

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Aiken Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 Augustus Road Aiken, SC 29801	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48214</p> <p>Based on review of facility policy, interview, and record review, the facility failed to ensure Resident (R)8 was free from misappropriation of (Oxycodone), a narcotic medication, for 1 of 1 resident.</p> <p>Findings Include:</p> <p>Review of the Facility Policy titled Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation last revised 05/01/24, states, All of our residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident property. Furthermore, it states, D . Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a reside: belongings or money without the resident's consent. Acts that may constitute the misappropriation of resident property include but are not limited to: the theft or attempted of a resident's money or personal property of any value or type .</p> <p>Review of the Facility Policy titled Controlled Substances dated 01/02/24, states, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. Furthermore, it states, Accurate accountability of the inventory of all controlled drugs is maintained at all times.</p> <p>Review of the Facility Policy titled Controlled Substance Storage dated 01/02/24, states .A. The Director of nursing, in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances.E. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented.</p> <p>Review of R8's Face Sheet revealed R8 was admitted to the facility on [DATE], with diagnoses including but not limited to: Alzheimer's, dementia, palliative care, anxiety and chronic pain.</p> <p>Review of R8's Physician Orders dated 02/16/24, revealed the following orders: oxycodone 5 milligrams (mg) Twice a Day (BID).</p> <p>Review of R8's Medication Administration Record (MAR) dated December 2024, revealed on 12/01/24, R8 did not receive her 5:00 PM scheduled dose.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility document titled Packing Slip dated 11/22/24, revealed on 11/23/24, Licensed Practical Nurse (LPN)1 signed for 28 tablets of 5 mg oxycodone for R8.</p> <p>Review of a facility document titled Visit Note Report dated 11/27/24, revealed the hospice nurse for R8, reconciled her medications and noted there to be 20 tabs of oxycodone.</p> <p>During an interview on 12/12/24 at 1:57 PM, LPN1 stated, she first noticed R8 was missing her Oxycodone on 12/01/24 at 9:00 AM during medication administration. LPN1 stated she did not physically count the number of cards and number of narcotic sheets during shift exchange and that she just went with it and did not confirm with Registered Nurse (RN)1. LPN1 was unable to state the facility's policy regarding narcotic sign off and instead, reported that she has always done it this way. LPN1 stated she had to call the pharmacy, who reported that R8 should not be out of Oxycodone due to the dosage and the last shipment date. LPN1 had to obtain a new prescription order for R8's oxycodone.</p> <p>During an interview on 12/12/24 at 2:14 PM, the Director of Nursing (DON) and Facility Administrator (FA) stated, Nurses are supposed to do a shift to shift report, where the off-going nurse gives the on-coming nurse, report. During this report, a narcotic count is done to ensure accuracy before exchanging keys. The narcotic count involves looking at all of the controlled substance cards and the number of pills left in each individual card to ensure it matches the number on the card and sign-off sheet. The DON further stated, that facility policy is, during hand-off each controlled substance card should match each sheet, and at the end nurses should count the total number of card and sheets. Unit Nurse Manager (UNM) are responsible for reconciling medication carts, twice a month and they should be looking at the narcotic sheets to ensure that the number that is counted is the number that is in the cart.</p> <p>Interview attempts with RN1 were unsuccessful.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48214</p> <p>Based on review of facility policy, record reviews and interviews, the facility failed to ensure an allegation of misappropriation towards Resident (R)8 was reported within 2 hours and failed to report accident/incident for R6 within 24 hours.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation last revised 05/01/24, states, The facility's Policy requires that it report all instances of abuse, neglect, exploitation and misappropriation of resident property, and suspicious injuries of unknown source that might indicate abuse, neglect, as required by state and federal law. Furthermore, it states, Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a residents' belongings or money without the residents consent. Acts that may constitute the misappropriation of resident property include but are not limited to: the theft or attempted theft of a resident's money or personal property . and The Administrator/designee in administrator absence will report to the State Agency and all other required agencies, per regulations.</p> <p>Review of R8's Face Sheet revealed R8 was admitted to the facility on [DATE], with diagnoses including but not limited to: Alzheimer's, dementia, palliative care, anxiety and chronic pain.</p> <p>Review of the Facility 2 Hour Initial Reportable received by the department on 12/06/24 stated, On 12/1/24 @ 9AM Nursing staff discovered a missing narcotic card. MD, RR notified. Investigation initiated. DEA informed of missing medication card. two nurses suspended. 5 day to follow. The initial report was sent 5 days after the incident occurred.</p> <p>Review of a Witness Statement signed by Licensed Practical Nurse (LPN)1, dated 12/02/24, stated, While passing medication, R8's 5 milligrams (mg) Oxycodone was not available on cart. The pharmacy was notified and asked if the medication could be taken from the cubex. Pharmacy stated that a new prescription was needed. Unit manager notified, MDS Coordinator aware.</p> <p>Review of R6's Face Sheet revealed R6 was admitted to the facility on [DATE]. R6 has diagnoses including but not limited to: Parkinson's, gout, disorientation, head injury and osteoarthritis.</p> <p>Review of the Facility's 2 Hour Initial Reportable received by the department on 11/04/24, revealed, Date/time of reportable incident: 11/04/24 at 7:22 PM Resident sustained fracture of olecranon process of right ulna following a fall . 5 day to follow.</p> <p>Review of R6's electronic medical records, revealed, R6's fall occurred on 10/19/24 and he was sent to the hospital and admitted , however the reportable was not sent until 16 days later.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress noted dated 10/19/24 at 1523, revealed, 10/19/24 1332 I was sitting at the nurse's station when a loud noise was heard coming from the direction of this [R6's] room. Upon entering this room [R6] was noted to be laying on the floor on his right side. [NAME] was laying on the floor beside him. He stated that he had got up to go to the restroom, and when he turned around he lost his balance and fell to the floor. No obvious injuries were noted. He had complaints of right shoulder and right hip pain. ROM to right shoulder was decreased per resident. He requested his daughter be contacted. At the request of resident and his daughter he was transported to [local hospital] via ambulance for further eval. [R6] is his own responsible party. NP [Nurse Practitioner] on call was notified.</p> <p>During an interview on 12/12/24 at 1:57 PM, LPN1 stated, she first noticed R8 was missing her Oxycodone on 12/01/24 during medication administration. LPN1 stated she did not physically count the number of cards and number of narcotic sheets during shift exchange and that she just went with it and did not confirm with Registered Nurse (RN)1. LPN1 was unable to state the facility policy regarding narcotic sign off and instead reported that she has always done it this way.</p> <p>During an interview on 12/12/24 at 2:14 PM, the Facility Administrator (FA) and Director of Nursing (DON) confirmed the misappropriation occurred on 12/02/24. FA further states that she was unaware that misappropriation needed to be reported and then stated, it's really a theft. FA also stated that R6's fall was not reported timely because they did not receive a confirmed diagnosis of a fracture until 11/04/24, eventhough R6 sustained a fall on 10/19/24 requiring him to be hospitalized .</p>		