STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425175	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Physical Rehabilitation and Wellness Center of Spa	8020 White Avenue Spartanburg, SC 29303

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, record review, interviews, and facility policy review, the facility failed to promote dignity during a dressing change for one of one resident (Resident (R) 25) of 25 sample residents. This failure caused R25 to have increased anxiety during a dressing change. Findings include: Review of the facility's policy titled, Social Services Policies and Procedures, dated 06/09/23, revealed . Well-being/Quality of Life: The Department addresses the physical, mental, social, and emotional well-being of each patient and resident served in the facility. in doing so, the Department assists every patient and resident to achieve maximum quality of life . Quality of life begins with the preservation of a sense of dignity and individuality . Review of R25's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses which included diabetes mellitus, asthma, and atrial fibrillation. Review of R25's admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/11/24 coded the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R25 was cognitively intact. R25 was also coded as having a skin tear with MASD [Moisture Associated Skin Damage] and was at risk for developing a pressure ulcer. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a dressing change observation on 11/25/24 at 2:45 PM to R25's sacrum area, Licensed Practical Nurse (LPN)5 entered R25's room and was explaining that her roommate was having to be transported to the hospital for a blood transfusion. Approximately ten minutes later, LPN5 came back into the room and held the privacy curtain together while two male attendants from the transport ambulance came into the room. LPN5 was asked if this could wait for a few minutes and she stated, No, this is an emergency. R25 became very anxious by trying to pull her gown down and trying to move her hips so that her sacral area could not be seen by the male ambulance attendants that had entered the room. R25 was in the first bed in the room and the roommate that was being transported to the hospital was in the second bed by the window. LPN5 proceeded to give report to the ambulance attendants, then they transferred the roommate to the stretcher and left the room. After the Wound Care Nurse (WCN) finished the dressing to R25, she apologized to the resident because there were male attendants that came into the room. During an interview with R25 after the dressing change the resident stated, I really didn't like them coming into my room at that time. If they could just have waited, it would have taken the nurse about five more minutes, and she would have been done. During an interview on 11/25/24 at 3:26 PM, LPN5 was asked if the practice was to allow male attendants with a transport team to come in a resident's room while R25 was having a dressing change to the sacral area. LPN5 stated, That was why I held the curtain together, so they would not see her. I deal with emergencies first. During an interview on 11/25/24 at 3:35 PM, the Director of Nursing (DON) stated, They could have waited five minutes for the nurse to finish the dressing change. The transport was urgent not emergent.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on interviews, record review, and review of facility documents, the facility failed to ensure showers were conducted according to resident preferences for one (Resident (R) 24) of 25 sampled residents. This failure denied the resident the right to self-determination for showers. Findings Include: Review of the facility's policy titled, Social Service Policies and Procedures, revision date of 10/01/20, revealed The Facility employs measures to ensure patient and resident personal dignity, well-being, and self-determination are maintained and will educate patients and residents regarding their rights and responsibilities. The Facility has established the Patient/Resident [NAME] of Rights and Responsibilities in accordance with state and federal regulations. The Facility will communicate the Patient/Resident [NAME] of Rights and Responsibilities to the patient and residents in a language or means of communication that ensures patient and resident understanding. The [NAME] of Rights is recognized and supported by all facility staff. Staff document the communication and provision of this information when provided to the patient, resident, and legal representative. The Facility will ensure residents can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. Review of R24's Face Sheet, located under the Face Sheet tab of the electronic medical record (EMR), revealed the resident was admitted on [DATE] with a diagnosis of spinal stenosis, site unspecified, hypertensive heart disease with heart failure, diabetes mellitus due to an underlying condition without and morbid (severe) obesity with alveolar hypoventilation. Review of R24's Physician Orders, located under the Orders tab of the EMR and dated 02/19/24, revealed that R24's shower days were Sunday and Thursday. Review of R24's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/24 and located under the MDS tab of the EMR revealed R24 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. It was recorded that R24 required partially to moderate assist with bathing. Review of R24's Care Plan, located under the Care Plan tab of the EMR, and revised 09/03/24, revealed ADL CARE ---- [R24] is at risk for complications related to the need for support with ADL CARE. She has chronic pain and impaired mobility, debility. Assist with bed mobility and transfers as needed. During an interview on 11/24/24 at 1:43 PM, R24 revealed she was not getting showers. R24 stated she should be getting way more showers than she was receiving. R24 stated she was supposed to get two showers a week. R24 stated they would provide her with a bed bath, but not a shower. She stated she would like a shower. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/26/24 at 2:42 PM, the Social Service Director (SSD) revealed that R24 had come to her office yesterday and had discussed going home. She stated R24 came by often, and she never mentioned not getting her showers. The SSD looked in the shower book for October and November, and R24 had only two shower days for those months, one on 10/23/24 and one on 11/21/24. The SSD stated she was getting with nursing about the issue. During an interview on 11/26/24 at 4:52 PM, the Administrator and Director of Nursing (DON) revealed resident showers were set up during their care plan meeting and noted in the physician orders. They stated they would look into why the resident only received two showers in the last two months.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on interview and record review, the facility failed to issue accurate Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) to one of two residents (Resident (R) 74) and a Notice of Medicare Non-Coverage (NOMNC) forms and a SNFABN to one of two residents (R75) reviewed for liability and beneficiary notices out of total sample of 25. This failure had the potential for residents or their responsible parties not to have all the information to make an educated decision about the ending of skilled services. Findings include: 1. Review of R74's electronic medical record (EMR) Census tab, revealed the resident was admitted on [DATE] for Medicare A services. Review of a document, completed by the facility and listing the residents who had been discharged from skilled services revealed R74 was issued a NOMNC on 09/19/24. It was documented that the facility did not issue the SNFABN to R74 because R74 did not appeal. 2. Review of R75's EMR Census tab revealed the resident was admitted on [DATE] for Medicare A skilled services. Review of a document, completed by the facility and listing the residents who had been discharged from skilled services, revealed R75's spouse was notified by phone that R75's Last Covered Day for skilled services was 07/19/24. It was recorded R75 received her skilled services through a managed care plan instead of Medicare, and that the resident could call United Healthcare for any assistance with her services. It was documented that R75 was not issued a SNFABN because no appeal was filed. During an interview on 11/26/24 at 1:07 PM the SSD stated she only issued the SNFABN for Medicare Part B residents in the building. When asked how she received the NOMNC to issue to residents, she stated she received them from a case manager. The SSD was not aware that she was supposed to create the NOMNCs for Medicare A residents in the facility and was under the impression that SNFABNs were only issued if a resident appealed the NOMNC they were issued. She was not aware the SNFABN was to be issued to any resident with remaining Medicare A days and remaining in the facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review, interview, and facility policy review, the facility failed to ensure a written copy of the baseline care plan was provided to the resident and/or responsible party (RP) within 48 hours for one of one resident (Resident (R) 25) reviewed for baseline care plans of 25 sample residents. This failure had the potential for residents and/or RP not to be informed of the plan of care. Findings include: Review of the facility's policy titled, Care Plan Process, Person-Centered Care, dated 05/03/23, revealed . Provide the resident and their legal representative (if applicable) a copy of the baseline person-centered care plan summary . Review of R25's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses which included diabetes mellitus, asthma, and atrial fibrillation. Review of R25's admission Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/11/24 coded the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R25 was cognitively intact. Review of R25's Baseline Care Plan located under Care Plan tab in the EMR, revealed this care plan was dated on 11/05/24 and had signatures of staff members but no documentation that the written baseline care plan was given to R25. During an interview on 11/26/24 at 8:35 AM, the Social Services Director (SSD) stated, I will attempt to go and give it to the residents but if they are hard to find in their rooms, I will sometimes forget to go back to give this information. During an interview on 11/26/24 at 10:00 AM, R25 stated, I don't remember getting anything from the staff about this. During an interview on 11/26/24 at 2:30 PM, the Director of Nursing (DON) stated, The Social Worker should make sure she gets a written form of the baseline care plan to the residents. If she is having trouble in getting this done, then she needs to ask someone to help her.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30260 Based on record review, interviews, and facility policy review, the facility failed to 1.) ensure the comprehensive care plan included the resident's religious preference for one of one resident (Resident (R) 42) reviewed for activities based on a resident's mental and psychosocial needs out of 25 sample residents. This failure had the potential to cause R42's psychosocial needs not to be met, and 2.) failed to develop a comprehensive care plan (CP) for a pressure ulcer for one of four residents (Resident (R) 25) out of 25 sampled residents. This failure had the potential for R25 to have an inaccurate plan of care for a stage four pressure ulcer. Findings include: Review of the facility's policy titled, Care Plan Process, Person-Centered Care, last revised 05/05/23, revealed: . The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes trying to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and understanding the resident's life before coming to reside in the nursing home. 1. Review of R42's Face Sheet, located under the Profile tab of the electronic medical record (EMR), revealed the resident was admitted on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (Primary), urinary tract infection, site not specified, pain in throat, sacrococcygeal disorders, not elsewhere classified, muscle wasting and atrophy, acute atopic conjunctivitis, and chronic pain syndrome. Review of R42's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/01/24 and located under the MDS tab of the EMR, revealed R42 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R42's Care Plan, located under the Care Plan tab of the EMR revealed under the Activities category, dated 10/03/19, Problem: [R42] prefers to do his activities in his room, such as listening to R&B [Rhythm and Blues] music/TV and visiting with friends and family .Goal . [R42] will engage in independent activities such as listening to music/TV talking on the phone to friends and family .Approach .Approach Start Date: 07/29/2022 Staff will play R&B, gospel, rap, jazz music of his interest during weekly visits. 07/29/2022 staff Will play religious services of his interest on his TV or our radio during weekly visits. During an interview on 11/24/24 at 1:45 PM, R42 stated the facility did not provide accommodation for his religious preferences and that all activities were Christian. R42 also stated that sometimes the facility gave him a ham sandwich and he did not eat ham because he is a Muslim. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/24 at 2:39 PM, the Activity Director (AD) stated R42 was invited to activities and participated occasionally in group activities when he was not in dialysis. The AD stated if he could not be there, activities would still provide him the snacks shared during activities. When asked what R42's religion was, she stated R42 was a Christian. When asked if R42's profile revealed his religion, the AD stated she was unaware. The AD stated she was aware R42 did not like pork products but did not know it was a religious preference. When informed activities listed in R42's care plan included gospel music, which the resident did not subscribe to it, the AD reiterated that she was unaware of R42's religious preferences and that the care plan entry was entered by her predecessor. During an interview on 11/25/24 at 2:57, the MDS Coordinator (MDSC) stated she was aware R42 was a Muslim but did not believe he actively practiced his religion. When asked if she had asked R42 whether he practiced his religion or if she assessed R42 for his religious preferences, she stated she had not. During an interview on 11/26/24 at 9:26 AM, the Registered Dietician (RD) stated she was not aware R42 was a Muslim with religion-related dietary preferences. The RD stated R42 had requested bacon and other pork products before. The RD stated she was not aware it was in R42's profile that he was a Muslim. During an interview on 11/26/24 at 10:14 AM, the Social Services Director (SSD) stated she had been the SSD for about one year. The SSD stated she was unaware R42 was a Muslim. The SSD stated she did not know if R42 was attending mosque or if he was an active Muslim. When informed that R42's religion was on his profile in his face sheet, the SSD stated she was new to the facility and did not know and that she would work with activities to honor R42's religious preferences. During an interview on 11/26/24 at 12:51 PM, the Dietary Manager (DM) stated she was aware he did not like pork, and this was reflected in his tray card. The DM stated she did not know why he did not like pork products and believed it was just his preference. During an interview on 11/26/24 at 6:07 PM, the Administrator stated he did not know R42 was a Muslim or what his religious preferences were. The Administrator stated that to his knowledge, R42 was very vocal, and his food preferences varied over a period of time, and that he had delivered pizza with pork products to R42's room on occasion. The Administrator acknowledged that it was on R42's profile that he was a Muslim, and the facility had failed to ensure that this information was reflected in R42's care plan. 28306 2. Review of R25's undated Face Sheet located under the Face Sheet tab of the EMR revealed the resident was admitted on [DATE] with diagnoses which included diabetes mellitus, asthma, and atrial fibrillation. Review of R25's admission MDS located under the MDS tab in the EMR with an ARD of 11/11/24 coded the resident as having a BIMS score of 15 out of 15 which indicated R25 was cognitively intact. R25 was also coded as having a skin tear with MASD [Moisture Associated Skin Damage] and was at risk for developing a pressure ulcer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R25's Physician Orders located under the Orders tab in the EMR revealed an order dated 11/15/24, which revealed Daily wound Treatment: Location stage 4 [sic] wound on sacrum, cleanse with wound cleanser/NS [Normal Saline], apply Medi Honey with alginate calcium w [with] silver, cover w [sic] boarder gauze dressing. Review of R25's Wound Evaluation & [and] Management Summary, dated 11/20/24 and located under the Wound Management tab of the EMR, revealed the resident had a stage four pressure wound to the sacrum and the treatment plan was Alginate calcium w [with]/silver apply once daily for 23 days; Leptospermum of [medical grade of honey] honey apply once daily for 23 days. Review of R25's Care Plan located under the Care Planning tab in the EMR and dated 11/12/24, revealed a Problem as .has a current wound/disruption of skin surface: MASD with skin tear. The Approach was CNA [Certified Nurse Assistant] to inspect skin, especially over bony prominences, during bathing and personal care. Encourage fluids to maintain hydration. Licensed nurse to complete wound observation .Minimize skin exposure to moisture from incontinence, perspiration, or wound drainage by mild cleansing agents and using skin barrier cream for skin protection .Use aseptic techniques when performing dressing changes. Dress and cover wo Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictates the need such as but not limited to falls and pressure ulcer development would [sic] before dressing other wounds, washing hands and observing aseptic technique. Use draw sheets or similar for positioning and turning to maintain skin integrity . A care plan for the stage four pressure area was not documented. During an interview on 11/26/24 at 11:00 AM, the Director of Nursing (DON) stated, I see the one [CP] for the MASD but do not see where they started one for the pressure ulcer. The nurses should have started one for that.

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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** 28306 Based on observation, interview, record review, and facility policy review, the facility failed to obtain a physician's order prior to the administration of oxygen for one of two residents (Resident (R) 25) out of 25 sampled residents. This failure had the potential for R25 to have adverse reactions from the administration of oxygen. Findings include: Review of the facility's policy titled, Oxygen Therapy, dated 02/12/24, revealed Verify the provider's order for the oxygen therapy . Review of R25's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses which included diabetes mellitus, asthma, and atrial fibrillation. Review of R25's admission Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/11/24 coded the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R25 was cognitively intact. During an observation on 11/24/24 at 2:10 PM and on 11/25/24 at 2:45 PM, R25 had oxygen on at two L/min (liters/minute) by nasal cannula. During an observation and interview on 11/25/23 at 9:10 AM, the Assistant Director of Nursing (ADON) accompanied the surveyor to R25's room. When the ADON was asked how much oxygen R25 was receiving by nasal canal, the ADON stated, It is on two and one-half liters/minutes. The ADON went to review the EMR and confirmed that R25 did not have an order for the administration of oxygen. ADON stated, You have to have an order for oxygen. During an interview on 11/26/24 at 10:19 AM, the Director of Nursing (DON) stated, There should be an order to administer oxygen.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review and interview, the facility failed to have collaboration of care with the dialysis center for one of two resident (Resident (R) 21) reviewed for dialysis out of 25 sampled residents. This failure had the potential to put R21 at risk for lack of communication between the facility and the dialysis center, Findings include: Review of R21's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) indicated R21 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus and end stage renal disease. Review of R21's admission Minimum Data Set (MDS) located in the EMR under the MDS Assessment tab with an Assessment Reference Date (ARD) of 10/31/24 revealed the resident was coded as receiving dialysis services while a resident in the facility. Review of R21's Physician Order located in the hard chart of the medical record, under the Orders tab, revealed orders, dated 10/24/24, which revealed R21 had dialysis on Mondays, Wednesdays, and Fridays. Review of R21's Hemodialysis Communication Record provided by the facility, revealed the records, dated 11/06/24, 11/15/24, and 11/18/24, had documentation missing from the dialysis center for shunt site (which described the location, dressings, pain and change in condition), lab values which described the events during the course of treatment, medications given at dialysis, recommendations, and food/fluid intake along with missing signatures and dates. The communication sheets for 11/06/24, 11/09/24, and 11/15/24 had documentation missing from the shunt observation of the dressing, assessment of the auscultation of the bruit, palpation of thrill, and if the resident reported pain. During an interview on 11/26/24 at 10:02 AM, the Director of Nursing (DON) stated, The nurses are to call dialysis center and get a verbal report if the communication sheet is not completely filled out. The nurses are also to do an assessment of the resident when they return to the facility.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 30260 Based on observation, record review, interview, and review of facility policy, the facility failed to maintain a medication error rate below five percent. Three errors/omissions out of 26 opportunities resulted in a medication error rate of 11.54% for three of three residents (Resident (R)13, R31, and R30) of 25 sample residents. This failure had the potential to cause residents to not receive the proper dosages of their medications. Findings include: Review of facility's policy titled, Physician Orders, last revised 05/05/23, revealed Medication/Treatment 1. The facility should not administer medications or biologicals except upon the order of a physician/prescriber lawfully authorized to prescribe them. 2. Elements of the medication order include: A. Full name, date of birth, and room number of the resident B. Name of medication C. Strength of medication, where appropriate D. Dosage E. Form of drug (tab, liquid, solution, etc.) F. Time or frequency of administration G. Route of administration H. Quantity or duration of therapy, if limited I. Diagnosis or indication of use J. Parameters for holding medication if indicated. K. Prescribers full name Review of the facility's policy titled, Medication Management Program, last revised on 05/05/24, revealed .4. Authorized staff must understand: A. Indications or reason for therapy. B. Effectiveness for achieving the therapeutic goal. C. Drug actions. D. The 8 Rights for administering medication: 1) The Right Patient/Resident 2) The Right Drug 3) The Right Dose 4) The Right Time 5) The Right Route 6) The Right Charting 7) The Right Results 8) The Right Reason .5. The same person authorized medical or licensed person prepares, administers, and records the medications . 15. Outdated medication is destroyed or returned to the pharmacy according to applicable state rules and regulations. A new supply of medication is obtained, when necessary. 16.Medications are dispensed at the time of administration. Pre-pouring or dispensing for a later administration time is not permitted .5.The authorized staff member validates the following information is documented on the MAR (Medication Administration Record): A. Correct physician's order and diagnosis for each medication. 8. Medication and label are correct .6.The authorized staff member reads the label on the medication three (3) times. A. Before removing the medication from the drawer. B. Before dispensing the medication. C. After dispensing the medication .11. Immediately after administering the medication to the resident, the authorized staff or licensed nurse will return to the medication cart and document medication administration with initials on the MAR. If a medication is not administered, the authorized staff or licensed nurse must explain why it was not given .16. Once removed from the package or container, unused doses should be destroyed following facility policy and documenting the destruction according to facility policy. 1. Review of R13's physician orders located under the Orders tab of the electronic medical record (EMR), revealed the order for insulin lispro (an anti-diabetic injection) 100 unit/mL with a sliding scale as follows: Per Sliding Scale If Blood Sugar is less than 60, call MD. If Blood Sugar is 200 to 249, give 2 Units. If Blood Sugar is 250 to 300, give 4 Units. If Blood Sugar is 301 to 349, give 6 Units. If Blood Sugar is 350 to 399, give 8 Units. If Blood Sugar is 400 to 449, give 10 Units. If Blood Sugar is 450 to 499, give 12 Units. If Blood Sugar is greater than 499, call MD. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Physical Rehabilitation and Wellness Center of Spa	8020 White Avenue Spartanburg, SC 29303

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication observation on 11/25/24 at 4:22 PM, Licensed Practical Nurse (LPN)2 checked R13's fingerstick blood sugar. The result was 293, indicating four units of insulin lispro per physician's order were required. LPN2 tuned the dial on the insulin pen containing the medication and approached R13 to give the medication. The surveyor requested to see the number of insulin units about to be given. LPN2 showed it to the surveyor and the dial was turned on five units. At the time of the observation, LPN2 stated the dial must have slipped, turned down the dial to the correct dosage of four units, and administered the medication to the resident. 2. During a medication observation on 11/26/24 at 8:45 AM in the 300 unit, LPN4 put multiple tablets, including one chewable aspirin 81 mg (milligram) for R31 into a cup. R31 was given all the pills in the cup to swallow including the chewable aspirin. During an interview on 11/26/24 at 8:52 AM, LPN4 admitted the aspirin was a chewable tablet and should have been given to the resident to chew. 3. During medication observation in the 300 unit on 11/26/24 at 3:47 PM, LPN7 opened the medication cart and in the cart was an unlabeled and unsecured medication cup containing two tablets. When asked what they were, LPN7 stated they were Lyrica and Carafate meant for R30 that should have been given by LPN4 at 2:00 PM. LPN4 stated the medications were not given because R30 was away from the unit at therapy. When asked what she was going to do with the open medications, LPN7 stated she was going to R30's room to see if he was back on the unit so she could give him the medications. LPN7 picked up the cup from the medication cart and proceeded to R30's room followed by surveyor. In R30's room, LPN7 approached R30 and explained to him that she had brought him the 2:00 PM medications Carafate and Lyrica that he had missed and tried to hand the cup containing the two mediations to R30. LPN7 stated she knew what the medications were because LPN4 had informed LPN7 that she left them in the cart before LPN7 left for the day. During an interview with the Director of Nursing (DON) and the Administrator on 11/26/24 at 5:37 PM the foregoing medication errors were discussed with them and the DON stated it was her expectation that LPN4 should have followed the correct route of chewing a chewable aspirin and that LPN7 should not have tried to give medications that she did not withdraw herself.

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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. 30260 Based on observation, interview, and review of facility policy, the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles for one of one resident (Resident (R) 13) and failed to ensure that all drugs and biologicals were stored in locked compartments for one of one resident (R30) out of 25 sample residents. This failure had the potential to cause residents to receive the wrong or contaminated medications. Findings include: Review of the facility's policy titled, Medication Management Program, last revised on 05/05/24, revealed . 5. The same person authorized medical or licensed person prepares, administers, and records the medications . 15. Outdated medication is destroyed or returned to the pharmacy according to applicable state rules and regulations. A new supply of medication is obtained, when necessary. 16. Medications are dispensed at the time of administration. Pre-pouring or dispensing for a later administration time is not permitted .5.The authorized staff member validates the following information is documented on the MAR (Medication Administration Record): A. Correct physician's order and diagnosis for each medication.8. Medication and label are correct .6. The authorized staff member reads the label on the medication three (3) times. A. Before removing the medication from the drawer. B. Before dispensing the medication. C. After dispensing the medication . 11. Immediately after administering the medication to the resident, the authorized staff or licensed nurse will return to the medication cart and document medication administration with initials on the MAR. If a medication is not administered, the authorized staff or licensed nurse must explain why it was not given . 16. Once removed from the package or container, unused doses should be destroyed following facility policy and documenting the destruction according to facility policy. 1. During medication observation in the 100 unit on 11/25/24 at 4:22 PM, Licensed Practical Nurse (LPN)2 took a pen containing the medication insulin lispro out of a transparent plastic bag that contained another identical looking pen with a different medication, with no open and discard date marked on the pen. The plastic bag containing the pen was marked with the name of the other medication, Lantus Solostar 100 U/ML (Units/ Milliliter) (a long-acting insulin). It was observed that the Lispro insulin pen was labeled with R13's name, room number and medication name. However, the date the medication was first opened and the discard date were not written on the pen. When asked when the pen was first opened, LPN2 stated she did not know as she was not the one who opened it. LPN2 stated the pen was good for 28 days after it was first opened. When asked if the medication was appropriate to give since it did not have an opened date and discard date written on it, LPN2 stated she was going to administer it to the patient because the way his sugars run, there is no way the pen could last 28 days. During an interview on 11/25/24 at 5:54 PM, the Infection Preventionist (IP) stated the insulin pen should have been marked with an open date and discard date and that LPN2 should not have given the undated insulin, and it should have been discarded immediately. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During medication observation in the 300 unit on 11/26/24 at 3:47 PM, LPN7 opened the medication cart and in the cart was an unlabeled and unsecured medication cup containing two tablets. When asked what they were, LPN7 stated they were Lyrica and Carafate meant for R30 that should have been given by LPN3 at 2:00 PM. During an interview with the Director of Nursing (DON) and the Administrator on 11/26/24 at 5:37 PM the forgoing medication storage and labelling concerns were discussed with them. The DON stated it was her expectation that LPN2 should have discarded the insulin pen that was unlabeled with open and discard dates and followed physician's order for the correct dosage, and LPN7 should not have tried to give medications that she did not withdraw herself and the medications were inappropriately stored.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on observation, interview, and record review, the facility failed to ensure food palatability for one of one resident (Resident (R) 73) reviewed for dialysis out of a total sample of 25. This failure had the potential to affect the resident's nutritional intake and cause food-borne illnesses. Findings include: Review of R73's Face Sheet located in the electronic medical record (EMR) under the Admission tab, revealed the resident was admitted to the facility on [DATE] with a diagnosis that included end-stage renal disease; the resident was on dialysis. Review of the quarterly Minimum Data Set (MDS), located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/13/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that R73 was cognitively intact for daily decision-making. During an interview on 11/24/24 at 1:49 PM, R73 revealed she attended dialysis on Tuesday, Thursday, and Saturday. R73 stated she left the facility around 5:00 AM and did not return until between 10:00 AM to 10:30 AM. R73 stated that upon return, her breakfast tray was in her room and that the food was cold. She stated that sometimes, staff would come and warm the food, but it was still not good. R73 stated she wanted to have a hot breakfast because all she had before going to dialysis was crackers. During an interview on 11/25/24 at 2:39 PM, Certified Nurse Assistant (CNA)1 revealed that when passing breakfast, R73's tray was placed in her room so that she could have breakfast upon her return from dialysis. CNA1 stated the tray was usually warmed up for R73. During an observation on 11/26/24 at 8:53 AM, R73's breakfast tray was taken to her room and left. The resident was out of the facility at dialysis. During an interview on 11/26/24 at 8:59 AM, the Registered Dietician (RD) stated she was not aware R73's breakfast tray was left in her room for two or more hours. She stated that it was not only a palatable issue but possibly foodborne illness issues as well. She stated eggs were not safe to be left out like that, and I can't imagine they would taste good warmed up. The RD stated that a tray should not be left in the room. During an interview on 11/26/24 at 11:50 AM, the Dietary Manager (DM) stated she was aware that R73's breakfast tray was left in the room so that she could have breakfast upon dialysis. The DM stated she did not see a problem with the tray being left, indicating that the CNAs reheated the food. The DM asked, What else are we supposed to do? DM stated R73 needed her breakfast upon return and that R73 did not take a snack bag with her. When asked about the food sitting out for at least two hours, the DM stated that they were not thinking about it that way. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/26/24 at 2:42 PM, the Social Service Director (SSD) stated she did not know R73's breakfast was being left in her room. The SSD stated that she had spoken with R73 several times, and R73 had never voiced a concern. During an interview on 11/26/24 at 4:52 PM with the Administrator and Director of Nursing (DON), they both stated that R73's tray should not be left in the room and the resident should be offered a fresh hot tray upon return from dialysis.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22411 Based on observations, interviews, and documentation review, the facility failed to ensure the proper handling of ready-to-eat foods in one of one kitchen. This had the potential to result in the transmission of foodborne illnesses for 107 of 112 residents residing in the facility. Findings include: Review of the Food and Drug Administration (FDA) regulations 61-25 Citation 3-301.11, located at https://www.fda.gov/food/retail-food-protection/fda-food-code, revealed, Ready-to-eat food is food that does not require additional preparation before consumption. This includes raw, washed, and cut fruits and vegetables as well as foods that require no additional cooking, such as sandwiches, salads, and breads. Suitable utensils must be used when handling ready-to-eat foods. During an observation on 11/26/24 at 11:50 PM lunch, the menu included hamburgers, French fries, lettuce, tomatoes, and pudding, staff were assisting with preparing plates on the line, but they did not have gloves on. One staff was noted to be doing a second review of the plates to ensure the plate was correct before closing the dome. On at least three plates, the staff member adjusted the hamburger on the plate and touched French fries hanging over the plate before putting the dome on top. The staff member did not wear gloves. During an interview on 11/26/24 at 12:30 PM, the Dietary Manager (DM) stated staff were not required to wear gloves when checking the plate and placing the dome on top. When asked about touching ready-to-eat food, the DM stated that gloves were to be worn. The DM was informed of staff touching the hamburger and French fries. The DM stated the staff member should have had gloves on. During an interview on 11/26/24 at 4:52 PM, the Administrator and Director of Nursing (DON) stated staff should not be touching ready-to-eat food with their bare hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, record review, and interviews, the facility failed to 1.) complete wound care in a manner to prevent cross-contamination for one of four residents (Resident (R) 25) reviewed for pressure ulcers, 2.) and failed to administer medications in a manner to prevent cross-contamination for three of three residents (R50, R53, and R31) observed for medication administration out of a total sample of 25, and 3.) failed to complete yearly reviews of the facility's infection control policies and procedures. These failures had the potential for spreading infections to the vulnerable population in the facility. Findings include: 1. Review of R25's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses which included diabetes mellitus, asthma, and atrial fibrillation. Review of R25's admission Minimum Data Set (MDS) located under the MDS tab in the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 11/11/24 coded the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of R25's Physician Orders located under the Orders tab in the EMR revealed an order, dated 11/15/24, which revealed Daily wound Treatment: Location stage 4 [sic] wound on sacrum, cleanse with wound cleanser/NS [Normal Saline], apply Medi Honey with alginate calcium w [with] silver, cover w [sic] boarder gauze dressing. During a dressing change observation to R25's sacrum and interview on 11/25/24 at 2:45 PM, the Wound Care Nurse (WCN) was asked if R25 should have been in Enhanced Barrier Precautions (EBP). WCN stated, Yes, she should, but I don't see a sign on the door. When asked if WCN had been wearing her gown and gloves during the previous dressing changes and WCN stated, I have to be honest and tell you I have not been wearing a gown. I look to see if a sign is on the door for the Enhanced precautions and if I don't see one, then I don't wear a gown. During the observation, the overbed table was wiped down with a Sani Cloth and a barrier was applied directly after cleaning. The WCN did not wait for the dry time of the Sani Cloth to have occurred. R25 had bowel movement on the buttocks prior to the dressing change. The WCN, using a wipe, wiped the resident's bottom cleaning the bowel movement in an upward fashion toward the wound. When cleaning the wound with the wound cleanser, the WCN patted the wound dry several times using the same 4x4. The WCN opened the container of Medi Honey and applied this to alginate calcium with silver. The WCN proceeded to apply this to the wound with the same gloves as she had used to open the Medi Honey container that had been stored in the wound care cart with the other supplies used for other residents. During an interview on 11/25/24 at 3:10 PM, the WCN stated, I should have waited for the dry time before I placed the barrier down on the overbed table. WCN was asked the dry time of the Sani Cloth that was used and WCN replied, It is two minutes. WCN continued to state, I forgot, and I should have used a new 4x4 to dry the wound instead of patting it dry with the same one. I should have changed my gloves after I had opened the Medi Honey container before I dressed the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/24 at 10:21 AM, the Director of Nursing (DON) stated, I expect the wound care nurse to follow physician orders and standard of nursing which includes infection control for a dressing change. During an interview on 11/25/24 at 5:55 PM, the Infection Preventionist (IP) nurse stated, The nurse should wait for the total dry time after wiping down the overbed table prior to placing a barrier on the table. You should never clean a resident toward the wound, you should always go away from the wound. The nurse should have changed her gloves after she opened the container of Medi Honey up and did not use the same gloves that she opened to apply the clean bandage to the wound. 30260 2. During medication administration observation on 11/24/24 at 5:00 PM, Licensed Practical Nurse (LPN)6 prepared to administer a tube feeding for R50. R50 had an enhanced barrier precautions sign on her door, an infection control tool indicating a requirement for gowns and gloves during high-contact resident care activities to reduce the spread of multidrug-resistant organisms. LPN6 entered R50's room to set up tubing, syringe, and tube feeding using a pump. LPN6 performed hand hygiene, donned a pair of gloves, and checked R50's PEG (percutaneous endoscopic gastrostomy) tube was inserted through the abdomen wall and into the stomach to provide nutrition for residual and placement. LPN6 then administered the tube feeding to R50. LPN6 did not wear a gown during the high contact procedure with R50. At 5:37 PM, LPN6 finished administering R50's tube feeding and with the same pair of gloves used during the administration, she gathered the used supplies and trash and touched the room door with the gloved hand to take out the trash. LPN6 discarded the trash in the bin attached to her medication cart and returned to R50's room with the same gloves. LPN6 returned to R50's room at 5:38 PM and ungloved without performing hand hygiene. LPN6 collected the rest of her supplies from R50's room and returned to her medication cart. During an interview on 11/24/24 at 5:44 PM, LPN6 stated she was not sure what the enhanced barrier sign on R50's door was for. LPN6 stated the sign must be for the staff to use gowns when performing personal care for the resident but did not believe it applied to her because she used a clean technique, wore gloves, and controlled any splash with a towel. LPN6 stated during report she was not told R50 had any active infection. LPN6 stated she had received infection control training in the facility. When told she was observed donning gloves without hand hygiene and failing to perform hand hygiene after taking off her gloves, she acknowledged the hand hygiene breaches. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During observation of medication administration with LPN2 on 11/25/24 at 8:18 AM, while standing at the medication cart, LPN2 placed a pair of gloves in her pocket and performed hand hygiene. LPN2 entered R53's room. LPN2 left the room to retrieve a vital sign machine. LPN2 returned to the room with the vital sign machine in a pouch and placed the pouch on R53's bed. Without performing any further hand hygiene, LPN2 donned the gloves in her pocket. LPN2 performed vital signs. LPN2 administered eye drops for R53 with the same gloved hands. LPN2 touched drawers in R53's room looking for the lidocaine cream. Without taking off the gloves LPN2 opened the lidocaine cream and applied the cream on R53's right upper arm. LPN2 replaced the cap on the lidocaine cream and retrieved cling film from the drawers to wrap the lidocaine cream on R53's right upper arm. Finding it difficult to lift the film with a gloved hand, LPN2 took off just one glove from her right hand, placed the glove on the bedside table, removed the cling film, wrapped it on R53 right upper arm, and then put the same glove on. LPN2 returned to her medication cart, retrieved cleansing wipes and used it to clean the blood pressure machine before finally taking off the gloves and performing hand hygiene. During an interview on 11/25/24 at 8:35 AM when informed of the foregoing breaches in hand hygiene and infection prevention and the fact that she used only one pair of gloves the entire time she was in R53's room LPN2 acknowledged the hand hygiene breaches. 4. During medication observation and interview on 11/25/24 at 4:22 PM, LPN1 donned a pair of gloves without first performing hand hygiene to enter R50's room to perform a fingerstick glucose test. After the fingerstick, LPN1 left R50's room with gloves still on, carrying glucometer, retractable lancet, and used alcohol wipes. LPN1 discarded trash in her cart appropriately, ungloved, and returned to the bathroom of R50 to wash her hands. LPN1 withdrew an insulin pen (insulin lispro) from the medication cart that had no open and discard date on it and applied a needle to the pen without first cleaning the rubber septum of the pen. LPN1 applied a pair of gloves. LPN1 gave the medication to R50. LPN1 ungloved without performing hand hygiene. LPN1 returned to the medication cart in the hallway, touched the computer, mouse, cart, and keys in pocket, before moving on to the next resident. At 4:35 PM, LPN1 donned a pair of gloves without performing hand hygiene and went to perform a fingerstick blood test on R13. On 11/25/24 at 4:40 PM, LPN1 returned with a glucometer, and used supplies from R13's room, ungloved at the medication cart, failed to perform hand hygiene after ungloving, touching the cart, computer, and mouse. LPN1 stated at that point she needed to go back into R13's bathroom to wash her hands. When asked why she did not use the hand sanitizer on her medication cart instead of making the journey back into R13's bathroom, LPN1 stated I thought we had to wash our hands before using sanitizer. During an interview on 11/25/2 at 4:42 PM, LPN1 acknowledged the hand hygiene breaches. During an interview on 11/25/24 at 5:54 PM the IP stated enhanced barrier precautions meant that when a resident had a urinary catheter, central line, PEG tube or wounds, staff were to wear enhanced personal protective equipment (PPE), no exceptions. 5. During medication administration observation and interview on 11/26/24 at 8:13 AM, LPN4 entered R31's room without first performing hand hygiene and without donning gloves. LPN4 placed the medication on the bedside table of R31 with no barrier. LPN4 delivered the medication to R31 without gloves. On 11/26/24 at 8:47 AM, LPN4 exited R31's room without performing hand hygiene and returned the albuterol to the medication cart. During an interview, LPN4 acknowledged the foregoing infection control breaches. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON and the Administrator on 11/26/24 at 5:37 PM the DON stated it was her expectation that staff must perform hand hygiene before donning gloves, and after taking them off, should not touch anything in between to prevent cross contamination. The DON also stated that it was her expectation that staff performed hand hygiene before entering a patient's room, and after ungloving. The DON stated LPN6 should have adhered to the EBP sign and worn a gown when administering tube feeding to a resident with a PEG tube. She stated LPN2 should have performed appropriate hand hygiene and should not have reused gloves. The DON stated LPN1 should have performed appropriate hand hygiene and cleaned the rubber septum of the insulin pen before use andLPN4 should have performed hand hygiene and used gloves when administering the albuterol. 6. Review of the facility's infection control policies and procedures, provided by the facility, revealed the revision or review of the policies that occurred on 07/20/23. During an interview on 11/25/24 at 10:30 AM, the DON stated, We had several revisions of the infection control policies last year. After reviewing the dates provided to me, the DON stated, These should have been reviewed in July of this year and it wasn't. During an interview on 11/26/24 at 3:15 PM, the Administrator stated, Then these (policies) weren't reviewed annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425175	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Physical Rehabilitation and Wellness Center of Spa	8020 White Avenue Spartanburg, SC 29303

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review, interviews, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer or provide documentation of consent or refusal for two of five residents (Residents (R) 25 and R37) and/or their representatives the opportunity for the residents to receive flu and/or pneumonia vaccines out of 25 sample residents. This failure had the potential to put these residents at more risk of developing flu and pneumonia. Findings include: Review of CDC website titled, Pneumococcal Vaccination: Summary of Who and When to Vaccinate, located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html, last reviewed 09/12/24, indicated .CDC recommends pneumococcal vaccination for all adults [AGE] years or older. The tables below provide detailed information . For adults [AGE] years or older who have not previously received any pneumococcal vaccine, CDC recommends you .Give one dose of PCV20 [pneumococcal conjugate vaccines] or PCV21 . If PCV15 is used, this should be followed by a dose of PPSV23 [pneumococcal polysaccharide vaccine] at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak .If PCV20 or PCV21 is used, Give a dose of PCV15 at least one year later .For adults [AGE] years or older who have only received a PPSV23, CDC recommends you .May give one dose of PCV20 or PCV21 .The PCV20 or PCV15 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults [AGE] years or older who have only received PCV13, CDC recommends you .Give PPSV23 as previously recommended For adults who have received PCV13, Give one dose of PCV20 or PCV21 or PPSV23 to be administered at least a year later . If PCV20 and PCV21 are used, their pneumococcal vaccinations are complete . 1.Review of R25's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] and was currently over [AGE] years old. Review of R25's Immunizations located under the Preventative Health tab of the EMR revealed there was no documentation of administration or refusal of the flu or pneumococcal vaccine for R25. 2. Review of R37's undated Face Sheet located under the Face Sheet tab in the EMR revealed the resident was admitted to the facility on [DATE] and was currently over [AGE] years old. Review of R37's Immunizations located under the Preventative Health tab in the EMR revealed the resident received one dose of PPSV 23 on 01/12/13. There was no documentation of further administration or refusal of any pneumococcal vaccine for R37. During an interview on 11/26/24 at 5:12 PM, the Infection Preventionist (IP) nurse stated, It would be up to me to keep up with. I wasn't aware we were not meeting this for the vaccinations. During an interview on 11/26/24 at 6:00 PM, the Director of Nursing (DON) stated, The IP nurse is responsible for the vaccinations.

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	425175	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Physical Rehabilitation and Wellness Center of Spa	8020 White Avenue Spartanburg, SC 29303

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on observation and interviews, the facility failed to ensure a safe, functional, sanitary, and comfortable environment which included clean baseboards in the hallways, clean mats in the kitchen, and clean and well repaired resident rooms for two of two residents (Resident (R) 124 and R209) reviewed for environment out of a total sample of 25. This failure could place residents and visitors in uncomfortable and unsanitary conditions. Findings include: During an observation on 11/24/24 at 12:27 PM, walking through the hallways, the baseboard had a build-up of dirt and debris in the hallways. The door to room [ROOM NUMBER] was chipped, with missing pieces of wood. During observations on 11/24/24 at 1:03 PM of R124's room, an area on the wall appeared to bepatched with a piece of sheet rock and some white paint. During observations on 11/24/24 at 2:34 PM of R209's room, the floor was sticky, and there was a thick buildup of dirt and debris on the baseboard. Some of the buildup was easily wiped away. During an observation of the kitchen on 11/26/24 at 12:00 PM, the mats on the floor were dirty with grime build-up. Between the holes of the mats were thick layers of grime build-up. During an observation and interview on 11/26/24 at 1:26 PM with the Administrator, Housekeeping Director (HSKP1), and Maintenance Director (MD), the Administrator revealed he was not sure the last time the floors were stripped and cleaned. He stated painting would be a part of a special project that the facility was getting ready to implement. HSKP1 indicated that a routine cleaning schedule was followed and that deep cleaning was completed in one to two rooms a day. She stated staff started at the ceiling and worked their way down. HSKP1 stated all the furniture was wiped down. The MD stated someone had been hired to help with special projects like painting, stripping, and waxing the floors.