIER Pruithhealth- Aiken | | STREET ADDRESS, CITY, STATE, ZIP CODE 830 Laurens Street North Aiken, SC 29801 | |

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) |
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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50346</p> <p>Based on facility policy review, record review, observations, and interviews, the facility failed to ensure that Resident (R)1's medications were not misappropriated for 1 of 1 resident reviewed for misappropriation.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Medication Administration: General Guidelines, with a last review date of 7/22/2024, revealed</p> <ul style="list-style-type: none"> -Medications are administered in accordance with written orders of the attending physician. -All current medications and dosage schedules, except topicals used for treatments, are listed on the patient/resident's medication administration record (MAR) or within the e-MAR system for facilities using electronic charting of medications. -Medications for one patient/resident are never administered to another patient/resident. <p>Review of the facility policy titled, Controlled Substance Diversion, with a last revision date of 4/29/24 reveals: It is the policy of [NAME] Health Pharmacy Services that medications listed as controlled substances (Scheduled I-V) under federal or state regulations will be properly stored with maintained accountability. Drug diversion is a medical and legal concept involving the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use.</p> <p>Review of the facility policy titled, Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, with a last review date of 11/15/24 reveals: It is the policy of PruithHealth and its affiliated entities (collectively, the Organization) to actively preserve each patient's right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, mistreatment, and misappropriation of patient property, (referred to collectively in this policy as abuse, neglect, mistreatment, and exploitation). The Organization and its partners should assure that best efforts are made to prevent any occurrences of any form of abuse, neglect, and exploitation.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of R1's face sheet revealed R1 was diagnosed with Anxiety Disorder. Review of R1's Physician orders revealed an order for Diazepam, Schedule IV tablet; 2 milligrams (mg); amt: 1 tab; oral Twice A Day 09:00 AM, 09:00 PM dated 7/2/24. There were no PRN (as needed) orders for Diazepam.</p> <p>Record review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/5/24 revealed R1 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, suggesting resident cognition is intact.</p> <p>Review of the facility document titled, Controlled Drug Record for [NAME] Health [NAME]. Dated 12/3/24 reveals:</p> <p>Date Medication was received 12/2/24</p> <p>Count of 30</p> <p>Drug: Diazepam tablet 2mg</p> <p>Order: 1 Tab by mouth twice daily.</p> <p>12/15/24 at 10 PM reveals count of 9 after 1 tablet given. Signed initials</p> <p>12/16/24 at 2 AM reveals count of 8 after 1 tablet given. Signed initials</p> <p>12/16/24 at 6 AM reveals count of 7 after 1 tablet given. Signed initials</p> <p>12/16/24 at 9 AM reveals count of 6 after 1 tablet given. Signed initials</p> <p>Record review of R1's Medication Administration Record (MAR) reveals:</p> <p>12/16/24 at 9 PM: Licensed Practical Nurse (LPN)1 administered Diazepam 2 mg to resident.</p> <p>12/16/24 at 9AM: LPN2 administered Diazepam 2 mg to resident.</p> <p>No recorded electronic documentation seen on MAR to indicate Diazepam 2 mg was given to resident by LPN1 at 2 AM and 6 AM as indicated by the Controlled Drug Record.</p> <p>Review of [NAME] Public Safety Incident Investigation/Report on 12/16/24 at 1945 (7:45 PM) revealed: 2 pills of diazepam 2 mg were documented as stolen by Officer Case (ID Number 883).</p> <p>Review of the facility document titled, Discipline 4 - Termination, dated 12/20/24 reveals staff member was terminated from the facility. Note states, Due to the serious nature of this allegation, and Partners failure to respond to requests for her statement regarding the matter, Partner is terminated from employment at this time.</p> <p>(continued on next page)</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of undated witnessed statement by LPN2, revealed, During my morning med pass I noticed a med error when signing out a narcotic for one of my resident's. First, I went back to the orders to make sure I wasn't making a medication error. The order said to give BID, 9a,9P. I saw where the medication was signed out as given 10p, 2a, 6a then I gave it at 9a. I immediately made the unit manager aware of the situation who then made the DHS aware.</p> <p>Observation of hall 400 med cart with LPN3 on 12/23/24 at 12 PM revealed no additional discrepancies in controlled medication outside of date under investigation.</p> <p>An interview with R1 on 12/23/24 at 11 AM revealed, she knows she takes her Diazepam pills twice a day for her anxiety. R1 revealed that on 12/15/24, LPN1 gave her her nighttime pills, which included her Diazepam. R1 knows her Diazepam was in the cup, as she states its a white circular pill. R1 revealed she always checks her medication cups before taking her medications to ensure she is getting only what she is supposed to be getting. R1 denied receiving any additional doses of Diazepam 2 mg the following morning at 2 AM and 6 AM.</p> <p>An interview with LPN1 on 12/23/24 at 12:12 PM revealed LPN1 does not remember pulling two additional doses of Diazepam for the resident. LPN2 revealed that if the Controlled Drug Record reflects LPN1 signing out 1 dose of Diazepam at 2am and 6pm, LPN1 reveals that she probably did sign out those medication. LPN1 is unsure why she pulled the additional doses, despite not having a PRN order for diazepam and only an active order for diazepam twice a day at 9 AM and 9 PM. LPN2 also does not recall whether she administered the medication to R1, but states that if she did pull those additional doses, then she most likely gave them to the R1. She is unable to determine if the resident was experiencing increased anxiety that would warrant extra doses of diazepam. When asked why she acted outside of the provider's orders, the nurse responded, I don't know.</p> <p>An interview with the Director of Nursing (DON) and Administrator (ADR) at 12/23/24 at 12:30 PM revealed that when it comes to proper medication administration, it is their expectation for staff to follow provider orders and not deviate from the order. Additionally, it is the expectation of the DON and ADR to complete controlled medication reconciliation and counts during shift change between the off going and ongoing nurse. DON revealed that when discrepancy was found by LPN2, LPN1 was suspended pending investigation. LPN1 ignored the facilities attempts to contact her during the investigation. Due to LPN1's lack of communication with facility during investigation and the nature of the allegation, DON reveals the facility decided to terminate LPN1's employment. DON and ADR revealed that LPN1 was in breach of facility policy. DON revealed that at the conclusion of the investigation, the 2 missing Diazepam pills were considered unaccounted for.</p> | | |