STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425145	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Aiken	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50087 Based on observation, interviews, record review, and review of the facility policy. The facility failed to prevent the misappropriation of controlled medication for one of one resident (Residents (R)99) reviewed. Findings include: Review of the facility policy titled Controlled Substance for Healthcare Centers dated 2014, revealed, It is the policy of Pruitthealth Pharmacy that medications listed as controlled substance (Schedules 1-V) under federal or state regulation will be properly stored with maintained accountability. Reconciliation of controlled substances will be performed at the end of each shift by licensed professional nurses. The healthcare center will obtain and keep on file any permits related to ordering and storing controlled substances required by state or federal agencies. Review of R99's Face Sheet revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to: trigeminal neuralgia, chronic pain, third degree burns involving 50-59% of body surface, burn of male genital region, post-traumatic stress disorder, acquired absence of right and left leg, and left fingers. Review of R99's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/25/24, revealed R99 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R99 was cognitively intact. Further review revealed R99 was on a scheduled pain medication regimen and reported severe pain. Review of R99's Care Plan last revised 07/29/24 states, R99 has chronic pain related to a history of burns and wounds, with the following interventions, Administer pain medications per physicians' orders. Review of R99's Physician Orders dated 08/14/24, indicated R99 was to receive Oxycodone- Scheduled II tablet: 11-tab amt: 1 tab: oral, Four Times a day, starting 06:00 AM, 12:00 PM, 06:00 PM and 12:00 AM. Morphine-Schedule II tablet extended release: 30 mg: amt: 1 tab: oral Special instruction: Give Morphine 30 ER 1 tab po every 12 hours for pain twice a day at 09:00 AM and 09:00 PM. Review of a Packing Slip dated 07/29/24 revealed that 2 cards of 30 pills of Oxycodone 10 mg (milligram) each with a total of 60 tablets all signed by the Director of Health Services (DHS). (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

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NAME OF PROVIDER OR SUPPLIER Pruitthealth- Aiken		STREET ADDRESS, CITY, STATE, ZIP CODE 830 Laurens Street North Aiken, SC 29801	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Packing Slip dated 08/13/24 revealed that 2 cards of 30 pills of Oxycodone 10 mg each with a total of 60 tablets all signed by the DHS. Review of R99's Controlled Drug Record (CDR) and Medication Administration Record (MAR) for Oxycodone 10 mg four times a day revealed several discrepancies. On August 11 at 2:00 PM and 10:00 PM doses were marked as not given due to Drug/item unavailable. August 12 at 06:00 AM, 2:00 PM and 10:00 PM, doses were marked as not given due to Drug/item unavailable. August 13 at 6:00 AM dose was marked as not given due to Drug/item unavailable. Further review revealed there was 1 card of Oxycodone 10 mg containing 30 pills that was missing. Review of a Focused Observation dated 08/13/24 at 11:36 AM, revealed, R99 was experiencing penetrating, shooting, twisting and aching pain at a level of 8 out of 10, indicating severe pain. During an interview on 09/10/24 at 11:00 AM, R99 stated, I have to take my medication because I will be in pain. I'm a double amputee and I was in a house fire that burned over 90 percent of my body. During an interview on 09/16/24 at 4:56 PM, License Practical Nurse (LPN)1 verified her statement, On Friday August 09, I didn't have a 2pm Oxycodone 10mg to give to [R99]. The nurse had given the last one at 6am that day. The resident reminds me often not to let his medication run out. I remember putting the order in the doctor's book and faxing it after it got sign; just can't recall what day. I notified the pharmacy on Saturday August 10, about the script and I was told they received it. When I returned to work on Sunday August 11; I was told in the report that the Oxycodone 10mg for [R99] July 29 (60) pills. I reviewed the Controlled Drug Inventory Form and noted 2 cards was signed in but only one was completed at 6am on August 09, 2024, and the other one was not present. I notified the DON [Director of Nursing] regarding this matter. I can't recall ever seeing the card in the medication cart. During an interview 09/11/24 at 5:10 PM, Registered Nurse (RN)1 verified her statement, On Wednesday, 8/7/24, I worked station 4 South cart. There were several narcotic prescriptions that were signed that I faxed to our pharmacy, was nearly out of oxycodone and morphine, both of which are scheduled. I called the pharmacy to ensure they did get the fax since we have been having intermittent issues with the fax. The pharmacy informed me that the morphine prescription was for immediate release. I rewrote the prescription as was ordered and placed it in [Medical Director] book for signature. I relayed this information to the nurse that relieved me on night shift. I also told the nurse om [sic] report that the medications should be in since I had confirmed verbally with the pharmacy that hard scripts had been received. There was only enough oxycodone for a day and a half. I worked another station the next day. During an interview on 09/16/24 at 10:06 AM, R99 stated, I was in a lot of pain. I was in pain for 2 to 3 days. The nurse did give me my Morphine medication and it helped a little bit, but not like the Oxycodone will. Yes, the nurse did inform me that they were looking for my Oxycodone. I'm on Medicaid, so they paid them. The in-house doctor here was mad, because that could mess up his license. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/16/24 at 1:15 PM, the DHS stated, When I got word about the incident, I came into the facility and interviewed the nursing staff that worked the cart that day and we also conducted a drug test on each nurse. It took about two hours to complete. I spoke with the Administrator; Unit Nurse and we told the pharmacist about the missing medication. A whole card of 30 oxycodone was missing, a medication that I had signed for prior. We needed approval from the facility to get another prescription. We do in-services with our nursing staff. We monitored his level of pain. The Unit Nursing Manager asked him about his level of pain. I did contact the physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48215 Based on record review and interviews, the facility failed to conduct a Preadmission Screening and Resident Review (PASARR) Level 1 for Resident (R)77 prior to admission. Additionally, the facility failed to refer R77 for a PASARR Level II, after a new diagnosis of a severe mental illness, for 1 of 3 residents reviewed for PASARR. Findings include: On 09/12/24 at 9:00 AM, the PASARR policy was requested, the Director of Nursing (DON) and Clinical Competency Coordinator (CCC) stated they do not have a PASARR policy. Review of R77's Face Sheet revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to: type 2 diabetes mellitus, tachycardia, and osteoarthritis. Further review of the R77's diagnoses, listed on the Face Sheet, revealed R77 was diagnosed with, Other psychotic disorder on 07/05/21. Review of R77's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/08/24, revealed a Brief Interview for Mental Status (BIMS) score of 8 out of 15 indicating R77 was moderately cognitively impaired, and had Potential Indicators of Psychosis for Delusions. Review of R77's Progress Note dated 05/11/24, revealed resident is alert to self with confusion and on 07/20/24 - 07/21/24, revealed resident is alert and oriented to self with hallucinations at times and has confusion. Review of [NAME] Psychiatric and Psychotherapy physician notes dated on 05/08/24, revealed, he is seen in follow up today. [R77]is now back on Haldol and Seroquel. Staff does not think [R77] is any different on it. Still yells and talks to people not there. Review of R77's PASSAR Level 1 dated 11/16/23, does not include the resident's psychotic disorder or antipsychotic medication. Further review revealed that a PASARR Level II was not recommended. During an interview on 09/12/24 at 1:53 PM, the Social Worker (SW)1 revealed that the decision to refer a resident for a PASARR Level II is based on if the resident is diagnosed with a psychotic disorder after admission. SW1 revealed she missed the diagnosis for R77 but is taking the steps necessary to refer the resident by contacting their physician to start the review.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 48215 Based on observation, interview and record review, the facility failed to ensure Resident (R)25 received a meal based on her preferences, for 1 of 13 residents reviewed during dining. Findings include: Review of R25's Face Sheet revealed the resident was admitted to facility on 04/19/24. R25 was admitted with diagnoses including but not limited to: varicose veins of right lower extremity with chronic obstructive pulmonary disease, diabetes mellitus due to underlying condition with diabetic nephropathy, venous insufficiency (chronic) (peripheral), muscle weakness, diastolic (congestive) heart failure, cognitive communication deficit, cellulitis, nutritional deficiency, and morbid (severe) obesity due to excess calories. Review of R25's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating the resident is cognitively intact. Review of R25's Diet Orders revealed an order dated 06/28/24 for, CCHO (consistent carbohydrate diet)/Liberalized diabetic plan with special instructions, which documented, no oatmeal, only grits, no fish and milk with breakfast. During an observation and interview on 09/12/24 at 1:11 PM, revealed R25 was served fish with her lunch. R25 stated she has an order to not have fish. R25 further stated, I have never eaten fish, and it is on my lunch ticket, but this happens all the time. Review of R25's Menu Ticket (which arrived on the lunch tray) on 09/12/24 at 1:11 PM, documented on the bottom of the ticket, NO FISH. During an interview on 09/12/24 at 9:21 AM, the Kitchen Manager (KM)1 stated, I am constantly reminding them to pay attention to the cards. The person calling out the resident meal should check and the person who puts the tray on the serving rack should check. During an interview on 09/12/24 at 1:59 PM, the Director of Nursing (DON) revealed the resident's preference and special diets should be listed on their meal ticket. The kitchen staff should ensure the resident's plate is in accordance with the ticket and the Certified Nursing Assistants (CNAs) should also be looking at the meal ticket to see the dislikes, and diet preferences are correct.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48215 Based on observations, interview, and review of facility policy, the facility failed to ensure foods were properly stored and labeled. Additionally, the facility failed to remove expired food items from storage, in 1 of 1 main kitchen. Findings include: Review of the facility policy titled Quick References Shelf Life list, Brief Summary Sheet with an effective date of [DATE], and last revised on [DATE], states, All opened refrigerator items must have a use by date . all items will be dated on date of arrival. Further review of the policy states, Meat, poultry, fish, pork, vegetables and soup . 3 days shelf life. Review of the facility policy titled Leftovers with an effective date of [DATE] and last revised on [DATE], states, 2. Leftovers will be covered, labeled, and dated: then stored appropriately (refrigerated or frozen if necessary) immediately after the end of the meal service . 4. Leftovers that have not been properly stored will be discarded. (When in doubt throw it out.) During a tour of the kitchen on [DATE] at 9:47 AM, the following was observed in the walk-in refrigerator: Six (6) sandwiches, wrapped, undated and unlabeled. One (1) container of unknown orange pureed item, stored undated and unlabeled. Five (5) hard boiled eggs, undated and unlabeled. One (1) container of labeled pork loin with a used by date of [DATE]. Nine (9) small 2% white milk cartons with an expiration date of ,d+[DATE]. During an interview on [DATE] at 10:00 AM, the [NAME] Aid revealed the produce is to be dated and labeled as soon as it comes into the refrigerator and if it is not labeled, the policy is to take the food out and trash it. During an interview on [DATE] at 10:15 AM, the Kitchen Manager (KM) revealed that a label and date should be on all open foods in the walk-in refrigerator. The label is for 3 days and after 3 days the food is discarded. During an interview on [DATE] at 9:30 AM, the KM revealed that the expired milk was thrown out right after we left on yesterday and that the label for the snack bags for the residents with dialysis should be dated and labeled after the bags are made. During an interview on [DATE] at 4:00 PM, the Administrator revealed that the items should be labeled and thrown out if not. They (kitchen staff) should be checking the dates daily.