STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425171	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McCormick Post Acute	204 Holiday Road MC Cormick, SC 29835

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 43050 Based on observation, record review, interview, and facility policy review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level I was completed correctly for two resident (Resident (R) 64 and R65) of four reviewed for PASARR I in a total sample of 38 residents. Findings include: Review of the policy provided by the facility titled, Admission Criteria, dated 03/2019, indicated .All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, the resident is referred to the state PASARR representative for the Level II screening process. The admitting nurse notifies the social services department when a resident is identified as having a possible MD, ID, or RD. The social worker is responsible for making referrals to the appropriate state-designated authority . 1. Review of R64's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including major depressive disorder and schizophrenia. Review of R64's Initial Assessment PASARR located under the Resident Documents tab in the EMR and dated 03/25/20 did not indicate any mental illness diagnosis. Further review revealed a diagnosis of major depressive disorder and schizophrenia. Review of R64's Diagnosis List, located under the Medical Diagnosis tab of the EMR and dated 02/15/24, revealed a diagnosis of major depressive disorder and schizophrenia on 02/15/21. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/04/24 at 12:10 PM, the Social Services Director (SSD) said when a resident was admitted she requested the PASARR level I from the hospital to be completed prior to admission. She said she would review it and ensure all the information was accurate and she reviewed the diagnosis. She looked at the hospital notes to see if there was any mental illness diagnosis and at any psychiatric hospital stays within the last two years or any behaviors. She would also look to see a resident was on a antipsychotic medications and she would make sure there was a check mark for mental illness. She said schizophrenia was only listed sometimes on the PASARR, but she was unable to explain what that meant exactly. She did not check R64 diagnosis and ensure the PASARR was accurate, but she should have. During an interview on 04/05/24 at 2:46 PM, the Director of Nursing (DON) said during the survey, the facility has identified there was an issue when the PASARR came the hospital and were not always completed accurately. She said social services will monitor and communicate with the state contact to ensure the Interdisciplinary Team (IDT) check physician orders and MDS assessments. She said she expected them to be completed accurately but they have lot of work to be done to ensure the process was done correctly. 2. Review of R65's EMR revealed an undated Admission Record, which indicated the resident was admitted to the facility on [DATE], with diagnoses that included schizophrenia and major depressive disorder. Review of R65's EMR quarterly MDS, with an Assessment Reference Date, of 01/18/24 revealed the resident had a Brief Interview for Mental Status score of 15 out of 15, which indicated the resident was cognitively intact. Section I of the MDS included an active diagnosis of schizophrenia. Review of R65's EMR Care Plan, dated 10/01/24, located under the Care Plan, tab indicated the resident had diagnoses of schizophrenia and took a antipsychotic medication (Olanzapine) at bedtime for schizophrenia. Review of R65's PASARR Level I provided by the facility and dated 09/29/23, revealed diagnoses of anasarca (edema), metabolic encephalopathy, malignancy of unknown primary, cocaine use, diabetes, congestive heart failure, hypertension, and mental health disorder. It listed Olanzapine 10 mg oral nightly as the psychotropic drug currently being used. No further evaluation was recommended. During an interview on 04/04/24 at 12:10 PM with the SSD revealed I check all PASARRs that come from the hospital prior to admission. I check for accuracy and look at all diagnosis and if any antipsychotic medications are being used. The schizophrenia diagnoses far R65 should have been on the PASARR level I and I did not see it. The resident was also on an antipsychotic and I missed that also. PASARR stated a mental health disorder and I did not question that diagnosis. Interview with the DON on 04/05/24 at 2:29 PM revealed The PASARRs will need to be reviewed for accuracy. We will have to change our process to catch mistakes upon admission.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, interview, record review and policy review, the facility failed to ensure oxygen was administered per physician orders and ensure there was an order in place for oxygen administration for two (Residents (R)23 and R103) reviewed for oxygen. Findings include: Review of the facility's policy titled Oxygen Administration, dated October 2010 revealed, the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify there is a physician's order for this procedure. 1. Review of R23's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnosis of acute respiratory distress. Review of R23's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 01/02/24, revealed a Brief Interview for Mental Status (BIMS), score of 12 out of 15 which indicated the resident had moderate cognitive impairment. Further review of the MDS revealed R23 received oxygen therapy while a resident. Observations on 04/03/24 at 8:24 AM, and 04/04/24 at 9:35 AM and at 11:10 AM revealed R23 wearing a nasal cannula and the oxygen setting was at 3 liters per minute (LPM). Review of R23's Care Plan, located under the Care Plan tab of the EMR dated 01/24/24, revealed The resident required the use of continuous oxygen. Interventions in place were to administer oxygen at 2 LPM via nasal cannula and monitor oxygen saturation via pulse oximetry. Review of R23's Physician Orders located under the Orders tab of the EMR dated 01/03/24, revealed an order for continuous oxygen at 2 LPM via nasal cannula. Review of R23's Treatment Administration Record (TAR) located under the Orders tab of the EMR, dated April 2024, revealed oxygen at 2 LPM via nasal cannula continuously was signed off on 04/04/24 by Licensed Practical Nurse (LPN)1 for the 7:00 AM to 3:00 PM shift. 2. Review of R103's Admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD) and pneumonia. Review of R103's admission MDS with an ARD of 01/12/24, revealed a BIMS score of 10 out of 15 which indicated resident had moderate cognitive impairment. Further review of the MDS revealed R19 received continuous oxygen therapy on admission and while a resident. Observations on 04/03/24 at 10:03 AM, 04/04/24 at 9:38 AM and 04/04/24 at 12:03 AM revealed wearing a nasal cannula and the oxygen setting was at 2.5 liters per minute. Review of R103's Care Plan, located under the Care Plan tab of the EMR dated 01/07/24, revealed The resident was at risk for complications with the respiratory system due to COPD. BIPAP as ordered . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R103 Physician Orders located under the Orders tab of the EMR, dated 04/03/24, revealed there was no order for continuous oxygen. During an interview on 04/04/24 at 11:14 AM, LPN1 observed R23's oxygen canister and confirmed the setting was at 3 LPM. She confirmed she checked his oxygen earlier and signed off on the MAR that R23 was on 2 LPM of oxygen. She said she thought the resident was supposed to be on 2 LPM and she thought it said 2 LPM when she looked at the concentrator. She did not notice it was set on 3 LPM. She verified R103 was on continuous oxygen but admitted there was no current order for oxygen and she was not sure why but there should have been. She did not notice there was not an order before today, but she said she did not work with the resident that often. She said she was not sure how staff were able to monitor the resident's oxygen without an order in place. During an interview on 04/05/24 at 2:46 PM the Director of Nursing (DON) said staff should be checking a resident's oxygen setting before they sign off on it on the MAR to ensure it was correct. And they should be checking to ensure it was correct each time. She stated the oxygen order for R103 may have dropped off but was not sure why that happened, and they notified the APRN and got an order in place. She said staff should have noticed there was no order when they were checking the residents and observing she was on continuous oxygen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, interview, and record review, the facility failed to ensure staff properly stored nebulizer masks when not in use for one of one sampled resident (Resident (R) 103). Findings include: Review of R103's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD) and pneumonia. Review of R103's admission Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 01/12/24, revealed a Brief Interview for Mental Status (BIMS), score of 10 out of 15 which indicated resident had moderate cognitive impairment. Further review of the MDS revealed R19 received continuous oxygen therapy on admission and while a resident. Observations on 04/03/24 at 10:03 AM, and 04/05/24 at 10:38 AM revealed nebulizer mask was not placed inside a bag lying underneath the bed and lying on top of the dresser next to the bed with the tubing hanging inside the trash can. Review of R103's Care Plan, located under the Care Plan tab of the EMR dated 01/07/24, revealed The resident was at risk for complications with the respiratory system due to COPD. BIPAP as ordered . During an interview on 04/05/24 at 11:43 AM LPN2 observed R103's nebulizer mask sitting out and exposed. She said she did not work at the facility that often and she would have to check to see what the policy/process for the facility was on how nebulizer masks should be stored when not in use. But as a nurse she said it should be covered and sealed to prevent any potential contamination of bacteria that would be an infection control concern. She said she came into the room earlier and observed the nebulizer mask left uncovered but left it because she wanted to check with facility staff on what their process was and where it should be stored. During an interview on 04/05/24 at 2:46 PM the Director of Nursing (DON) said R103 has been known to get the nebulizer mask out of the bag but stated she was not care planned for that and she should have been. But she said she expected staff to store nebulizers masks in a plastic bag when not in use as an infection control prevention.