

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Heritage Home of Florence Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 515 South Warley Street Florence, SC 29501	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801</p> <p>Based on observations, facility policy, and interviews, the facility failed to remove expired medications and biologicals from 1 of 4 medication carts and from 1 of 1 medication storage rooms. Additionally, the facility failed to ensure the medication room was properly secure.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Medication Storage in the Healthcare Centers with revised date 04/09/24 revealed, Policy Statement: .The medication supply is accessible only to licensed nursing personnel and pharmacy personnel .Procedure: 2. Only licensed nurses and the pharmacy personnel are allowed access to medications Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. 3. Nurses are required to check all medications for deterioration and expiration before administration. Nurses are also required to inspect medication storage facilities, including medication carts, routinely .12. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exists.</p> <p>During an observation and interview on 10/08/24 at 8:28 AM of the Chestnut Medication Storage Room revealed, Rugby Hemorrhoidal Suppositories with 12 suppositories in each box. Box One was observed with lot number 2JT0434 and expiration date 08/24. Box Two was observed with lot number 2KT0513 and expiration date 09/24. There was a total of 24 expired suppositories. Licensed Practical Nurse (LPN)1 verified the medication supplies were expired and removed them from the medication storage room on Chestnut.</p> <p>During an observation and interview on 10/08/24 at 11:48 AM of the Chestnut Medication Storage Room revealed, BD Vacutainer Safety-Lok Blood Collection Set: Four (4) packages with lot number 1F2281 and expiration date 06/30/24. In addition, there was [NAME] Povidone-Iodine, USP Swab Stick packets with 16 single swab packets containing the lot number CJB08-01 and expiration date 08/05/24. LPN2 verified the medication supplies were expired and removed them from the medication storage room on Chestnut.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 10/08/24 at 11:53 AM of the Chestnut Front Hall Cart revealed. Hydrocodone-Acetaminophen 5-325 mg with dispensed date of 08/04/23. There were 21 tablets in the bottle. LPN2 verified the medication was expired with the pharmacy as of 08/04/24 and removed the bottle from the medication narcotic drawer on the Chestnut Front Hall Cart. The medication will be given to the Director of Nursing for disposal.</p> <p>During an interview on 10/10/24 at 9:40 AM, the DON stated that the pharmacy consultant and account managers from [NAME] Health check for expired medications on the medication carts and medication rooms. Unit supervisors and nurses on the floor are responsible for checking for expired supplies however there is no check off to ensure compliance. If items are found to be expired, they should be discarded.</p> <p>Additionally, unauthorized access to medication storage room by unlicensed personnel was observed.</p> <p>During an interview on 10/08/24 at 8:10 AM, Certified Nursing Assistant (CNA)3 entered the medication storage room on the Chestnut unit while the surveyor was present. Upon entry, the surveyor was notified that the CNA3 needed to warm a resident tray in the microwave on the counter. When asked if this was the designated room to use the microwave for the unit, CNA3 confirmed and stated that there was another microwave on the other unit but the only room to warm food on Chestnut. When asked how was the room accessed, it was confirmed that a code was used. When asked what the code was, the CNA provided the code.</p> <p>During an interview on 10/08/24 at 8:20 AM, LPN1 and unit manager confirmed that the lock was on the door was related to medication storage. When asked who should have access to the room where medications were stored, it was stated that only the nurses. LPN1 was asked if any unlicensed personnel come into the medication room such as nursing assistants. The nurse reported that nursing assistants are allowed in to heat food in the microwave. When asked how do nursing assistants get access to the locked room it was reported that everyone knows the code. It was asked if any other staff access the room and it was reported that the housekeepers come in to clean the microwave. LPN1 stated that this has been going on the [AGE] years she has been employed.</p> <p>During an interview on 10/08/24 at 8:39 AM, Housekeeper (HSK)1 reported that there was another person assigned to clean the Chestnut medication room microwave.</p> <p>During an interview on 10/08/24 at 8:41 AM, HSK2 confirmed that the assigned housekeeper had access to enter the medication room on Chestnut to clean the microwave. When asked what the code was, it was confirmed. When asked if it was known what is stored in the cabinets and refrigerator, it was reported as unknown. It was confirmed that the practice of entering the medication room to clean the microwave had been occurring for a while.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/08/24 at 8:44 AM, the DON confirmed that only nursing staff, specifically licensed nurses should have access to the medication room. It was confirmed that stock medication were stored in the medication room in unlocked cabinets and it was confirmed that other staff are able to access the room. However, the DON agreed that other staff should not have access although there is a lock on the door and both licensed and unlicensed staff have the code. The DON stated, Honestly I had not thought about this . about stock being accessible. The only thoughts the DON had was about the need for the narcotics to be double locked. When asked about how long this practice had been in process, it was reported that they had switched pharmacy around 2020 and stock meds were not in the room prior to this switch. Stock medications were maintained only on the medication carts and there was no excess.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835</p> <p>Based on facility policy, record review, observation and interview, the facility failed to ensure ordered supplements were provided for 1 of 2 residents. (R)50 reviewed for nutritional supplements.</p> <p>Findings include:</p> <p>Record review of the facility policy dated 07/03/2019 titled, Telephone/Verbal Orders From Physician revealed under the policy, Licensed staff may obtain orders from their extenders via verbal order or telephone orders. The nursing staff may repeat the order back to the physician or extender for verification if necessary. The physician signs the order on his/her next visit.</p> <p>Record review of R50's medical record revealed she was admitted to the facility on [DATE] with diagnosis that include but are not limited to anemia, hyperlipidemia, cerebral infarction, anxiety, gastroesophageal reflux and osteoporosis.</p> <p>Record review of R50's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 13, indicating she is cognitively intact.</p> <p>Record review of the Registered Dietician's (RD) quarterly assessment of R50 dated 09/07/24 revealed unintentional weight loss of 10.40% x 180 days. R50 receiving nutritional supplements of IN-HOUSE supplements twice a day (BID) (LUNCH AND DINNER) (providing 400 calories, 12 gram protein) and Ice Cream BID (LUNCH and DINNER) (providing 280 calories, 4 grams protein) for nutrition and weight gain. Resident receiving nutritional supplements of IN-HOUSE BID (LUNCH AND DINNER) (providing 400 cal, 12 gm protein) and Ice Cream BID (LUNCH and DINNER) (providing 280 cal, 4 gm protein) for nutrition and weight gain.</p> <p>Review of R50's orders revealed an order for House Shake dated 03/15/24 to receive at lunch and dinner.</p> <p>On 10/09/24 at 12:25 PM, an observation of R50's lunch tray revealed an ice cream was with her meal, but no House Shake was delivered. R50 stated, My ice cream is melted. I don't get the milkshakes, they give them to my roommate occasionally. Review of her meal ticket recorded her meal as regular, thin liquid and ice cream was written in on the ticket. Milkshake was not recorded on her lunch menu ticket.</p> <p>On 10/09/24 at 2:40 PM, an observation revealed snacks received from the kitchen. R50 did not have any supplement/snack on the tray.</p> <p>On 10/09/24 at 5:25 PM, R50's dinner tray was delivered. Observation of the meal tray revealed ice cream on her tray, but she did not receive the ordered supplement.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/10/24 at 9:25 AM, an interview with the Dietary Manager (DM) revealed, When the resident has an order for the Health Shakes, the RD will put that on the meal ticket. She said R50 gets it for lunch and dinner and she also gets ice cream. The DM reviewed R50's meal ticket dated 10/10/24 for lunch, and said, it isn't here. The ice cream is here. The DM said the dietary staff would not know to give the House Shake if it was not on the meal ticket.</p> <p>On 10/10/24 at 8:59 AM, an interview with the Director of Nursing (DON) revealed House Shakes are delivered by the kitchen. Sometimes it's ordered with meals and sometimes it comes up as a snack. She reviewed R50's medication administration record (MAR) and stated, it is not on the MAR for the nurses to sign it as given.</p> <p>On 10/10/24 at 11:35 AM, an interview with the Unit Manager revealed, I put the order in for the House Shake for lunch and dinner on 03/05/24. She said, I don't know why she has not received her House Shakes when I gave them the communication sheet that the order was written.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37781</p> <p>Based on review of the facility policy, record review, observation, and interview, the facility failed to ensure hand hygiene was followed for 1 of 4 residents, (R)58, reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>Review of the facility policy, date unspecified, titled, Wound Care/Dressing Change Procedure states under the policy, Clean the wound according to the order. Remove gloves and place in the trash. Hand hygiene. Put on clean gloves. Apply clean dressing as ordered. Remove gloves and place in the trash can. Make resident comfortable. Hand hygiene.</p> <p>Record review revealed R58 was admitted on [DATE] with diagnoses that included but not limited to dementia, depression, Alzheimers' Disease, dysphagia, and hypertension.</p> <p>Review of R58's treatment orders revealed a treatment order dated 09/03/24 to cleanse sacral wound with normal saline, apply medihoney and calcium alginate to wound bed, and cover with a dry dressing until healed. Apply house barrier cream and antifungal powder to skin surrounding wound to prevent moisture one time a day.</p> <p>Record review of a progress note dated 10/08/24 recorded Wound physician rounded and assessed R58's stage 4 pressure ulcer wound to sacrum. Surgical excisional debridement done at bedside by wound doctor.</p> <p>An observation of wound care on 10/09/24 at 11:27 AM with Registered Nurse (RN)1 revealed, She gowned and washed her hands, then applied gloves. The treatment supplies were already setup on R58's overbed table,</p> <p>to include a small tube of Medi-honey, calcium alginate, extra protective cream (EPC) anti fungal powder, normal saline and gauze on a towel on the overbed table. Privacy was maintained and her curtains were closed. The blankets were pulled down, and R58 was turned onto her side. There was no dressing observed. There was a foul odor emanating from the open wound. A deep crater was observed with a small amount of</p> <p>slough on the inside of the wound bed. RN1 cleaned the wound with normal saline solution and gauze. She discarded the gauze and removed the gloves, washed her hands and donned new gloves. She then applied Medi-honey into wound, with q-tip. She removed her gloves, but did not wash or sanitize her hands and applied another pair of gloves. She applied EPC cream with her fingered glove around the peri wound. She discarded one glove and applied another without sanitizing her hands. She placed the calcium alginate into the wound. She removed both gloves, and again failed to sanitize her hands. She applied the outer dressing, Mepore island dressing and applied antifungal powder, sprinkled to outer wound dressing and the dressing. She removed gloves, failed to wash or sanitize her hands, and donned new gloves. She repositioned R58 and turned her onto her left side with a wedge. Afterward, she removed her gloves. RN1 bagged all discarded items then removed the gown. She washed her hands and exited the room with the bag of soiled items.</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>On 10/09/24 at 11:45 AM, during an interview with RN1, when asked why she failed to sanitize her hands after multiple gloves changes?, she stated, I should have sanitized my hands or washed my hands between glove changes. When I removed the one glove, it was because I didn't touch anything with the other glove.</p> <p>On 10/09/24 at 11:50 AM, during an interview with the Unit Manager, she stated, The nurses are supposed to sanitize after they remove gloves during a dressing change and apply new gloves.</p> <p>During an interview with the Director of Nurses (DON) on 10/10/24 at 8:59 AM, she stated, It's required to perform hand hygiene, before a dressing change, after removing a dressing, after completing the treatment. Whenever gloves are removed, they should sanitize their hands. Typically they remove both gloves, not just one, and then sanitize.</p> <p>49818</p> <p>Based on review of the facility policy, record review, observation, and interview, the facility failed to ensure hand hygiene was followed for 1 of 4 residents, (R)58, reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>Review of the facility policy, date unspecified, titled, Wound Care/Dressing Change Procedure states under the policy, Clean the wound according to the order. Remove gloves and place in the trash. Hand hygiene. Put on clean gloves. Apply clean dressing as ordered. Remove gloves and place in the trash can. Make resident comfortable. Hand hygiene.</p> <p>Record review revealed R58 was admitted on [DATE] with diagnoses that included but not limited to dementia, depression, Alzheimers' Disease, dysphagia, and hypertension.</p> <p>Review of R58's treatment orders revealed a treatment order dated 09/03/24 to cleanse sacral wound with normal saline, apply medihoney and calcium alginate to wound bed, and cover with a dry dressing until healed. Apply house barrier cream and antifungal powder to skin surrounding wound to prevent moisture one time a day.</p> <p>Record review of a progress note dated 10/08/24 recorded Wound physician rounded and assessed R58's stage 4 pressure ulcer wound to sacrum. Surgical excisional debridement done at bedside by wound doctor.</p> <p>An observation of wound care on 10/09/24 at 11:27 AM with Registered Nurse (RN)1 revealed, She gowned and washed her hands, then applied gloves. The treatment supplies were already setup on R58's overbed table,</p> <p>to include a small tube of Medi-honey, calcium alginate, extra protective cream (EPC) anti fungal powder, normal saline and gauze on a towel on the overbed table. Privacy was maintained and her curtains were closed. The blankets were pulled down, and R58 was turned onto her side. There was no dressing observed. There was a foul odor emanating from the open wound. A deep crater was observed with a small amount of</p> <p>(continued on next page)</p>		

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