

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/21/2025
NAME OF PROVIDER OR SUPPLIER  Springdale Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  146 Battleship Road Camden, SC 29020	

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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, record review and interview, the facility failed to ensure Resident (R)5 was free from significant medication errors. Specifically, R5 was discharged from the hospital and admitted to the facility on [DATE], with physicians orders for seizure medications, the facility failed to administer the medication as ordered resulting in the resident experiencing seizure activity and being sent to the hospital, for 1 of 1 resident reviewed for significant medication errors.</p> <p>On 05/21/25 at 10:35 AM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 05/06/25. The IJ was related to 42 CFR 483.45 - Pharmacy Services.</p> <p>On 05/21/25 at 11:32 AM, the facility presented an acceptable plan of removal. On 05/21/25 at 1:30 PM, the survey team validated the facility's corrective actions and determined that the facility showed due diligence in addressing the noncompliance. The SA is considering this IJ at Past Non-compliance effective 05/08/25.</p> <p>An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F760, constituting substandard quality of care.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Medication Management Program (email revision 01/15/2025), states, B. The facility will ensure the schedules for administering medications: 1. Maximize the effectiveness of the medications. 4. Authorized staff must understand: A. Indications or reason for therapy. B. Effectiveness for drug, achieving the therapeutic goal. C. Drug actions. D. The 8 rights for administering medication: 2. The right drug, 3. The right dose, 4. The right time.</p> <p>Review of R5's Face Sheet revealed the facility admitted R5 on 05/06/25, with diagnoses including, but not limited to: metabolic encephalopathy, seizure disorder and status epilepticus. R5 was discharged to the hospital on [DATE] at 8:40 PM due to seizure activity.</p> <p>Review of R5's Physician's Orders revealed the following orders: Keppra 500 milligrams per 5 milliliters (mls) and R5 is to receive 10 mls 2 times daily at 06:00 AM and 06:00 PM. Lacosamide (Vimpat) 100 milligrams (mgs) 1 tablet 2 times daily at 06:00 AM and 06:00 PM. Zonisade 100 mgs per 5 mls and R5 is to receive 15 mls at 10:00 PM.</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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of R5's Medication Administration Record (MAR) for May 2025, revealed that R5 did not receive one dose of Keppra, three doses of Vimpat and two doses of Zonisade.</p> <p>Review of the admission Baseline Care Plan for R5 revealed, Services and treatments to be administered by the facility will be identified, Target date of 05/14/2025.</p> <p>Review of R5's Progress Note dated 05/07/25 at approximately 8:40 PM, revealed, At approximately 8:40 PM. This nurse was notified by family member that resident was having a seizure. Upon entering the room resident was lying in bed in supine position having unresponsive with seizure like activity. She was repositioned to right side. Vital signs obtained was Bp -179/76, P- 130, RR-22, SPO2 -98% on room air. Supervisor notified and 911 was called. Resident had a total of 6 seizures with duration of 1-3 minutes. Onset was between of 3-4 minutes. She was transported by EMS via stretcher to [local hospital]. Accompanied by her brother.</p> <p>During an interview on 05/20/25 at 1:22 PM, Licensed Practical Nurse (LPN) Unit Manager stated, there was no order from the hospital, so she had to get a hard script and call the provider to let them know they do not have the medication here at the facility. LPN Unit Manager further stated that was on 05/06/25. A call was placed to the Medical Director to see if she wanted to change the medication, discontinue the medication, or give something else. LPN Unit Manager stated, The resident missed maybe 3 doses. Her expectation was, the nurses should have called the physician.</p> <p>During an interview on 05/20/25 at 6:20 PM, LPN2, the night shift supervisor, stated that the Vimpat was not delivered by the pharmacy and no hard script was sent from the hospital. LPN2 stated the Zonisade was not delivered and the pharmacy did not contact us and let us know this medication was on backorder. LPN2 continued that the Keppra was delivered but the pharmacy does not deliver until 9:00 PM or 9:30 PM. LPN2 concluded that the resident was fine on 05/06/25. I reported to work at 8:00 PM on 05/07/25 and the resident started seizing shortly after I reported to work.</p> <p>During an interview on 05/20/25 at 6:30 PM, the Director of Nursing (DON) stated the nurses should go by the discharge summary from the hospital. They should put the orders into Matrix Care. The DON stated that the Vimpat was not in the emergency box, the hospital did not send a hard script and the resident did not receive Vimpat, but did receive Keppra and the Zonisade. The DON further stated that the floor nurse does the assessments and observations and the Unit Manager does the admissions by putting the orders in the computer. The facility realized there was no hard script for the Vimpat the evening of 05/06/25, and no one notified the physician until 05/07/25 in the AM. The resident was discharged to the hospital with seizure activity at 8:40 PM on 05/07/25. The DON further stated the resident had missed the morning dose and the evening dose of Vimpat. After reviewing the Medication Administration Record (MAR) on 05/20/25 at 7:15 PM, the DON confirmed that the resident did not receive 1 dose of Keppra, 3 doses of Vimpat and 2 doses of Zonisade. The DON concluded that she was not aware that the resident missed that many doses of her antiseizure medications.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/21/25 at 8:30 AM, the Nurse Practitioner (NP) revealed she was in the facility in the AM on 05/07/25, she is on call from 6:00 AM until 6:00 PM and after 6:00 PM, calls go to an on-call service. The NP stated, I received no calls and the on-call service received no calls from the facility pertaining to hard scripts or R5 not receiving her seizure medications. I was told by the Unit Manager on 05/07/25 between 8:00 AM and 9:00 AM, that the resident needed a hard script for Vimpat. The Unit Manager apologized and stated that with everything going on, she had forgotten to call me the previous day. I E'scribed the script at that time. The NP stated she expects the nurse to notify her if they do not have a medication that the resident needs. She stated there were no triage notes from the on-call to let her know the resident was sent out to the hospital. The NP stated that she was not aware that R5 did not receive the Vimpat nor the Zonisade, Missing several medication doses for seizures could have been detrimental to this resident. She ended up on life support.</p> <p>On 05/21/25 at 11:32 AM, the facility presented an acceptable plan of removal, which included the following:</p> <p>The following measures were immediately implemented upon notification of the facility:</p> <p>1. Corrective action for residents found to have been affected by the deficiency:</p> <p>a. R5 was found to be affected by the alleged deficient practice.</p> <p>b. On 05/08/2025 a review of all residents admitted on seizure medications since 05/05.2025 was completed to validate orders for seizure medications and that medicatio were available. No discrepancies were identified.</p> <p>c. On 05/08/2025, the Director of Nursing was re-educated by the Clinical Consultant on the following:</p> <p>Medication Management policy specifically medications that are unavailable.</p> <p>Validate the Medication Reconciliation is completed at admission with providers.</p> <p>Medications that are unavailable, specifically seizure medications-process for notifying the provider for scripts, and utilization of the in house stat box.</p> <p>The below process regarding admission medication reconciliation.</p> <p>The following process will be implemented:</p> <p>1. Director of Nursing or designee will review new admission medication reconciliation for completion Monday through Friday for four weeks. Concerns to be addressed at time of discovery.</p> <p>2. Director of Nursing and or designee will review medication administration report for unavailable medication and interventions. Monday through Friday for four weeks. Concerns to be addressed at the time of discovery.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Licensed nurses will complete medication reconciliation upon admission and communicated to the provider for additional orders if indicated. Any unavailable medications (those not available in stat safe/emergency box) will require a call to the pharmacy to have the medication delivered. The after-hours pharmacy may be need to be contacted to have a medication delivered quickly. If the medication that will be delivered, will result in a late medication administration, the provider must be notified for further orders.</p> <p>d. Licensed nurse in the facility will be re-educated by 05/08/2025. Staff not re-educated by 05/08/2025 will be educated prior to next scheduled shift. New hires will receive education during new hire orientation.</p> <p>Licensed nurses will be educated on the following:</p> <p>Medication Management policy specifically medications that are unavailable.</p> <p>Validate the Medication Reconciliation is completed at admission with providers.</p> <p>Medications that are unavailable, specifically seizure medications- process for notifying the provider for scripts, and utilization of the in house stat box.</p> <p>The below process regarding admission medication reconciliation.</p> <p>The following process will be implemented:</p> <ol style="list-style-type: none"> <li>1. Director of Nursing or designee will review new admission medication reconciliation for completion Monday through Friday for four weeks. Concerns to be addressed at time of discovery.</li> <li>2. Director of Nursing and or designee will review medication administration report for unavailable medication and interventions. Monday through Friday for four weeks. Concerns to be addressed at the time of discovery.</li> <li>3. Licensed nurses will complete medication reconciliation upon admission and communicated to the provider for additional orders if indicated. Any unavailable medications (those not available in stat safe/emergency box) will require a call to the pharmacy to have the medication delivered. The after-hours pharmacy may be need to be contacted to have a medication delivered quickly. If the medication that will be delivered, will result in a late medication administration, the provider must be notified for further orders.</li> </ol> <p>e. Ad hoc QAPI held on 05/08/2025.</p> <p>f. Medical Director was notified of the incident and plan for improvement on 05/08/2025.</p> <p>g. The process will be reviewed in QAPI for a minimum of 3 months.</p> <p>2. Corrective action for residents that may be affected by the deficiency:</p> <p>a. The Medical Director was notified of the IJ on 05/08/2025.</p> <p>(continued on next page)</p>		

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