STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425168	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Inn Post Acute	501 Gulliver St Fountain Inn, SC 29644

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to store respiratory equipment appropriately for 2 (Resident (R)5 and R66) of 3 sampled residents reviewed for respiratory care.Findings included: An undated facility policy titled, Storage of Respiratory Equipment, indicated, All respiratory equipment shall be stored in a manner that maintains cleanliness, prevents contamination, ensures readiness for use, and complies with infection prevention and life safety standards. Procedures 1. General Storage Requirements * Respiratory equipment must be stored: * In a clean, dry * Off the floor and away from sinks, toilets, and splash zones * Protected from dust, moisture, and temperature extremes * Storage areas must be clearly labeled and routinely inspected. 1. An admission Record indicated the facility admitted R66 on 12/13/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, mixed simple, and mucopurulent chronic bronchitis. R66's Brief Interview for Mental Status dated 12/15/2025, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The Baseline Care Plan Person-Centered Care Planning, with an effective date of 12/15/2025, revealed interventions and goals to include the resident should have supplemental oxygen at 2 liters by way of a by wat of AVAPS/CPAP every night at bedtime. R66's Order Summary Report, with active orders as 12/17/2025, revealed an order dated 12/14/2025 for average volume-assured pressure support/continuous positive airway pressure (AVAPS/CPAP) every night at bedtime. During an observation on 12/15/2025 at 10:50 AM, R66's face mask for their CPAP was observed lying on the bedside table not in a bag. During an interview on 12/16/2025 at 1:18 PM, R66 stated they brought the CPAP from home and used it every night. R66 stated they did not know if staff ever placed the CPAP mask in a bag. During an interview on 12/17/2025 at 3:03 PM, Licensed Vocational Nurse (LVN)2 stated a resident's CPAP mask should be bagged and labeled with a date. During an interview on 12/16/2025 at 1:25 PM, LVN8 stated CPAP masks should be bagged and the nurses were responsible for bagging the masks. (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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/2025 at 12:16 PM, the Director of Nursing (DON) stated a resident's CPAP mask should be cleaned and bagged. The DON stated she expected a resident's CPAP mask to be in a bag if it was not in use. During an interview on 12/18/2025 at 12:36 PM, the Administrator stated a resident's CPAP mask should typically be stored in a bag when not in use. 2. An admission Record revealed the facility admitted R5 on 11/25/2024. According to the admission Record, the resident had a medical history that included diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and asthma. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/2025, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident received oxygen therapy. R5's Care Plan Report included a focus area revised 07/17/2025 that indicated the resident was at risk for complications with the respiratory system due to asthma, COPD, chronic respiratory failure, congestive heart failure, dyspnea, and shortness of breath. Interventions directed staff to administer nebulizer treatments as ordered (initiated 12/16/2024). R5's Order Summary Report with active orders as of 12/17/2025, revealed an order dated 12/12/2024, for albuterol sulfate inhalation nebulization solution 2.5 milliliters (ml)/3 ml 0.083%, inhale 3 ml orally every six hours as needed for shortness of breath. During an observation on 12/15/2025 at 12:14 PM and 12/16/2025 at 1:19 PM, R5's nebulizer machine was observed uncovered. at the bedside of the resident. During a concurrent interview and observation on 12/16/2025 at 1:26 PM, LVN4 stated residents' respiratory equipment should be covered when not in use, usually inside of a plastic bag. LVN4 observed R5's nebulizer mask stored in the nebulizer machine's built-in holder and not covered. LVN4 stated R5's nebulizer should have been covered. During an interview on 12/18/2025 at 12:18 PM, the Director of Nursing (DON) stated she would expect a resident's nebulizer mask to be stored in a bag when not in use. The DON stated covering the nebulizer masks would be the responsibility of the nurses. During an interview on 12/18/2025 at 12:37 PM, the Administrator stated he would expect nursing staff to maintain respiratory equipment in accordance with the DON's guidance. During an interview on 12/18/2025 12:47 PM, Registered Nurse (RN)5, who served as the Infection Preventionist, stated she would expect respiratory equipment to be stored in a bag with the resident's name on it.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview, record review, and facility policy review, the facility failed to provide care and services necessary to maintain or improve the highest practicable physical well-being of a resident receiving dialysis by not following physician-ordered fluid restrictions for 1 (Resident (R)70) of 1 sampled resident reviewed for dialysis.Findings included:A facility policy titled, Encouraging and Restricting Fluids, revised 10/2010, indicated, The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. The policy specified, 1. Follow specific instructions concerning fluid intake or restrictions. 2. Be accurate when recording fluid intake.An admission Record indicated the facility admitted R70 on 10/14/2025. According to the admission Record, the resident had a medical history that included diagnoses of end stage renal disease, hypotension of hemodialysis, and dependence on renal dialysis.A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/03/2025, revealed R70 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received dialysis.R70's Care Plan Report included a focus area initiated 10/15/2025, that indicated the resident required hemodialysis due to a diagnosis of end stage renal failure. Interventions directed the staff to provide a fluid restriction of 360 milliliters (ml) for breakfast, 240 ml for lunch, 240 ml for dinner, 180 ml for the 7:00 AM to 7:00 PM shift, and 180 ml for the 7:00 PM to 7:00 AM shift, for a total of 1200 ml per day.R70's Order Summary Report with active orders as of 12/17/2025, revealed an order dated 10/25/2025 for a fluid restriction of 360 ml for breakfast, 240 ml for lunch, 240 ml for dinner, 180 ml for the 7:00 AM to 7:00 PM shift, and 180 ml for the 7:00 PM to 7:00 AM shift, for a total of 1200 ml per day.R70's medication administration record (MAR) for the timeframe 10/01/2025 - 10/31/2025, revealed the staff recorded the resident received 1080 ml of fluids during the 7:00 AM to 7:00 PM shift on 10/16/2025, 1080 ml of fluids during the 7:00 PM to 7:00 AM shift on 10/16/2025, 700 ml of fluids during the 7:00 AM to 7:00 PM shift on 10/17/2025, 240 ml of fluids during the 7:00 PM to 7:00 AM shift on 10/17/2025, 360 ml of fluids during the 7:00 AM to 7:00 PM shift on 10/21/2025, 840 ml of fluids during the 7:00 AM to 7:00 PM shift on 10/30/2025, and 840 ml of fluids during the 7:00 PM to 7:00 AM shift on 10/30/2025.R70's MAR for the timeframe 11/01/2025 - 11/30/2025, revealed evidence to indicate the resident exceeded the ordered 180 ml of fluids during the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 11/03/2025, 11/04/2025, 11/06/2025, 11/07/2025, 11/08/2025, 11/10/2025, 11/13/2025, 11/17/2025, and 11/20/2025 - 11/30/2025.R70's MAR for the timeframe 12/01/2025 - 12/31/2025, revealed evidence to indicate the resident exceeded the ordered 180 ml of fluids during the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 12/02/2025 - 12/04/2025, 12/06/2025, 12/07/2025, 12/09/2025, and 12/11/2025 - 12/17/2025.During an interview on 12/19/2025 at 8:12 AM, Licensed Vocational Nurse (LVN)6 confirmed R70 was on fluid restriction, which meant there was a limit on the amount of fluids the resident could receive.During an interview on 12/19/2025 at 8:45 AM, LVN2 stated R70 should not be given more than 1,200 ml of fluids per day.During an interview on 12/19/2025 at 9:42 AM, the Director of Nursing stated staff should monitor a resident's fluid intake if the resident had an order for a fluid restriction.During an interview on 12/19/2025 at 9:55 AM, the Administrator stated staff should adhere to a resident's fluid restriction.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and facility policy review, the facility failed to ensure appropriate storage and disposal of drugs and biologicals during observation of medication administration with 1 (Resident (R)74) of 5 residents observed for medication administration.Findings included:A facility policy titled, Storage and Expiration Dating of Medications and Biologicals, revised 06/30/2025, revealed, 5. Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.A facility policy titled, Disposal of Medications, revised 08/26/2025, revealed, 13.2 Wasted single doses of medications for disposal should [be] disposed of in a manner that limits access to them by unauthorized personnel or residents.During medication administration observation on 12/17/2025 at 9:24 AM, Licensed Vocational Nurse (LVN)2 prepared medication to be administered to R74. LVN2 dropped one multivitamin with minerals capsule and placed the capsule into the medication cart trash can.During an interview on 12/17/2025 at 9:50 AM, LVN2 stated he did not realize he disposed of a multivitamin with minerals capsule in the medication cart trash can. LVN2 stated medication should be disposed of in the medication cart sharps container.During an interview on 12/17/2025 at 10:57 AM, the Director of Nursing stated she would expect wasted medications to be disposed of in a sharps container or in a drug disposal solution and not in a regular trash can.During an interview on 12/18/2025 at 12:39 PM, the Administrator stated he would expect nursing staff to dispose of medications in a sharps container or something that was biosafe.