STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425293	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgefield Post-Acute	226 WA Reel Drive Edgefield, SC 29824

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to maintain food service equipment and food storage areas in a clean and sanitary condition and failed to ensure sanitizing solutions were maintained at an effective concentration. Specifically, the facility failed to maintain kitchen equipment (including walk in refrigerators and freezers, reach in refrigerators, ice machine, handwashing sinks, and dish room drainage) in good repair and free from rust, mold, food debris, and leaks; and failed to ensure sanitizers were maintained at appropriate concentrations for effective sanitation. These deficient practices had the potential to affect 100 of 104 residents (excluding four residents on tube feedings) and had the potential to result in food contamination and foodborne illness.Findings include:Review of the facility's undated policy titled Sanitization . All . equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair. 3. All equipment, food contact surfaces . are cleaned and sanitized using heat or chemical sanitizing solutions. 9. Service area wiping cloths are drained, cleaned, and sanitized per manufactures instructions. 10. Ice machines and ice storage containers are drained, cleaned, and sanitized per manufactures instructions .During an initial kitchen tour on 04/15/26 at 8:53 AM, revealed the handwashing sink in the kitchen lacked a nearby trash receptacle for paper towels, requiring staff to walk across the cooking area to dispose of dirty paper towels after handwashing.During observation on 04/15/26 at 9:02 AM, the walkˆin refrigerator floor was observed to be rusted due to a leaking drainpipe from the cooling unit. The rusted area measured approximately five feet by six feet. The threshold into the walkˆin refrigerator was loose, and the floor surface was uneven with a noticeable dip.During an observation on 04/15/26 at 9:02 AM, the second reachˆin refrigerator (Traulsen brand) had multiple red, pink, and brown food debris stains on the bottom interior surface.A followˆup observation on 04/16/26 at 11:41 AM, with the Dietary Manager (DM) and Certified Dietary Manager (CDM), confirmed the food debris remained and had not been cleaned.During an observation on 04/15/26 at 9:05 AM, the reachˆin ice machine was observed to have rust measuring approximately eight inches along the door hinge. Continued observation confirmed the ice machine remained in use.During an observation on 04/15/26 at 9:08 AM, the walkˆin freezer door and surrounding surfaces were observed to have a splotchy gray substance on both sides of the door, extending from ceiling to floor. The substance measured approximately two feet wide at the bottom narrowing to six inches at the top on the left side, three feet on the right side, and 36 inches across the base of the door.During an observation on 04/15/26 at 9:14 AM, dish machine logs reflected quaternary ammonium sanitizer readings of 100 parts per million (PPM) (standard for sanitation is 200 PPM). At the same time, the dish room sink drain was observed backing up with soap suds measuring approximately two feet wide, one foot long, and three inches deep due to improper drain placement.During an observation of sanitizer buckets on 04/15/26, the DM tested the sanitizer concentration using test strips and obtained a reading of 100 PPM, which the DM indicated was not sufficient for proper sanitation.During an interview on 04/15/26 at 9:19 AM., Dietary Aide 1 stated, I don't know what the chemical concentration should be. I'm new. I've been here two weeks.During an (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview on 04/16/26 at 11:23 AM, the CDM stated the gray substance in the walk-in freezer was mold and had been present since I've been here, approximately 12 years. The CDM further stated the rusted and deteriorated freezer flooring could contaminate food. The CDM concluded sanitizer buckets should be changed every two hours and that dish room sanitizer should be maintained at 100-200 PPM, with 200 PPM being the expected effective concentration.During an interview on 04/17/26 at 9:25 AM, the Minimum Data Set Coordinator (MDSC)1 (acting in the capacity of Director of Nursing) declined to comment when asked about the expectation for continuing use of the rustˆaffected ice machine.During an interview on 04/17/26 at 10:45 AM, the Administrator stated the rusty ice machine should not be used because it could cause illness. The Administrator confirmed the replacement door was approved on 04/13/26, and repairs to the leaking drainpipe were made after being brought to attention during the survey. The Administrator further stated he was aware that the dish room drainpipe did not properly align with the floor drain and had been aware of the issue previously, stating staff would sometimes kick the pipe out of place.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain resident rooms and bathrooms in good repair for 5 of 49 resident rooms sampled, (Rooms 129, 200/203, 225, 227, and 224/226). These failures included damaged air conditioning units, chipped and broken furniture, cracked drywall, bathroom fixtures in disrepair, and lack of a formal maintenance system. This resulted in an environment that was not consistently safe or wellˆmaintained.1. During an observation on 04/15/26 at 10:51 AM, of room [ROOM NUMBER] revealed the air conditioning unit was broken, the controller was filled with dust, and the metal cover was rusted and falling off with paint flecking. The footboard of the resident's bed had chipped Formica (a durable, heat-resistant composite material made from layers of [NAME] paper impregnated with melamine resin and hardened under high pressure) with exposed particle board. The armoire had chipped surfaces on the top drawer and corner with exposed particle board, and the bottom drawer was chipped approximately one foot long by four inches high, creating rough and damaged surfaces in the resident room.2. During observations on 04/15/26 at 8:51AM until 11:45AM revealed the following:room [ROOM NUMBER] - When entering the bathroom from this room, three floor tiles were broken.room [ROOM NUMBER] - The bathroom floor tiles around the wall near the toilet were cracked and missing pieces of the tiles.room [ROOM NUMBER] - The drywall was cracked above the air conditioning unit. The drywall was cracked around the sink in the bathroom.room [ROOM NUMBER] - In the bathroom, the drywall was damaged around the toilet and the wall across from the toilet was gouged.Rooms 223/225 - In the shared bathroom, the drywall was cracked behind the toilet.Rooms 224/226 - In the shared bathroom, the room smelled of urine, and the sink was scraped along the edges.During an interview on 04/17/26 at 11:08 AM, the Maintenance Director (MD) stated that the air conditioning unit in room [ROOM NUMBER] would require full replacement and indicated that he was not aware of the damage in the room. The MD stated, I need to replace the whole air conditioning unit, and no one told me about the damage in the room.During an interview on 04/17/26 at 10:46 AM, the MD stated that the cracked linoleum needed caulking in the bathroom between rooms 200/203 and he would enter the maintenance request in TELS (a computerized maintenance repair log system) and stated he didn't know about the damage to the door edge. During an interview on 04/17/26 at 10:49 AM, the MD stated that in room [ROOM NUMBER], he was unaware there was cracked drywall above the air conditioner and unaware that in the bathroom of room [ROOM NUMBER] the drywall was cracked around the sink. The MD said it needs clean and repainted and put the repair need into TELS now. The MD they have been on the bathroom since the first of the week, but the cracked drywall around the sink was never addressed. During an interview on 04/17/26 at 10:51 AM, the MD stated that in the bathroom of room [ROOM NUMBER], he was unaware the drywall around the sink was cracked and needed repaired. The MD put the damaged environment into the TELS program. During an interview on 04/17/26 at 10:52 AM, MD stated that the bathrooms between room [ROOM NUMBER] and 226 needed the sink replaced due to the sink was scratched. The MD said he would put the repair need into TELS to replace the sink.In a subsequent interview on 04/17/26 at 10:56 AM, the MD stated that staff could enter maintenance concerns into the TELS system. He stated that he attempted to perform room rounds approximately once per month, primarily to change light bulbs, and acknowledged that he did not have a policy for routine maintenance or repairs, stating the issues observed were items he never would have noticed.

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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** Based on observation, interview, and facility policy review, the facility failed to promote and maintain dignity during dining services for 3 of 21 Residents (R)61, R33, and R37, reviewed who ate in the Main Dining Room. This failure resulted in residents experiencing prolonged waits for meals and being assisted in a manner that did not preserve dignity.Findings include:Review of the facility policy titled, Assistance with Meals revealed, . Facility staff will serve resident trays and will help residents who require assistance with eating. 3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals; . c. avoiding the use of labels when referring to residents (e.g., feeders) .During an observation on 04/15/26 at 11:56 AM, R33 and R37 were brought to the dining room and placed at a table together. They were not provided their meal trays. Staff served the other 19 residents, while R33 and R37 remained without food. At 12:45 PM, R33 was moved to a different table, provided a meal tray, and was assisted with his meal. At 12:50 PM, R37 was moved to a different table and assisted with his meal. During an observation on 04/15/26 at 12:27 PM, the Infection Preventionist (IP) was observed standing while assisting R61 with his meal. The IP fed the resident from a bowl while standing beside him and telling him, You don't have to be afraid. There was an empty chair next to the resident. Review of R33's admission Record found under the Profile tab of the electronic health record (EMR) revealed R33 was admitted on [DATE], with diagnoses including but not limited to, convulsions, intellectual disabilities, legal blindness, aphasia, hearing loss, cataract, protein-calorie malnutrition, dysphagia, oral phase, cognitive communication deficit and type 2 diabetes mellitus. Review of R33's Quarterly Minimum Data Set (MDS) found under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 04/08/26, revealed R33 was dependent for eating (meaning helper does all of the effort to complete the activity). Review of R33's Care Plan, revealed R33 requires staff assist with Activities of Daily Living (ADL) and mobility due to cognitive, communication, and physical impairments and the goal was to assist resident with all meals and snacks. Review of R37's admission Profile found under the Profile tab of the EMR revealed R37 was admitted on [DATE] with diagnoses including but not limited to, anemia, hip fracture, non-Alzheimer's dementia, seizure disorder, and malnutrition. Review of R37's Quarterly MDS found under the MDS tab of the EMR with an ARD of 01/16/26, revealed his Brief Interview for Mental Status (BIMS) score was coded as 99 indicating R37 was unable to answer the questions and the staff assessment had to be completed. R37 had short-term and long-term memory loss and severely impaired decision-making skills - never/rarely made decisions and was dependent on staff for eating (meaning Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity.) During an interview on 04/15/26 at 12:53 PM, the IP stated, They [R33 and R37] are feeders and we serve them last. The IP further explained that usually there wasn't another Certified Nursing Assistant (CNA) available, so residents did not have to wait as long. The IP stated staff should sit down while assisting residents with meals.During an interview on 04/17/26 at 12:00 PM, the Minimum Data Set Coordinator (MDSC)1 confirmed that staff should sit while assisting residents with meals.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were not left at the bedside for a resident who was not assessed as able to self-administer medications, for 1 of 1 Resident (R)11. This failure placed the resident at risk for unsafe medication use and improper self administration.Findings include:Review of the facility policy titled Self-Administration of Medications revealed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 3. If it is deemed safe and appropriate for the resident to self-administer medications, this is documented in the medical record and the care plan . 8. Self-administered medications are stored in a safe and secured place, which is not accessible by other residents. 9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge.Review of the admission Record located in the electronic medical record (EMR) under the Profile tab revealed R11 was admitted on [DATE], with diagnoses including but not limited to, dependence on respirator [ventilator] status, tracheostomy status, type 2 diabetes mellitus without complications, morbid (severe) obesity with alveolar hypoventilation, anxiety disorder, obesity, class 3, anemia in chronic kidney disease, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, dyskinesia of esophagus, chronic kidney disease, stage 3a, and mood disorder due to known physiological condition with manic features.Review of R11's Quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date of 04/13/26, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R11 was cognitively intact. Further review of the MDS revealed R11 was taking antibiotics.Review of R11's Care Plans section of the EMR revealed there were no care plans related to R11's ability to self-administer medications and did not state resident was on antibiotics.Review of R11's Physician Orders located in the EMR under the Orders revealed no physician orders authorizing self^administration of medications and no physician orders allowing medications to be kept at the bedside.Review of R11's Assessments tab did not reveal any assessments evaluating the resident's ability to safely self^administer medications.During an observation and interview on 04/16/26 at 4:07 PM, Azithromycin (macrolide antibiotic effective against bacterial infections) was observed stored in a three^drawer plastic container in R11's room. At 4:10 PM, R11 stated the facility had not organized her tracheostomy supplies since she moved in the prior year. During this time, the resident displayed a blood glucose glucometer kept on her bed, indicating she was conducting blood sugar testing independently. R11 stated the Azithromycin was with her trach supplies since she moved in on 04/15/25 and the doctor at home had her testing her blood sugar and that was her meter from home. During an observation and interview with Licensed Practical Nurse (LPN)7 on 04/16/26 at 4:28 PM, a box of Azithromycin 250 mg tablets, labeled with directions to take twice daily for four days from CVS, was found in the bottom drawer of R11's tracheostomy supply container. LPN7 stated the medication was not supposed to be kept at the bedside. A few minutes later, the resident again presented her blood glucose monitor kept at the bedside. LPN7 stated the resident should not have a glucometer on her bed or bedside table and that it should not be kept in the room.Despite identifying the medication as unauthorized, at 4:45 PM on 04/16/26, LPN7 left the CVS medication in the resident's room.During an observation with LPN6 on 04/17/26 at 8:47 AM, revealed a personal^use blood glucose glucometer was located in the R11's room. LPN6 stated the resident was not allowed to have the device in her room or self^administer blood sugar testing.During an interview on 04/17/26 at 8:47 AM, LPN6 verified there was no physician order for R11 to keep medications at the bedside or to (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self^administer medications. LPN6 stated she was unaware of the resident being authorized to have medications in her room, or assessed to have medications at the bedsideDuring an interview on 04/17/26 at 8:48 AM, LPN6 stated that if staff find medications in a resident's room, the medication should be removed, verified, and not left at the bedside. She added that staff would need to determine whether a resident is appropriate for self^administration before allowing medications in the room.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, record review, and facility policy review, the facility failed to ensure that 1 of 1 resident (Resident (R)85), reviewed for restraints out of a total sample of 49, was properly assessed for the use of positioning devices (pillows used as a restraint) intended to reduce the risk of rolling, crawling, or falling out of bed. In addition, the facility failed to ensure that informed consent was obtained and documented for the use of a chair alarm. (Cross Reference F684 and F689) Findings include:Review of a facility policy titled, Use of Restraints dated 12/2007, indicated, . Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls . 'Physical Restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body . The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition . and this restricts his/her typical ability to change position or place, that device is considered a restraint . Restraints may only be used when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restrain is required to . Treat the medical symptom . Protect the resident's safety; and . Help the resident attain the highest level of his/her physical or psychological well-being . Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following . The specific reason for the restraint (as it relates to the resident's medical symptom) . How the restraint will be used to benefit the resident's medical symptom; and . The type of restraint, and period of time for the use of the restraint Review of R85's electronic medical record (EMR) titled admission Record, located under the Profile, indicated that the facility admitted the resident on 01/20/26, with a diagnosis including but not limited to, Alzheimer's disease. Further review revealed R85 was receiving hospice services.Review of R85's EMR titled admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/27/26 and located under the MDS tab, indicated the staff could not determine the resident's Brief Interview for Mental Status (BIMS) score. The assessment indicated that the resident was able to ambulate with supervision or touching of staff. The assessment revealed that she was totally dependent on staff for all activities of daily living. The assessment indicated that the facility used no restraints with R85, including a chair alarm. Review of R85's EMR titled, Care Plan, located under the Care Plan tab and dated 01/20/26, revealed the resident was care planned for being at risk for falls due to a history of falls and crawling out bed. In addition, the resident's care plan identified that the resident was at risk for psycho-social behaviors of crawling out of bed, disrobing, and combativeness with staff, all related to her diagnosis of dementia. Review of R85's EMR titled, Progress Notes, located under the Prog (Progress) Note tab, failed to contain evidence of informed consent for the use of a chair alarm. Review of R85's EMR titled physician Orders, located under the Orders tab, failed to contain an order for an assessment authorizing the use of positioning devices that could restrict the resident's movement, nor was there an order for a chair alarm. During an observation on 04/16/26 at 10:44 AM, R85 was in bed, and her bed was in a low position. During this observation, an interview was conducted with Restorative Nurse Aide (RNA)1 who stated there were times that the resident would dangle her legs off the bed. During an observation and interview on 04/16/26 at 4:22 PM, Licensed Practical Nurse (LPN)1/Unit Manager for Peach entered R85's room. LPN1 stated that the resident would attempt to roll out of bed. During this interview, the resident was observed in bed. There was a pillow on the left side of her head, positioned under the flat sheet. Observed another pillow on the left side of the bed under the flat (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheet positioned on the side of the resident's feet. The bed faced the resident's door. LPN1 confirmed the positioning of the pillows and stated that the facility did not use side rails, and the pillows were not restraints. LPN1 stated that there was currently no bed alarm for the resident since the resident would destroy the bed alarm. LPN1 stated that the resident used a chair alarm currently. Observed the chair alarm attached to the back of the resident's wheelchair during this interview. LPN1 stated that the resident did attempt to roll out of bed. LPN1 confirmed the pillows located under the flat sheet were not directly under the resident and prevented the resident from rolling or falling out of bed. During an interview on 04/16/26 at 4:34 PM, Certified Nurse Aide (CNA)1 stated that R85 did try to roll out of bed, and the pillows were placed under the flat sheet to prevent the resident from rolling out. CNA1 confirmed the chair alarm was placed on the resident's wheelchair to prevent the resident from getting out of her wheelchair. CNA1 stated that the resident could walk but was not to walk. Observed the resident in bed and her legs were dangling off the side of her bed. During an observation on 04/16/26 at 5:16 PM, R85 had two pillows under the flat sheet.During an interview on 04/17/26 at 8:21 AM, Registered Nurse (RN)1, who was a hospice nurse, stated that hospice did not provide the facility with a chair alarm for R85.During an interview on 04/17/26 at 8:40 AM, MDS Coordinator (MDSC)2, who was the acting Director of Nursing (DON), and Regional Director of Clinical Services, stated a restraint was a device that a resident cannot easily remove. A request was made for informed consent for the use of positioning pillows and a chair alarm, and this was not provided by the end of the survey.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure 1 of 3 residents (Resident (R)12) and their resident representatives (RR), reviewed for emergent hospital transfer out of a total sample of 49 residents, were provided with a written bed hold policy and transfer notice that contained the appeal process. This failure had the potential to affect the resident and their RR by not having the knowledge of how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following hospitalization for residents transferred to the hospital.Findings include:Review of R12's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE]. Review of R12's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/06/26, and located under the MDS tab of the EMR, revealed R12 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated R12 was cognitively intact.Review of R12's Progress Note, dated 01/17/26 and located under the Progress Note tab of the EMR, revealed R12 had a change in condition. An order was received to send the resident to the hospital for urgent evaluation and treatment. Review of R12's Notice of Proposed Transfer/Discharge, dated 01/19/25 and provided by the facility, revealed that the document did not include the appeal process or entity information that handled appeals. During an interview on 04/17/26 at 1:55 PM, the Social Services Director (SSD) stated she was unsure which agency handled appeals, but she believed it was in [NAME], SC. She was unaware the facility transfer form did not include this information. She stated she just used the form that was provided by their corporate office. During an interview on 04/17/2026 at 8:46 AM, Minimum Data Set Coordinator (MDSC)1 (in DON absence) stated she was unsure of the process and did not comment but stated she expected the facility to be in compliance with regulations.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure 2 of 2 residents (Resident (R)94 and R109) out of 49 sampled residents, had an accurate Minimum Data Set (MDS) assessment. Failure to code the MDS correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment of the residents.(Cross Reference F883) Findings include:Review of the CDC website titled, PneumoRecs VaxAdvisor App (Application) for Vaccine Providers, dated 01/09/25, indicated . Give one dose of PCV15, PCV20, or PCV21 at least 1 year after the last does of PPSV23. Regardless of which vaccine is used . their pneumococcal series is complete Review of the RAI manual, dated 10/2024 and located in the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual by CMS, revealed, . It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment .1. Review of R94's electronic medical records (EMR) titled, admission Record, located under the Profile tab, indicated that the facility admitted the resident on 11/30/21. Review of R94's EMR titled quarterly MDS, with an Assessment Reference Date (ARD) of 03/24/26 and located under the MDS tab, indicated that the resident was up to date on her pneumococcal vaccine.Review of R94's EMR titled, Immunizations, located under the Immun (Immunization) tab, indicated the resident received Pneumovax 23 (PPSV23) on 12/03/21. There was no evidence that the resident or her representative was offered the PCV20 or the PCV21 vaccine. 2. Review of R109's EMR titled, admission Record, located under the Profile tab, indicated that the facility admitted the resident to the facility on [DATE]. Review of R109's EMR titled quarterly MDS, with an ARD of 04/02/26 and located under the MDS tab, indicated that the resident was up to date on her pneumococcal vaccine. Review of R109's EMR titled, Immunizations, located under the Immun tab, indicated the resident received PPSV23 on 10/06/22. There was no evidence that the resident or her representative was offered the PCV20 or the PCV21 vaccine. During an interview on 04/17/26 at 8:40 AM, the MDS Coordinator (MDSC)2, who was also the acting Director of Nursing (DON), and the Regional Director of Clinical Services (RDCS) stated that they were unaware of the updated CDC requirements for the pneumococcal vaccines and confirmed that the MDS assessments for R94 and R109 were inaccurate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to: 1. Ensure neurological checks were conducted as ordered by the medical provider after 1 of 2 residents (Resident (R)85) reviewed for falls, was found on the floor crawling (a potential unwitnessed fall) out of a survey sample of 49. This failure to complete neurological checks placed the resident at risk for potential neurological decline; 2.) Follow the facility's policy regarding the assessment and documentation of open areas for 1 of 1 resident (R9) reviewed for open skin areas in the sample of 49 residents. The failure to accurately assess and document the resident's open areas as indicated in the facility's policy had the potential to affect the notification of the provider for treatment when the open areas size increased or the areas showed signs of infection; and 3.) Ensure proper positioning and use of an assistive seating device for 1 of 1 resident (R33). Specifically, the facility failed to ensure the resident's Broda chair (A Broda Chair is a specialized wheelchair designed to provide advanced comfort, support, and safety for individuals with complex mobility or positioning needs) was consistently set up and used according to safe positioning principles. This failure placed the resident at risk for improper positioning, loss of postural support, and potential injury.Findings include:1. Review of a facility policy titled, Neurological Assessment (Routine), dated 10/2023, indicated, . The purpose of this procedure is to provide guidelines for conducting a routine neurological assessment . There was no evidence in the policy that addressed how to monitor a resident after an unwitnessed fall. Review of R85's electronic medical record (EMR) titled admission Record, located under the Profile tab, indicated that the facility admitted the resident on 01/20/26.Review of R85's EMR titled admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/27/26 and located under the MDS tab, indicated that the staff could not determine a Brief Interview for Mental Status (BIMS) score. The assessment indicated that the resident could walk with supervision or touch assistance. The assessment revealed that the resident had a history of falls.Review of R85's EMR titled Care Plan, located under the Care Plan tab and dated 01/20/26, indicated that the resident was at risk for falls. The care plan identified that the resident had a history of crawling on the floor.Review of R85's EMR titled Care Plan, located under the Care Plan tab and dated 01/21/26, indicated that the resident was at risk for psychosocial behaviors of crawling out of bed.Review of R85's EMR titled nursing Progress Notes, located under the Prog (Progress) Note tab and dated 01/22/26, indicated that a nurse was called into the resident's room. The resident was found crawling on the floor (a potential unwitnessed fall) towards the door. The nurse assessed the resident, and the resident sustained no injuries.Review of R85's EMR titled Nurse Practitioner (NP)2 Progress Notes, located under the Prog Note tab and dated 01/22/26, revealed that NP2 was notified of an unwitnessed fall sustained by the resident. NP2 noted that the resident sustained no injuries but directed the staff to conduct neurological checks per facility protocol.Review of R85's EMR titled Physician Orders, located under the Misc (Miscellaneous) tab and dated 01/22/26, revealed, . Neuro checks with VS [vital signs] s/p [status post] fall as follows: q [every] 15min [minutes] x [times] 1 hours, q30 min x 1 hour, hourly x 4 hours, q4h x 24 hours. Notify a clinician of any change in condition . There was no evidence in the clinical record that showed the clinical staff implemented the medical provider's orders.During an interview conducted on 04/17/26 12:25 PM, the Administrator stated that if NP2 ordered neurological checks then the staff should have completed them.During an interview conducted on 04/17/26 at 1:39 PM, the MDS Coordinator (MDSC)2, who was also the acting Director of Nursing (DON), stated that the staff more than likely did not complete the neurological checks since R85 had the behavior of crawling on the floor. MDSC2 stated it was important to do neurological checks after an unwitnessed fall since the facility wanted to monitor the resident's condition.2. Review of the facility's policy titled, Wound Care, dated 2001, indicated, . The following information should be recorded I [sic] the resident's medical record . 6. All assessment data (i.e., (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound bed color, size, drainage, obtained when inspecting the wound.Review of the facility's policy titled, Skin Assessment: Best Practice, provided by the MDSC, indicated, Assessment of a resident's skin condition helps define prevention strategies . use the following guidelines: . Weekly skin Assessment, a weekly skin assessment is completed once a week and describes the current condition of the patient's skin.Review of R9's Face Sheet, under the Profile tab, revealed an admission date of 03/06/26, with diagnoses including but not limited to, uropathy, chronic kidney disease, urinary tract infection (UTI), and retention of urine.Review of the EMR Care Plan, under the Care Plan tab, revealed, Skin Risk Resident is at risk for skin breakdown related to Cardiovascular disease, Chronic Obstructive Pulmonary Disease (COPD), cognitive Impairment, Dementia, Diabetes, impaired ADL ability, impaired mobility, incontinence of Bowel Redness to sacrum present on readmission to facility . Revision on: 03/10/26 with intervention of administer treatment as ordered.Review of R9's admission MDS, with an ARD of 03/13/26 and located under the MDS tab of the EMR, revealed R9 had a BIMS score of 7 out of 15, which indicated R9's cognition was severely impaired. The MDS indicated that R9 had no Pressure ulcers (PURs).During an observation on 04/17/26 at 9:24 AM, Licensed Practical Nurse (LPN)1 performed a treatment to R9's sacral area. The left buttock had one open area, and the right buttock had one scabbed area. The sacral area had extremely red/purple excoriation.Review of R9's Nursing Comprehensive Skin Evaluation/Assessment, dated 03/06/26, provided by Medical Records (MR) revealed, skin warm, discoloration to buttocks . coccyx area few small open areas.Review of R9's Nursing Comprehensive Skin Evaluation/Assessment, dated 03/16/26, provided by MR indicated, skin warm, discoloration to buttocks . coccyx area few small open areas.Review of R9's Nursing Comprehensive Skin Evaluation/Assessment, dated 03/23/26, provided by MR indicated, skin warm, discoloration to buttocks . coccyx area few small open areas.Review of R9's EMR Skin Notes in Progress Notes under the Progress Notes tab, dated 03/24/26, indicated, Resident observed with large open area (no measurements) to sacral area, area observed as pink and red and actively bleeding .Review of the Skin Notes dated 03/25/26 indicated, writer assessed sacral region . there were open areas (no measurements or indication how many open areas), sacral area is excoriated .Review of R9's Nursing Comprehensive Skin Evaluation/Assessment, dated 03/30/26 provided by MR, indicated, skin warm, discoloration to buttocks . coccyx area few small open areas.Review of R9's Nursing Comprehensive Skin Evaluation/Assessment, dated 04/06/26, provided by MR indicated, skin warm, discoloration to buttocks . coccyx area few small open areas.Review of R9's Nursing Comprehensive Skin Evaluation/Assessment, dated 04/13/26, provided by MR indicated, skin warm, discoloration to buttocks . coccyx area few small open areas.During an interview on 4/16/25 at 4:25 PM, LPN8/Wound nurse stated that she could not find in the EMR documentation of the measurement of the open areas on R9's sacrum since his admission on [DATE] until 04/16/26 Review of R9's Progress Notes by NP1, under the Progress Notes tab in the EMR, revealed for dates of 04/03/26, 04/10/26, and 04/15/26, NP1 documented in the NP Progress Notes the area was a sacral decubitus ulcer.During an interview on 04/17/26 at 9:04 AM, with MDSC1 and the Regional Director of Clinical Services (RDCS), the RDCS stated that when an open area is found, the wound nurse is to assess the area within 24 hours. MDSC1 stated that the expectation was that the wound nurse would describe the area following the facility's policy regarding documentation with the weekly note. MDSC1 and RDCS were shown documentation in the EMR that indicated R9 had a few open areas with no measurements and other documentation that indicated the area to the sacrum as a large open area, and the NP1 describing the sacrum in the NP1's progress notes as a sacral decubitus ulcer.During an interview with NP1 on 04/17/26 at 1:03 PM, he stated that he had seen the area in the last two weeks. He stated that the excoriation to the sacral area appeared to be a fungal infection. He stated that he did not recall that his progress notes indicated the area was a decubitus ulcer.3. Review of R33's Face Sheet, located under the Profile tab of the EMR revealed R33 was admitted to the facility on [DATE], with diagnoses including but not limited to, seizure disorder, severe intellectual disability, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	legal blindness, aphasia, and hearing loss, with a history of impaired cognition and severely impaired decisionˆmaking skills.Review of R33's quarterly MDS, with an ARD of 04/08/26 and located under the MDS tab of the EMR, revealed R33 was rarely or never understood, had short-term and long-term memory problems, was severely impaired for daily decision-making skills, and used a manual wheelchair. R33 was dependent for positioning and mobility.During an observation on 04/15/26 at 12:01 PM, R33 was seated in a Broda chair in the dining room. The left shoulder bolster was loose, barely attached with Velcro, and not touching the resident's shoulder, failing to provide lateral support. The bolster was not readjusted until 45 minutes later.During an observation on 04/15/26 at 3:35 PM, the same left shoulder bolster was again observed hanging off the side of the Broda chair, not positioned to support the resident.During repeated observations on 04/16/26, revealed continued lack of proper positioning. At 11:12 AM, R33 was seated in the Broda chair in the hallway with no shoulder bolsters positioned on either side. At 11:58 AM, R33 remained seated in the Broada chair without shoulder bolsters. At 1:33 PM, R33 was seated in the Broda chair in his bedroom at the foot of the bed, still without shoulder bolsters in place.During an interview on 04/16/26 at 1:37 PM, Certified Nursing Assistant (CNA)2 stated the shoulder cushions were loose and slid down near the resident's bottom due to the resident rocking sideˆtoˆside. The CNA stated she attempted to tighten the straps, but the cushions remained loose at elbow level. She reported therapy had shown her how to position the resident in the Broda chair.During an interview on 04/16/26 at 1:45 PM, CNA3 and the Director of Rehabilitation (DOR) stated the cushions were meant to provide lateral support and should be properly placed each time staff positioned the resident in the chair. The bolsters slipped down because they were not placed or tightened properly.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, interview, and facility policy review, the facility failed to complete a root cause analysis for a potential unwitnessed fall for 1 of 2 residents (Resident (R)85), reviewed for falls out of a total sample of 49. Without identifying why the resident was found on the floor, the cause of a potential fall (e.g., toileting needs, environmental hazards, medication effects, poor footwear, lack of assistance) was not identified, and the same risk factors remain unaddressed.Findings include:Review of a facility policy titled, Falls - Clinical Protocol, dated 03/2018, indicated, . Falls should be categorized as . Those that occur while trying to rise from a sitting or lying to an upright position . Those that occur while upright and attempting to ambulate . Other circumstances such as sliding out of a chair or rolling from a low bed to the floor . The policy failed to identify the need for a root cause analysis for falls. Review of R85's electronic medical record (EMR) titled admission Record, located under the Profile tab, indicated that the facility admitted the resident on 01/20/26.Review of R85's EMR titled admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/27/26 and located under the MDS tab, indicated that the staff could not determine a Brief Interview for Mental Status (BIMS) score. The assessment indicated that the resident could walk with supervision or touch assistance. The assessment revealed that the resident had a history of falls. Review of R85's EMR titled, Care Plan, located under the Care Plan tab and dated 01/20/26, indicated that the resident was at risk for falls. The care plan identified that the resident had a history of crawling on the floor. Review of R85's EMR titled, Fall Risk Observation/Assessment, located under the Eval (Evaluation) tab and dated 01/20/26, revealed that the resident scored 28, which determined the resident was considered to be at high risk for falls. Review of R85's EMR titled Care Plan, located under the Care Plan tab and dated 01/21/26, indicated that the resident was at risk for psychosocial behaviors of crawling out of bed.Review of R85's EMR titled nursing Progress Notes, located under the Prog (Progress) Note tab and dated 01/22/26, indicated that a nurse was called into the resident's room. The resident was found crawling on the floor (a potential unwitnessed fall) towards the door. The nurse assessed the resident, and the resident sustained no injuries. Review of R85's EMR titled Fall Risk Observation/Assessment, located under the Eval tab and dated 01/22/26, revealed that the resident scored 28 which determined the resident was considered to be at high risk for falls. Review of R85's EMR failed to contain evidence of a root cause analysis of R85's crawling on the floor (a potential unwitnessed fall). During an interview on 04/16/26 at 3:35 PM, the Administrator stated that the facility did not complete a fall investigation since the family shared that the resident had a history of placing herself on the ground. During an interview conducted on 04/17/26 at 8:40 AM, the MDS Coordinator (MDSC)2, who was the acting Director of Nursing (DON), and the Regional Director of Clinical Services (RDCS) stated that a fall investigation was to be completed after a fall. MDSC2 stated a fall investigation was not completed since the crawling was a typical behavior for R85, and the facility did not consider the resident's crawling (a potential unwitnessed fall) a fall.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails; document discussion related to risk versus benefits; and obtain signed informed consent prior to bed rail use for 1 of 3 residents (Resident (R)64), reviewed for side rails out of 49 sampled residents. The lack of alternate side rail measures and proper assessment/consent could lead to a potential restraint or side rail entrapment. Findings include:Review of the facility policy titled Bed Safety and Bed Rails with a revised date of August 2022, revealed, Policy Statement . The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Policy Interpretation and Implementation . Use of Bed Rails . 3. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.Review of R64's Face Sheet, in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE], with diagnoses that included but was not limited to, hypertensive heart disease with heart failure.Review of R64's Care Plan, located under the Care Plan tab of the EMR and revised 02/03/26, revealed R64 may use quarter side rails for mobility as clinically indicated. Review of R64's Bed Rail/Entrapment Risk Evaluation, located under Assessments tab in the EMR and dated 02/03/26, revealed no documentation that alternates were explored prior to bed rail/side rail use. Further review revealed no documentation related to risks versus benefits or informed consent, and the assessment indicated that bedrails were not being considered or used. Review of R64's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/17/26, and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated R64 was severely cognitively impaired.Review of R64's Physician Orders, located under the Orders tab in the EMR and dated 04/2026, revealed no current order for side rail use.During an observation on 04/15/26 at 5:35 PM, R64 was in bed, with the head of the bed upright, and side rails were up on both sides. During an interview on 04/17/26 at 8:06 AM, Licensed Practical Nurse (LPN)6 stated she completed R64's admission bedrail assessment. She stated she could not remember if alternatives were explored prior to bedrail use or if there were a discussion of risk and benefits and informed consent. She stated she was unaware that R64's bedrail assessment indicated he did not have bedrails and they were not being considered.During an observation on 04/17/26 at 8:15 AM with LPN6, R64 was sitting on the edge of the bed. There were side rails on both sides of the bed. During an interview on 04/17/2026 at 8:46 AM, Minimum Data Set Coordinator (MDSC)1 (in DON absence) stated there should not be bedrails on a resident's bed if the assessment indicated they were not in use or being considered.

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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. Based on observation, record review, interview, and facility policy review, the facility failed to ensure proper personal protective equipment (PPE), specifically ex-large disposable gloves were available for staff use prior to entering into a contact/droplet transmission-based precaution (TBP) room and/or failed to post proper TBP signage for contact/droplet precautions for 2 of 2 residents (Resident (R)87 and R75), reviewed for TBP out of a total sample of 49. This increased the likelihood that infectious organisms could be transmitted from residents to staff, other residents, or the environment.Findings include:Review of a facility policy titled, Isolation - Categories of Transmission-Based Precautions, dated 09/2022, indicated, . Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents . When a resident is placed on transmission - based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution .The signage informs the staff of the type of CDC (Centers for Disease Control) precaution(s), instructions for use of PPE .1. Review of R87's electronic medical record (EMR) titled, admission Record, located under the Profile tab, indicated that the facility admitted the resident on 03/19/26.Review of R87's EMR titled Encounter progress notes, located under the Prog (Progress) Note tab and dated 04/15/26, indicated the resident tested positive for respiratory syncytial virus (RSV).Review of R87's EMR titled physician Orders, located under the Orders tab and dated 04/15/26, indicated that the medical provider ordered that the resident be placed under contact/droplet precautions.During an observation on 04/15/26 at 1:29 PM, of R87's room, there was signage on the outside of door indicating Enhanced Barrier Precautions (EBP) were required. Licensed Practical Nurse (LPN)6 donned gown and gloves and entered the room. During an observation on 04/15/26 at 4:45 PM, the signage outside R87's door indicated R87 was on Droplet and Contact precautions. During an observation and interview conducted on 04/16/26 at 2:24 PM, the Housekeeper was observed to don (put on) a gown and a pair of bright green and black work gloves prior to entering into R87's room. Posted was a contact/droplet precaution sign. The Housekeeper was immediately interviewed after this observation and confirmed he was ready to enter the resident's room. The Housekeeper stated that he has worn the gloves before he enters a TBP room and takes the gloves home to wash them. The Housekeeper stated that the facility does not provide extra-large gloves. The top drawer of the three-drawer container was opened and there were only medium and large sized disposable gloves. During an interview on 04/16/26 at 2:26 PM, the Housekeeping Supervisor stated that the facility did have extra-large gloves, but there were not in the drawers for staff to use.During an interview on 04/17/2026 at 8:06 AM, Licensed Practical Nurse (LPN)6 stated she did not don eye protection when she entered room R87's room on 04/15/26 at 1:29 PM to assist the resident. She stated the EBP sign was not accurate, and the room should have had contact and droplet precautions in place due to the resident testing positive for influenza. She stated she was aware prior to entering the room on 04/15/26 at 1:29 PM that the resident in Bed A had tested positive for influenza on 04/14/26, and the signage should have been changed to contact and droplet precautions. LPN6 stated she should have donned eye protection when providing care.2. Review of R75's EMR titled admission Record, located under the Profile tab, indicated that the facility admitted the resident on 10/03/22.Review of R75's EMR titled physician Orders, located under the Orders tab and dated 04/15/26, indicated that the medical provider ordered to place the resident on contact/droplet precautions for being positive for RSV. During an observation conducted on 04/15/26 at 12:05 PM, R75's room had EBP sign posted on the outside. EBP signage does not meet contact/droplet TBP requirements. During an observation and interview conducted on 04/15/26 at 12:26 PM, several staff were observed to enter into R75's room without PPE, such as a gown and gloves. The Minimum Data Set Coordinator (MDSC) 1 was observed to instruct the staff to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	don proper PPE prior to entering R75's room. An interview was conducted with MDSC1, who was the acting Director of Nursing (DON), and confirmed that the incorrect sign was posted on the resident's room and stated a contact/droplet precaution sign was not posted to alert the staff of the PPE required prior to entering the resident's room. During an interview conducted on 04/17/26 at 8:40 AM, MDSC1 and Regional Director of Clinical Services (RDCS) both stated that staff needed to follow the policies for infection control. RDCS stated that the process was for a resident to be tested for a disease process and once the information comes in to alert the staff. Both stated that there were extra-large gloves in stock.During an interview conducted on 04/17/26 at 11:53 AM, MDSC1 stated that the expectation for TBP and staff included the appropriate sign and then the appropriate PPE to be donned and doffed (take off).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, the facility failed to ensure an antibiotic was not used without the presence of a diagnosed infection for 1 of 1 resident (Resident (R)9) reviewed for antibiotic stewardship out of a total sample of 49. The failure had the potential to increase the risk of adverse events, including the development of antibiotic-resistant organism, from unnecessary or inappropriate antibiotic use.Findings include:Review of the facility's policy titled, Antibiotic Stewardship, dated 2001, revealed, The antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program . when a culture and sensitivity is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued .Review of R9's electronic medical record (EMR) Face Sheet, under the Profile tab, revealed an admission date of 03/06/26 with diagnoses including but not limited to, uropathy, chronic kidney disease, urinary tract infection (UTI), and retention of urine.Review of R9's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/26 and located under the MDS tab of the EMR, revealed R9 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated R9's cognition was severely impaired. The MDS indicated that R9 had an indwelling urinary catheter.Review of R9's EMR Progress Notes, in the Progress Notes tab, revealed from admission on [DATE] to 04/09/26 when R9 went to the urology appointment, there was no documentation the resident was experiencing signs or symptoms of a UTI. Review of the Progress Notes dated 04/09/25 indicated, resident went to urology appointment.ordered to get U/A [urinalysis] and C&S [culture and sensitivity] .collected and sent to ECH [lab's name]. Review of R9's EMR Documents tab revealed the Urinalysis Report, dated 04/10/26 with the signature of NP1 with the handwritten order for Cipro 250 BID [twice per day] x [times] 5 d [five days]. The urinalysis indicated, Color (A-Abnormal); Clarity Turbid (A); Nitrite Positive (A); Protein 3+ (A); blood 4+ (A); WBC [White Blood Count] innumerable (A); RBD [Red Blood Count] 50-100 (A); Bacteria 2+ (A); and Mucus 1+ (A).Review of R9's EMR Orders, under the Orders tab, revealed, Cipro [antibiotic] Oral Tablet 250 milligram (mg) Give 1 tablet by mouth two times a day for UTI for 5 Days dated 04/10/26.Review of R9's EMR Progress Notes, in the Progress Notes tab and dated 04/11/26, indicated, seen by NP [Nurse Practitioner (NP1)] ordered Cipro [an antibiotic] for UTI, no odor or abd [abdominal pain noted or reported. Review of R9's EMR Progress Notes, in the Progress Notes tab and dated 04/13/26, indicated, Resident remains on Cipro for UTI No c/o [complaint of] burning or abd discomfort.NP1 made aware of the C&S report, NP1 stated don't worry about it he's on Cipro and he has the Urology appt [appointment] coming up.Review of R9's EMR Progress Notes, in the Progress Notes tab and dated 04/14/26, indicated, Resident is afebrile and denies dysuria and burning. No hematuria [blood in urine] noted. Review of the Progress Notes revealed no further documentation that R9 had complaints of dysuria or burning.Review of R9's EMR Medication Administration Record (MAR), under the Orders tab, revealed R9 received the Cipro on 04/10/26 at 8:00PM through 04/15/26 at 9:00AM which no indication for usage.During an interview on 04/17/26 at 2:42 PM, the MDS Coordinator (MDSC)1 stated the facility should follow federal regulation about prescribing an antibiotic. MDSC1 stated that R9's urinalysis was contaminated and that the C&S could not be performed. The MDSC confirmed that there was no follow up after the facility was notified of the urinalysis report was discussed with NP1.During an interview on 04/17/26 at 3:13 PM, NP1 stated that he started the resident on Cipro prophylactically and that he never saw the C&S report. He stated he was not aware that the urine was contaminated.During an interview on 04/17/26 at 3:35 PM, MDSC1 confirmed that after the contaminated urine report was reported to NP1 on 04/11/26, there was no follow-up conducted. MDSC1 stated that there was no evidence in the EMR that R9's urologist was notified and asked if the provider wanted to repeat the urinalysis and obtain a C&S.During an interview on 04/17/26 at 3:56 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425293	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgefield Post-Acute	226 WA Reel Drive Edgefield, SC 29824

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, MDSC1 stated that the facility followed the McGeer's (standardized surveillance definitions used to identify infections in long-term care (LTC) facilities, ensuring consistent reporting and monitoring of infections) criteria. During an interview and review of the facility's Antibiotic Stewardship manual in the presence of MDSC1, revealed no documentation that R9's use of the antibiotic Cipro and the diagnosis of UTI had been reviewed using the McGeer's criteria. MDSC1 confirmed that the facility did not follow the McGeer's criteria for UTI

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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 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** Based on interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer 2 of 5 residents (Residents (R)94 and R109) reviewed for flu/pneumonia vaccinations and/or their representatives, the opportunity for the residents to be vaccinated in accordance with nationally recognized standards. This practice had the potential to increase the risk for residents to contract pneumonia.Findings include:Review of the facility policy titled Pneumococcal Vaccine with a revision date of October 2023, revealed, Policy Statement All resident are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation . 7. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.Review of the CDC website titled, PneumoRecs VaxAdvisor App (Application) for Vaccine Providers, dated 01/09/25, indicated, . Give one dose of PCV15, PCV20, or PCV21 at least 1 year after the last does of PPSV23. Regardless of which vaccine is used . their pneumococcal series is complete .1. Review of R94's electronic medical records (EMR) titled, admission Record, located under the Profile tab, indicated that the facility admitted the resident on 11/30/21. Review of R94's EMR titled, Immunizations, located under the Immun (Immunization) tab, indicated the resident received Pneumovax 23 (PPSV23) on 12/03/21. There was no evidence that the resident or her representative was offered the PCV20 or the PCV21 vaccine. 2. Review of R109's EMR titled, admission Record, located under the Profile tab, indicated that the facility admitted the resident to the facility on [DATE]. Review of R109's EMR titled, Immunizations, located under the Immun tab, indicated the resident received PPSV23 on 10/06/22. There was no evidence that the resident or her representative was offered the PCV20 or the PCV21 vaccine. During an interview conducted on 04/17/26 at 8:40 AM, the Minimum Data Set Coordinator (MDSC)1, who was the acting Director of Nursing (DON), and the Regional Director of Clinical Services (RDCS) both stated that they were unaware of the updated CDC recommendations for pneumococcal vaccines. The facility's Infection Preventionist was unavailable to be interviewed while onsite.