

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Oakbrook Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 Travelers Boulevard Summerville, SC 29485	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801</p> <p>Based on review of the facility policy, record review, observations, and interviews, the facility failed to ensure that the environment was free from accidents for Resident (R) 231.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Pharmacy Services Policies and Procedures. Subject: 4.4 Self-Administration of Medications dated 04/17/2024 stated, Procedures: 2. Interdisciplinary Care Team (IDT) assessment will be performed upon admission, readmission and quarterly with the MDS assessment for a resident choosing to self-administer . 3. Residents are not permitted to self-administer or store controlled substances at the bedside.</p> <p>Review of R231's Face Sheet revealed R231 was admitted to the facility on [DATE] with diagnoses including but not limited to: presence of prosthetic heart valve, atherosclerotic heart disease of native coronary artery without angina pectoris, and allergic rhinitis.</p> <p>Review of R231's Physician Orders revealed no order for medication to be kept at the bedside, and no order for self-administration for R231.</p> <p>During an observation and interview on 02/09/25 at 11:03 AM, Fluticasone spray was observed in the windowsill with a prescription label. R231 stated that the spray was left in room for her to administer.</p> <p>During an observation and interview on 02/09/25 at 11:07 AM, Licensed Practical Nurse (LPN)4 verified order for medication in computer and stated that R231 did not have an order to self-administer or to have medication left at bedside. LPN4 reported that the medication is over the counter and sometimes they leave it at bedside.</p> <p>During an interview on 02/11/25 at 11:58 AM, the Director of Nursing (DON) reported that her expectations are that the nursing staff should not leave medications at bedside. They should observe the resident taking the medication and then the medication if not a pill would need to go back in the medication cart. She reported that they do have wandering residents. In addition, she reported that education was provide to the resident this morning to R231 because they found stool softener that the resident had family to bring in. She looked in the medical record and stated, I do not see an order for self-administration.</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 0693</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835</p> <p>Based on review of the facility policy, record review, observations, and interviews, the facility failed to ensure Resident (R)281 received prescribed tube feeding for 1 of 1 resident receiving tube feeding. This failure caused R281's blood sugar levels to drop, warranting additional orders needing to be obtained to increase his blood sugar to an acceptable level.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Enteral and Parenteral Feedings, with a complete revision of May 5, 2023 revealed Nutritional complete enteral (tube) feedings may be indicated for residents who are unable to obtain adequate nutritional intake orally or whose clinical condition demonstrates that enteral feedings are unavoidable. Obtain a physicians order for all enteral feedings. Communicate orders with nutrition services. Monitor and report problems and complications to the Physician and nutrition services.</p> <p>Record review of R281's medical record revealed he was admitted to the facility on [DATE] with diagnosis that include, but are not limited to malignant neoplasm of base of tongue, hypertension, and type 2 diabetes mellitus.</p> <p>Record review of R281's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score as 15, indicating R281 was cognitively intact.</p> <p>Record review of R281's Physician orders revealed enteral feeding Osmolite 1.5 at 70 cubic centimeters (cc) an hour x 22 hours with 175 cc's every 4 hours water flush, every shift. Start feeding at 6:00 AM and stop feeding at 4:00 AM to give a total of 22 hours, dated 02/05/2025.</p> <p>Record review of R281's Physician orders revealed, Lantus U-100 Insulin give 14 units; subcutaneous, Special Instructions: If BS is <70 or >400 notify provider, at 09:00 AM.</p> <p>Record review of R281's Physician orders revealed Glucose-15 (dextrose) gel, 1 tube; oral once, one time. Start time, 5:30 PM.</p> <p>Record review of R281's progress note dated 02/10/2025 at 12:23 PM revealed, 9am (fasting blood sugar)FSBS 76 Insulin given as ordered. Order states to hold insulin if less 70. 11:40 AM FSBS 53 and 54. Glucagon 1 (milligram) mg given (subcutaneous) sc. 11:55am FSBS 63, 12N FSBS 64, 2nd Glucagon SC given 12:15PM FSBS 79 MD aware.</p> <p>Record review of R 281's progress note dated 02/10/2025 at 01:57 PM recorded, 1:55 FSBS 70.</p> <p>Record review of R281's progress note dated 02/10/2025 at 01:40 PM recorded, 12:30 FSBS 83. 1:30pm FSBS 67 MD notified, received order for Glucose el 15 via g tube.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a progress note dated 02/10/2025 at 05:26 PM recorded, FSBS 52-54 R281, alert and oriented x 4. Stated he had no discomfort. Nurse Practitioner (NP) notify received order for Glucose 15 gel via g tube.</p> <p>An observation and interview with R281 on 02/10/25 at 12:44 PM revealed, I feel better. My sugar was low. They gave me Glucatorl. I was laying in bed, they checked my sugar, it was low, they gave me insulin this morning. He said, I need to get food in me. He confirmed he cannot eat anything by mouth, but can have ice chips. Observed Osmolite 1.5, no rate on Osmolite bottle. A water bag marked 75cc/hour. Water was infusing at 174 milliliter (ml) every 4 hours per the rate on the pump. The pump was on, infusing water.</p> <p>An interview on 02/10/2025 at 12:55 PM with Registered Nurse (RN)1 revealed, His blood sugar (BS) was 76 at 11:40 AM. Then earlier it was 53. I got another machine, rechecked it, it was 54. Then I gave him Glucagon. He got a second shot of Glucagon. He is on tube feeding 22 hours, then off for 2 hours. R281 is aware of what's going on. He had insulin around 9 am, Lantus 14 units. His BS was 76, so I gave it. The last check it was 83. I told the nurse during an observation he was getting water, not feeding. She said, It will alternate for the flush. He is getting his feeding.</p> <p>On 02/10/2025 at 4:12 PM, an observation of R281's pump revealed water flush was still running. R281 said, It has been running clear, since you left earlier. This surveyor then went out to get the nurse. RN1 stated, His blood sugar is 72, it dropped from 80. I can't understand why his blood sugar is still dropping. This surveyor told RN1 the water flush has been running each time I entered the room. RN1 then stated, It should be alternating. This surveyor requested RN1 come to R281's room. R281 stated to RN1, It's been running clear since you were in here earlier. He confirmed that the feeding has not been running and he's been checking. He stated, I'm burning up. RN1said, I will turn off the pump and restart it, it may be the machine.</p> <p>On 02/11/2025 at 8:26 AM, during an interview with RN1, she stated, I turned the whole thing off and reset it. I didn't look at the machine when you came in. With your help I was able to figure it out. It was an education. It seemed to be a freak malfunction of the pump. I should have looked to see what was going in, I didn't even realize. She said, At 11:40 AM was the first Glucagon injection. The next was at 12:15 PM. I gave the glucose gel in the gastrostomy tube (G/T) at 5:32 PM.</p> <p>On 02/11/2025 at 9:05 AM, an interview with the Director of Nurses (DON) revealed, she was aware of R281's low blood sugar. She stated, My nurses use the pumps everyday. There is a way to go back and look in the history. If the resident has a G/T and the blood sugar was low, I'd look at the feeding to ensure that it has been running correctly and for the proper amount of time. It sounds like it was backwards. I can look at the pump history and try to figure out was was going on.</p> <p>A second interview with the DON on 02/11/2025 at 10:52 AM revealed, she went back 2 days, a total of 48 hours. She stated, R281 received TF, 1439 ml. He received 1394 ml of water for 48 hours. He received 609 ml of TF in 24 hours, it should have been 1540 ml of feeding. The water was 872 ml and he should have received 522 ml in the 48 hours. She said, My nurse said she didn't reset the settings. The MD went into the room and didn't notice it either. I appreciate you found it and talked to RN1 about it. We are continuing to monitor him for 72 hours. The Registered (RD) will be here today and will assess him.</p> <p>(continued on next page)</p>		

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F 0693 Level of Harm - Actual harm Residents Affected - Few	<p>An interview was conducted on 02/11/2025 at 11:20 AM with the NP. She stated, The MD saw R281 yesterday and consulted with me about his blood sugar and insulin. She said she was going to drop his insulin according to his blood sugars dropping yesterday. Close to 8 pm I got a phone call that his blood sugar was dropping again. I asked, did anyone make sure his pump is running properly. The nurse said, yes I checked the pump. They had me on speaker. I asked multiple times, was it the tube feeding? MD's don't know how to check the pump. I ordered gel, his bs was in the 50s, I think 53. RN1 told me she checked the pump, looked to ensure it was running, and she said she didn't actually check to see if the TF was running versus the water.</p> <p>On 02/11/2025 at 11:42 AM, the DON returned and stated she was going to change out the pump on R281.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835</p> <p>Based on review of the facility policy, record review, observation, and interview, the facility failed to ensure Resident (R)58 was free from significant pain for 1 of 2 residents reviewed for pain.</p> <p>Findings include:</p> <p>Review of the facility policy with a complete revision date of May 5, 2023 titled, Pain Management revealed that Pain can be defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is whatever the experiencing person says it is, existing whenever the experiencing person it does. Negative verbalizations and vocalizations, groaning, crying, whimpering or screaming. Facial expressions, grimacing, frowning, fright or clenching the jaw. Based on the evaluation, the IDT, resident physician, and the resident and or representative will develop, implement, monitor, and revise as necessary interventions to prevent or manage the residents pain.</p> <p>Record review of R58 revealed she was admitted to the facility on [DATE] with diagnosis that include, but not limited to pain right knee, paraplegia, end stage renal disease and type 2 diabetes mellitus.</p> <p>Record review of R58's Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/04/2025 revealed a Brief Interview of Mental Status (BIMS) score of 13, revealing she was cognitively intact.</p> <p>Record review of R58's Physician's orders revealed she does not have anything ordered for pain.</p> <p>Record review of R58's Medication Administration Record (MAR) dated February 2025 revealed there was no pain monitoring recorded.</p> <p>Record review of a Pain Assessment in Advanced Dementia Scale dated 01/20/2025 for R58, recorded a score of zero, indicating no pain.</p> <p>Record Review of Physician progress notes for R58, by Nurse Practitioner (NP) dated 02/02/2025 recorded, Able to demonstrate flexing both knees, left more than right. Admits to keeping right leg extended most of the time to avoid pain. Diagnosis: Right knee pain, unspecified chronicity. Past Medical History included lower extremity paralysis, chronic lower extremity paresis and deconditioning. New order, Tylenol 500 milligram, 2 tablets by mouth 3 times a day.</p> <p>During an interview on 02/09/25 at 1:44 PM, R58 stated, My right thigh, it hurts me. I take pain medication.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A follow-up interview with R58 at 12:35 PM on 02/10/2025, when asked if she was well, as she was grimacing, she stated, I was sleeping and it woke me up. I can't hardly move it, it really hurts, it's so stiff, referring to her right knee as she was holding it and rubbing it. I've not had anything yet for pain. R58 said her pain was a 10 out of 10. R58 was observed wincing in pain, stating Lord, have mercy making facial grimaces. At 12:37 PM, this surveyor requested she put her call light on for assistance. At 12:38 PM, a Speech Therapist (ST) answered the call light. Overheard ST say to resident, Let me go get the nurse. At 12:42 PM, a nurse was observed entering the room.</p> <p>On 02/11/2025 at 8:59 AM, an interview with the ST revealed, Poor thing, she was in pain yesterday, her right leg. She had a lot of pain in the right and she couldn't move it too much. I grabbed Licensed Practical Nurse (LPN)3, she was behind me. We went into the room and then I left and let the nurse take care of her. She had facial grimacing and tears coming down.</p> <p>On 02/11/2025 at 9:44 AM, an interview with LPN3 revealed, She was complaining of her right knee hurting. I went to look, pulled the cover back. She cried when I put my hand on it, and she said, Ouch. I told her I will let the NP know. She was at the end of the hall seeing a patient. I told the NP, R58 was hurting, I asked her to please go into the room and look at her. I looked for pain medication and didn't see anything ordered. I gave the NP a note. A lot of times she [NP] will put a note in the computer after she goes home and write notes/orders. Later, I was doing a follow up and asked R58 did the NP come in and see her. I didn't ask her if she was in pain. She couldn't remember if the NP came into the room when I asked her. It was after dinner.</p> <p>On 02/11/2025 at 10:02 AM, an interview with the NP revealed, Yesterday they said they put in the book a note to see R58 for pain and I said I'd see her tomorrow. The knee pain is known, since I met her over a year ago. Now consistently, the last 2 visits, it's been knee pain. The NP reviewed her notes and stated, Oh yes, I ordered Tylenol. I put in an order electronically to the pharmacy. The system or internet will glitch, it will stay in queue. It appears to look like the order went through on my end, and then it didn't. I didn't realize her order didn't go through. I usually follow up a week later on her and had planned to see her.</p> <p>On 02/11/2025, an interview at 12:23 PM with the Director of Nurses (DON) revealed, I was helping the NP yesterday morning with her computer, orders weren't going through. She said she ordered Tylenol for R58. She should have pain monitoring on her MAR. That is a problem. The nurse should have followed up to be sure the order had gone through. R58's never complained of pain that I know of and she should have been followed up more closely.</p> <p>On 02/11/2025 at 12:30 PM, during an interview with R58, she stated, I've been in and out of the hospital so long, you just find a way to handle it and the pain. I just manage through it, crying and laying here. The last month or so, the right knee just gives me problems and it hurts. It's not as bad as it was right now. I can't remember if anyone ever gave me anything for it, I know I was crying.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801</p> <p>Based on review of the facility policy, record review, observations, and interviews, the facility failed to ensure that Resident (R)34 was free of significant medication error for 1 of 1 reviewed for insulin administration.</p> <p>Findings include:</p> <p>Review of the facility policy: Staff education/orientation policies and procedures. Competency: Medication Administration-Insulin Pen dated 01/12/2024 stated, Performance Criteria: Priming the Pen: 1. Removes the outer needle cap and dials 2 units. 2. Points the pen up and presses the plunger button to expel 2 units of insulin.</p> <p>Review of R34's Face Sheet revealed R34 was admitted to the facility on [DATE] with diagnoses of but not limited to: Hypoglycemia and Type 2 diabetes mellitus with diabetic neuropathy.</p> <p>Review of R34's Physician Orders revealed order for Insulin Lispro: Insulin pen give 3 units subcutaneous with meals at 8:00 AM, 11:30 AM, and 5:00 PM. Additionally Physician Orders revealed order for Insulin Lispro Insulin pen per sliding scale before meals and at bedtime at 6:00 AM, 11:30 AM, 4:30 PM, and 8:00 PM. If blood sugar is 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units, 401-450 give 12 units, 451-500 give 16 units. If greater than 500 call NP/PA.</p> <p>During an observation and interview on 02/09/25 at 4:00 PM, observed Licensed Practical Nurse (LPN)5 complete a Finger Stick Blood Sugar (FSBS) on R34. Blood sugar value observed to be 413. LPN5 administered a total of 15 units of insulin per orders, without priming the insulin pen.</p> <p>During an interview on 02/09/25 at 4:16 PM, LPN5 agreed that she should have primed the needle before dialing up the dose to be administered.</p> <p>During an interview on 02/09/25 at approximately 4:45 PM, the Director of Nursing (DON) confirmed that on the check off titled, Staff Education/Orientation Competency: Medication Administration-Insulin Pen, priming the pen is part of the procedures in completing the task of administering insulin.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 25335</p> <p>Based on review of the facility policy, observations, record reviews and interviews, the facility failed to ensure that medications were properly stored and labeled in 2 of 2 medication rooms and 2 of 3 medication carts.</p> <p>Findings include:</p> <p>A review of the facility policy entitled Medication Storage revised 4/17/24 states:</p> <p>Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. In accordance with State and Federal laws, the facility will store all drugs and biologicals in locked compartments under proper temperatures and other appropriate environmental controls to preserve their integrity.</p> <p>Once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates of opened medications.</p> <p>Once any multi-dose packaged medication or biological is opened nursing will mark multi-dose products (e.g. (for example) .insulin) with the date opened and follow manufacturer/supplier guidelines with respect to expiration dates.</p> <p>All Scheduled medications and other drugs subject to abuse are stored in a separate, permanently affixed area and are under double lock.</p> <p>On 2/10/25 at approximately 10:59 AM inspection of the Dogwood Medication Room revealed:</p> <ul style="list-style-type: none"> - the refrigerator container one vial of Tubersol (tuberculin purified protein derivative) 5 tuberculin units/0.1 ml (milliliter) 10 tests/package by Sanofi, opened and approximately 1/2 full and not dated as to opened date. The Tubersol was stored in the manufacturer's box which bore a pharmacy label which stated Date of First use ____ Discard 30 days after first use. The Sanofi package insert, dated October, 2021 stated: A vial of TUBERSOL which has been entered and in use for 30 days should be discarded - the open metal shelving unit contained a locked, but not permanently affixed Control E-Kit 16. This E-kit contained these controlled substances: alprazolam 0.25 mg (milligram) x 3, Clonazepam 0.5 mg x 3, Hydrocodone/Acetaminophen 5 mg/325 mg x 3, Hydrocodone/Acetaminophen 10 mg/325 mg x 3, Lorazepam 0.5 mg x 3, Morphine Sulfate 20 mg/ml 15 ml x 1, Oxycodone 5 mg x 3. Oxycodone 10 mg x 3 and Tramadol 50 mg x 3. <p>-one opened bottle of Urinalysis Reagent Strips by Medline, Lot 98122100008 with expiration date of 12/28/24.</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 - Some</p>	<p>On 2/10/25 at approximately 11:09 AM during an interview, Registered Nurse (RN)1 confirmed that the vial of Tubersol was opened and in-use, that the Control E- Kit 16 was not fastened to the shelf where it was stored and that the Urinalysis Reagent Strips had expired.</p> <p>On 2/10/25 at approximately 11:22 AM, inspection of the Dogwood Medication Cart #1 revealed multiple insulin syringes (Toujeo, Lispro Kwik, Lantus Solostar, Novolog Flex) which were in-use and had been opened and not dated as to opened date or were unopened and stored in the medication cart. These insulin syringes bore pharmacy label which stated Discard 28 days after opening and store unopened pen in the refrigerator.</p> <p>On 2/10/25 at approximately 11:39 AM during an interview, Licensed Practical Nurse (LPN)1 inspected and confirmed that multiple insulin syringes had been opened and/or unopened with the opened insulin syringes not been having dated when opened and that the unopened insulin syringes should have, according to pharmacy labelling, been stored in the refrigerator.</p> <p>On 2/10/25 at approximately 11:36 AM inspection of the [NAME] Medication Cart #1 revealed multiple insulin syringes (Basalgar Kwikpen, Lispro Kwik, Lantus Solostar, Novolog Flex) which were opened, in-use and not dated as to opened date or were unopened and stored in the medication cart. These insulin syringes bore la pharmacy label which stated Discard 28 days after opening and store unopened pen in the refrigerator.</p> <p>On 02/10/25 at 11:48 AM, during an interview, LPN2 inspected and confirmed that multiple insulin syringes had been opened and/or unopened with the opened insulin syringes not been having dated when opened and that the unopened insulin syringes should have, according to pharmacy labelling, been stored in the refrigerator.</p> <p>On 2/10/25 at approximately 11:53 AM, inspection of the [NAME] medication room revealed:</p> <ul style="list-style-type: none"> -an empty, unsecured to refrigerator shelf and locked controlled substance tackle box inside the locked refrigerator. -one opened bottle of Urinalysis Reagent Strips by Medline, Lot 98122100008 with expiration date of 12/28/24. <p>On 2/10/25 at approximately 12:04 PM, LPN1 confirmed that the controlled substance tackle box was empty and was not affixed to refrigerator shelf and that the Urinalysis Reagent Strip had expired.</p> <p>On 2/10/25 at approximately 12:36 PM, the Director of Nursing (DON) inquired and was informed of the findings. She confirmed that insulin should have been dated and/or stored correctly, that expired medications should be discarded and stated controlled substance e-kit was not attached to the shelf, but was unaware of a regulation requiring it to be attached.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Oakbrook Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 Travelers Boulevard Summerville, SC 29485	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835</p> <p>Based on review of the facility policy, observations, and interviews, the facility failed to ensure foods stored in the main walk in refrigerator and dry storage were labeled, dated and not expired. This failure could potentially affect all 85 residents in this facility, who consumed food from the kitchen.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Food Safety in Receiving and Storage with a complete revision date of [DATE] states, Check expiration dates and use by dates to assure the dates are within acceptable parameters. Store foods at least 6 inches off the floor .Refrigerated, ready to eat Time/Temperature Control for Safety Foods are properly covered, labeled, dated with a use by date .</p> <p>During an observation on [DATE] at 10:41 AM, the following food items were observed in the walk in refrigerator and freezer and verified by the Cook;</p> <p>1 can of beef base open and dated [DATE].</p> <p>1 plastic bag of chicken nuggets that was open, not sealed or dated.</p> <p>1 plastic bag of french fries, open and not dated.</p> <p>During an observation of the dry storage on [DATE] at 10:55 AM, the following food items were observed and verified by the Cook;</p> <p>Approximately 18 cases of food not put away, on the floor, several were open and cans were on the floor directly without pallet.</p> <p>An open bottle of vanilla open, not dated, with the lid missing.</p> <p>Italian crushed seasoning, cinnamon rosemary and nutmeg all open, not dated.</p> <p>A large salt bin open, with the lid inside the salt.</p> <p>An interview with the [NAME] on [DATE] at approximately 11:10 AM revealed, :The lid on the containers are not supposed to be in the salt. She confirmed all open foods are to be labeled and dated with open date and expiration date. She also said, There was a delivery on Friday, the food should have been put away.</p> <p>An interview on [DATE] at 8:30 AM with the Certified Dietary Manager (CDM) confirmed, When we get a delivery, they need to put up the groceries, get them off the floor. Place end dates on cans, spices are tagged with a yellow sticker, and we rotate stock. Once pulled, they zip lock with a sticker, name of product, date open. Once open we have 3 days to use, then discard. Those would be refrigerated items. You have to have the date open.</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 - Many</p>	<p>An interview on [DATE] at 2:10 PM with the Administrator revealed, When the food is delivered, it should be put away by the next shift. To be stored, they need to be 6 inches off the floor. Food items that are in the refrigerator and the freezer need to be dated upon opening them. Also, all food should be labeled when it is delivered. The lids for the storage should not be in the food product.</p>		