STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425176	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Nursing Center	105 Medford Drive Darlington, SC 29532

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 - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, and record review, the facility failed to provide continuous oxygen therapy for one (Resident (R)62) of one resident reviewed for respiratory. This failure could potentially cause R62's condition to exacerbate. Findings include: Review of R62's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 12/18/24, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE] and had a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicating moderate cognition impairment. R62 had diagnoses of acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, shortness of breath, wheezing, and received oxygen therapy. Review of R62's order, dated 09/10/24, located in the EMR under the Order tab revealed Oxygen: Oxygen at 2L[liter]/mins[minutes] via NC[nasal cannula] continuously, every shift. Review of R62's care plan, revised 01/13/24, located in the EMR under the Care Plan, revealed The resident has risk for altered respiratory status/difficulty breathing r/t [related to] dx [diagnosis] of Respiratory Failure with oxygen dependence. Hx [history] of COVID-19, hx of pneumonia. An intervention included Administer oxygen as ordered. Assist resident with positioning nasal cannula as tolerated. On 02/06/25 at 10:42 AM, R62's door was closed, and a green dot was noted on the door frame. The surveyor knocked on the door and did not receive a response. The door was opened, and Certified Nurse Aide (CNA)1 was observed at R62's bedside performing personal care. After care was completed on 02/06/25 at 10:54 AM, R62 was observed laying on her back with the bed flat with no pillow or blanket and R62 asking for her oxygen. R62 then pointed to her nasal cannula out of R62's reach that was located on the right side of the bed. During an interview on 02/06/25 at 10:56 AM, CNA1 was informed R62 was requesting her oxygen via the nasal cannula. CNA1 stated when she gets R62 in the wheelchair R62 will put in on. (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 - Few	On 02/06/25 at 1:18 PM, R62 was in her room in the wheelchair eating lunch and wearing a nasal cannula. R62 was in no distress. R62 was asked if she had her oxygen on when CNA1 was providing incontinent care earlier that morning. R62 stated, No, CNA1 took it off. R62 was asked if she took it off and R62 stated, No the CNA did. R62 was asked if she was okay with the oxygen being off during her personal care and R62 stated, No, she would rather have it on. R62 stated some girls keep it on and some take it off, but she would rather have it on as it makes her feel better. During a follow up interview on 02/06/25 at 1:23 PM, CNA1 confirmed she took R62's nasal cannula off during incontinent care because R62 gets moved back and forth and CNA1 didn't want to tug on the tubing. CNA1 was asked why the oxygen wasn't put back on R62 after she had completed her incontinent care and R62 was laying on the bed waiting for CNA1 to retrieve the mechanical left and to transfer her into the wheelchair as 18 minutes had passed without oxygen. CNA1 did not comment. During an interview on 02/06/25 at 1:31 PM, the Director of Nursing (DON) was asked about CNA1 taking off R62's oxygen nasal cannula during incontinent care and what her expectation was. The DON stated, CNA1 should have kept it on during care unless R62 takes it off or refuses, but R62 didn't. The DON stated an oxygen policy would be provided. At the time of the exit, no policy was provided.

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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 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** 36190 Based on observation, interview, and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP) while performing incontinent care for one (Resident (R)62) of two residents reviewed for infection control. This deficient practice could potentially lead to increased risk of infection and complications for R62 with an open gastrostomy stoma. Findings include: Review of the facility policy titled Enhanced Barrier Precautions, revised 03/24, provided by the facility revealed It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that use targeted gown and gloves during high contact resident care activities. b. PPE [personal protection equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include: .d. Providing hygiene . f. Changing briefs or assisting with toileting. Review of R62's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 12/18/24, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE] and had a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicating moderate cognition impairment, was incontinent of bowel and bladder, and had diagnoses of dementia, gastrostomy status, and cutaneous abscess of abdominal wall. Review of R62's order, dated 02/05/25, located in the EMR under the Order tab revealed Enhanced Barrier Precautions every shift related to Encounter for Attention to Gastrostomy; Encounter for Prophylactic Measures, unspecified. Review of R62's care plan, revised 08/16/24, located in the EMR under the Care Plan tab revealed The resident requires assistance with ADLs [activities of daily living] related to dx [diagnoses] of AFIB [atrial fibrillation], dementia, HTN [hypertension], DM [diabetes mellitus], malnutrition, dysphagia, PEG [percutaneous endoscopic gastrostomy] tube placement, and limited mobility. An intervention included Enhanced Barrier Precautions. On 02/06/25 at 10:42 AM, R62's door was closed, and a green dot was noted on the door frame. The surveyor knocked on the door and did not receive a response. The door was opened, and Certified Nurse Aide (CNA)1 was observed at R62's bedside performing personal care without wearing the appropriate gown. On 02/06/25 at 10:52 AM, CNA1 was observed leaving R62's room. CNA1 was asked if she was supposed to wear PPE while providing personal care for R62. CNA1 stated, Yes, and confirmed she did not have a gown on and the green dot on R62's door meant Enhanced Barrier Protection (EBP). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/25 at 11:31 AM, the Infection Preventionist (IP) was asked if R62 was under EBP. The IP stated, Yes, and R62 had the green dot on her door that identified to staff R62 was under EBP. The IP stated R62 was under EBP due to R62's gastrostomy site being still open. The IP stated once the site was closed, the EBP would be removed. The IP was asked should the nurse aides wear PPE during R62's personal care. The IP stated, Yes. The IP was informed CNA1 did not utilize PPE during R62's incontinent care on 02/06/25 at 10:42 AM. The IP stated maybe CNA1 was confused about the EBP and thought it wasn't necessary. The IP was informed CNA1 confirmed she did not use PPE but should have. The IP stated that more education was necessary. During an interview on 02/06/25 at 1:27 PM, the Director of Nursing (DON) was asked about CNA1 not wearing PPE during R62's incontinent care and what her expectation was. The DON stated CNAs should wear PPE and they have been educated on it.