STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425310	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hollow of Sumter Rehabilitation Center	1761 Pinewood Road Sumter, SC 29154

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interview, and facility document review, the facility failed to provide a safe, clean, and comfortable environment for residents in 2 (rooms [ROOM NUMBER]) of 7 rooms observed. Specifically, room [ROOM NUMBER] had a ceramic soap dish that was broken in half, resulting in jagged, sharp edges, and room [ROOM NUMBER] had a clogged sink. Findings include: During an interview on 04/30/26 at 9:25 AM, the Administrator (ADM) stated the facility did not have any policies regarding a homelike environment, building repair, or repair reporting. 1. An observation on 04/28/26 at 2:38 PM in room [ROOM NUMBER] revealed the soap dish inside the resident's bathroom was observed to be broken and missing half of its structure. The broken part exposed sharp and jagged edges of what remained of the soap dish. During an observation on 04/30/26 at 8:50 AM in room [ROOM NUMBER], the soap dish in the bathroom was still broken. During a concurrent observation and interview on 04/30/2026 at 10:14 AM with Licensed Practical Nurse (LPN)5 in room [ROOM NUMBER], LPN5 stated that the broken soap dish had the potential to pose a hazard to any resident who used it. LPN5 stated she did not know whether there was a work order for the broken soap dish. 2. An observation on 04/28/26 at 2:24 PM in room [ROOM NUMBER] revealed the bathroom sink was clogged and water was not draining. During an observation on 04/30/26 at 8:57 AM in room [ROOM NUMBER], the bathroom sink was clogged. During an interview on 04/30/26 at 9:01 AM, Housekeeper (HK)4 stated that he told the Maintenance Director about the sink two to three weeks prior, and the Maintenance Director poured de-clogging solution in the sink; however, he stated it did not resolve the problem. HK #4 stated he did not know what other attempts had been made to repair the issue. A facility Maintenance Punch List revealed no documented concerns or repairs for room [ROOM NUMBER]'s broken soap dish or room [ROOM NUMBER]'s clogged sink. Facility Work Order documents for the timeframe from 11/05/25 through 04/30/26 indicated no documented evidence that a Work Order had been completed for room [ROOM NUMBER]'s broken soap dish or room [ROOM NUMBER]'s clogged sink. During an interview on 04/30/26 at 1:57 PM, the Maintenance Director stated he was responsible for facility repairs. The Maintenance Director stated that staff notified him of maintenance requests verbally and in writing via a work order log binder located at each of the nursing stations. Per the Maintenance Director, staff were supposed to log work orders in the binder, even if they had verbally notified him of an issue. However, he stated that staff did not always follow up with logging work orders after verbal notification. The Maintenance Director stated that he was notified approximately three weeks prior that the sink in room [ROOM NUMBER] was clogged, and he poured acid in the pipe to resolve the problem. He stated he was not aware that the sink was clogged again. According to the Maintenance Director, he was not aware of room [ROOM NUMBER]'s broken soap dish. During an interview on 05/01/26 at 2:37 PM, the Director of Nursing (DON) stated that he expected residents to have a clean, safe, and functional environment. During an interview on 05/01/26 at 2:50 PM, the ADM stated that she expected repairs to be addressed.

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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(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. Based on observation, interview, record review, Devilbiss 515 Series Instruction Manual review, and facility document review, the facility failed to maintain oxygen concentrators consistent with professional standards of practice for 2 (Resident (R)11 and R18) of 6 residents who utilized oxygen. Specifically, the facility failed to clean R11's oxygen concentrator filter weekly and failed to ensure preventative maintenance/servicing was completed for R11 and R18's oxygen concentrators. Findings included: During an interview on 04/30/26 at 10:33 AM, the Director of Nursing (DON) stated that the facility did not have a policy related to preventative maintenance or cleaning for oxygen concentrators. 1. An undated Devilbiss 515 Series Instruction Manual revealed, The air filter and connector should be cleaned at least once a week. To clean, follow these steps: 1. Remove the air filter, located on the back of the unit. Remove the oxygen outlet connector (if used). 2. Wash in a solution of warm water and dishwashing detergent Figure 10. 3. Rinse thoroughly with warm tap water and towel dry. The filter should be completely dry before reinstalling. An admission Record revealed the facility admitted R11 on 12/09/25. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD), vascular dementia with anxiety, sleep apnea. and hypertension (high blood pressure). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/18/2025, revealed that R11 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed that the resident experienced shortness of breath or trouble breathing when lying flat and was receiving continuous oxygen therapy. R11's Care Plan Report dated 12/09/2025, included a focus area, that indicated the resident was at risk for respiratory complications related to a diagnosis of COPD, sleep apnea, and hypercapnia. Interventions (undated) directed staff to start supplemental oxygen as ordered and monitor for effectiveness. An Order Recap Summary for the timeframe from 12/27/2025 through 04/30/26 revealed that R11 had an order dated 01/12/26 for 3 liters (L) of supplemental oxygen via nasal cannula for an oxygen saturation level of less than 90%. The Order Recap Summary also contained an order dated 01/12/26 for staff to change and date the oxygen tubing and water humidification every Sunday night shift. An undated facility document revealed R11 utilized a Devilbiss Healthcare oxygen concentrator. R11's April 26 Medication Administration Record [MAR] revealed staff signed the MAR indicating they had changed and dated the resident's oxygen tubing and water humidifier bottle every Sunday on the night shift on the following dates: 04/05/26, 04/12/26, 04/19/26, and 04/26/26. There was no documented evidence that staff had cleaned the oxygen concentrator's air filter/connector. During an observation on 04/28/26 at 11:30 AM, R11 was observed lying in bed wearing an oxygen cannula, and an oxygen concentrator was on the floor next to the bed. The observation revealed that the oxygen concentrator filter was dislodged and was covered with visible dirt and lint. During an observation of R11 on 04/29/26 at 5:10 PM, the resident was observed lying in bed wearing an oxygen cannula and the oxygen concentrator was on the floor next to the bed. Resident 11's oxygen concentrator was observed to have thick, grayish white lint and dirt that covered the filter. The lint was so thick on the filter that it could not be pulled off with the fingers. During an observation and concurrent interview on 04/30/26 at 10:11 AM, Resident 11's oxygen concentrator was observed with visible thick, grayish white lint and dirt that covered the filter. Licensed Practical Nurse (LPN) #7 stated the filter was dirty and that it needed to be cleaned or changed. She further stated that the night shift nurses were responsible for ensuring the oxygen tubing was changed, filters were cleaned or replaced, and the entire concentrator was wiped down with alcohol wipes at least once a week, and if they appeared dirty. During an interview on 04/30/26 at 10:17 AM, the Unit Manager (UM) stated that the nurses and management team were responsible for ensuring concentrators were cleaned and filters were changed weekly on Sunday.^The UM stated that the night shift nurses were responsible for cleaning the concentrators and changing the tubing. The UM stated she had not looked at R11's oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concentrator. During an interview on 04/30/26 at 10:59 PM, LPN8 stated that she worked the night shift and that night shift staff were responsible for cleaning oxygen concentrator filters. She stated that she had taken care of R11, and at times staff could not enter the resident's room at night due to the resident's behavior, which resulted in things being missed. During an interview on 4/30/26 at 11:21 AM, the DON stated that he expected oxygen concentrators to be cleaned weekly on Sunday night and as needed. He stated that any staff member could clean them. The DON stated that he had not seen R11's concentrator and had not been notified that it was dirty. During an interview on 04/30/26 at 1:41 PM, the Administrator stated that the expectation was for the facility to follow protocol. During an interview on 05/01/26 at 9:52 AM, the Regional Nurse Consultant (RNC) stated nursing staff should monitor the cleanliness of oxygen concentrators when changing out the tubing, but there was no documentation that they were monitoring the cleaning of the oxygen concentrators. 2. An undated manufacturer's Devilbiss 515 Series Instruction Manual revealed, The following troubleshooting chart will help you analyze and correct minor oxygen concentrator malfunctions. If the suggested procedures do not help, switch to your reserve oxygen system and call your [medical supply homecare provider]. Do not attempt any other maintenance. The manual did not address preventative maintenance/servicing. A list provided by the facility of residents who utilized oxygen concentrators revealed two residents, R11 and R18, utilized the DeVilbiss brand concentrator. During an interview on 04/30/26 at 1:57 PM, the Maintenance Director stated that the oxygen concentrator company was responsible for their machines and performed maintenance and servicing. He was unable to provide any records indicating the oxygen concentrators had received preventative maintenance or servicing. He stated it was the responsibility of the DON or the Unit Manger (UM) to contact the 800 number on the machines to have them serviced and checked regularly. During an interview on 04/30/26 at 11:21 AM, the DON stated that he did not have any knowledge of when the last time the facility oxygen concentrators had been serviced. He stated he did not know who to call about servicing the concentrators.ˆHe was unable to provide any documentation indicating when the oxygen concentrators had received preventative maintenance or servicing.ˆ During a follow-un interview on 04/30/26 at 3:22 PM, the DON stated their oxygen provider company maintained the concentrators that they (the oxygen provider company) provided. During a telephone interview on 05/01/26 at 9:35 AM, a Customer Service Representative (CSR) from the oxygen provider company revealed that they did not provide DeVilbiss Healthcare concentrators to the facility. During an interview on 04/30/26 at 1:41 PM, the Administrator stated that the expectation was for the facility to follow protocol. She stated that she was not aware of any timeframe or schedule for cleaning or maintenance of the oxygen concentrators.

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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 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. Based on facility policy review, facility document review, record review, and interview, the facility failed to ensure that dialysis services were consistent with professional standards of practice including monitoring and documenting of ongoing assessment and oversight of a resident before and after dialysis treatments, and documentation of ongoing communication and collaboration with the dialysis center for 1 (Resident (R)28) of 1 resident reviewed for dialysis. Findings included: A facility policy titled, End-Stage Renal Disease, Care of Resident with, revised September 2010, revealed, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care.^ A facility policy titled, Charting and Documentation, revised July 2017, revealed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. An admission Record revealed the facility admitted R28 on 04/10/26. According to the admission Record, the resident had a medical history that included diagnoses of ESRD, dependence on renal dialysis, type 2 diabetes without complications, hypocalcemia, essential hypertension, hyperkalemia, and hypomagnesemia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/15/26, revealed R28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident received insulin, and special treatments included hemodialysis. R28's Care Plan Report included an undated focus area that indicated the resident was at risk for complications related to the diagnosis of diabetes mellitus and indicated that the resident received insulin injections. Undated interventions directed staff to administer medications, including insulin, as ordered, and report abnormal fingerstick blood sugar levels to the physician per the ordered ranges. The Care Plan Report included an undated focus area that indicated the resident needed hemodialysis related to ESRD. Undated interventions directed staff to check and remove the dressing at the right subclavian access site daily as ordered; document any bleeding or leakage from the site and apply pressure as needed; monitor/document/report as needed any signs and symptoms of infection to the access site such as redness, swelling, warmth or drainage; monitor/document/report any signs or symptoms of renal insufficiency such as changes in level of consciousness, changes in skin turgor, oral mucosa, and changes in heart and lung sounds as needed; and monitor/document/report any signs or symptoms of bleeding, hemorrhage, bacteremia, or septic shock, as needed. The Care Plan Report included an undated focus area that indicated the resident had a potential for fluid alterations related to ESRD and indicated the resident was on hemodialysis and used diuretic medications. Undated interventions directed staff to administer medications as ordered, monitor/document for side effects and effectiveness, and monitor vital signs as ordered/per the protocol and record. R28's Order Summary Report, with active orders as of 04/29/26 included an order, dated 04/13/26, for dialysis chair time scheduled for 12:30 PM. The order specified that transportation pickup was arranged for 12:00 PM and the resident was to be ready by 11:00 AM. The order indicated that a progress note was to be completed prior to the visit. The order specified that dialysis was to be completed every day shift every Monday, Wednesday, and Friday. A facility agreement between the facility and the dialysis provider used for Resident #29 titled, Long-Term Care Facility Outpatient Dialysis Services Agreement, effective 11/01/2013, revealed, Preparation of ESRD Residents included The Nursing Facility shall ensure that ESRD Residents are prepared to spend an extended length of time at the ESRD Dialysis Unit and have received proper nourishment and any medications prescribed, as appropriate, before coming to the ESRD Dialysis Unit. The agreement also revealed, Collaboration of Care included Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing Facility and ESRD Dialysis Unit. R28's dialysis binder included a page that revealed, When documenting a resident returning from (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis, the goal is to clearly show their condition, any changes, and continuity of care. Keep it concise but clinically complete. Here is a guide you can follow. The document revealed, Start with arrival details, which specified Time of return from dialysis; Mode of transport; and Who accompanied (if applicable). The document also revealed, Assess and document the condition immediately, which specified, Level of consciousness (alert, drowsy, confused); General appearance (stable, fatigued, pale, etc. [et cetera; and so forth]), Vital signs (BP [blood pressure], pulse, respirations, temperature, 02[oxygen] if needed). The document revealed, Note dialysis-related observations, which specified Presence of common post-dialysis symptoms including Fatigue, Dizziness, Hypotension, and Nausea/vomiting; and any complications reported by dialysis staff. The document revealed, Check the access site, which specified AV fistula/graft or catheter; Bruit/thrill present (if applicable); and Bleeding, swelling, redness, or dressing condition. The document revealed, Review weight and fluid status, which specified, Pre-and post-dialysis weight if available; and Signs of fluid overload or dehydration. The document revealed, Pain assessment, which specified Location, rating (0-10), and intervention if needed. The document continued, Medications and treatments, which specified Meds [medications] given post-dialysis (if ordered); and Any new orders received. The document continued, Safety measures, which specified Fall precautions (especially if weak/dizzy); and Assistance with ambulation. The document continued, Resident response, which specified How they tolerated dialysis overall; and Any complaints or statements from the resident. The document continued, End with status and plan, which specified Current condition (stable, resting, etc.), and What staff will continue to monitor. The binder contents included the phone number to the dialysis center. R28's dialysis binder included a Dialysis Communication Record form, which included a section to be completed by the facility and a section to be completed by the dialysis center. The form revealed the section completed by the facility included general information, including the resident's name; physician's name; facility contact information; and dialysis frequency, time, and center. The form revealed the section also completed by the facility included pre-dialysis information, which included Vital Signs, Medications Administered, Medications Held, Meal Provision, and the resident's Condition Alert. The form revealed the section to be completed by the dialysis center included Pre-dialysis Weight, Post Dialysis Weight, if there were any incidents related to the dialysis, Antibiotics Given, Lab Work Completed, Post Dialysis Vital Signs, and Recommendations/Follow Up. R28's April 26 Medication Administration Record [MAR] indicated that the resident was transferred to dialysis on 04/15/26, 04/17/26, 04/20/26, 04/24/26, and 04/29/26 according to the order. The MAR revealed no coding for 04/22/26. Per the MAR, the resident refused dialysis on 04/27/26. R28's dialysis binder revealed the following: -An undated Dialysis Communication Record with the information completed by Licensed Practical Nurse (LPN)3 and by the dialysis center. - A Dialysis Communication Record, dated 04/24/26, completed by LPN5 and by the dialysis center. - An undated Dialysis Communication Record completed by LPN7 and not completed by the dialysis center. - A Dialysis Communication Record revealed the section to be completed by the facility was completed by LPN7 but was undated, and the section to be completed by the dialysis center was completed and dated 04/22/26. - An undated Dialysis Communication Record completed by the Unit Manager (UM) and by the dialysis center. Also included were additional vital signs documented at the bottom of the form with a time of 6:00 PM written. - An undated Dialysis Communication Record completed by the UM and by the dialysis center. - An undated Dialysis Communication Record completed by the dialysis center but not the facility. R28's Progress Notes revealed no pre-dialysis notes on 04/15/26, 04/20/26, 04/22/26, 04/24/26, or 04/29/26. R28's record revealed no evidence that the facility's staff completed a post-dialysis assessment of the resident on 04/15/26, 04/17/26, 04/22/26, 04/24/26, or 04/29/26. During an interview on 05/01/26 at 11:45 AM, LPN9 stated that there was a form that staff filled out that went with R28 to dialysis. She stated that staff checked the resident's vital signs and administered the medications prior to the resident going to dialysis. She stated that the nurses put the information on the form, not in the electronic medical record. She stated that when (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident returned from dialysis, they got the dialysis binder back, and the form included information, such as post dialysis weight and vital signs. She stated that staff checked the resident's vital signs again, and they also went on the form. She stated that staff had to call the dialysis center if they did not document on the form, but she never had to call them. LPN9 reviewed the communication form for 04/15/26 and stated that the UM helped her that day and filled out the communication form for her. She stated she checked the resident's blood pressure because she had to with the medication the resident took. She stated that the UM helped with the other vital signs. She stated that they got the communication form back when the resident returned, and it went into the dialysis binder. She stated staff were supposed to enter a progress note into the electronic medical record when the resident went to dialysis and when the resident came back from dialysis. She stated they documented how the resident left, such as on a stretcher. She stated staff did not have to document the weight or vital signs because that information was on the communication form. During an interview on 4/30/26 at 11:41 AM, LPN2 stated that there was a dialysis binder for R28 with communication forms. She stated that there was not a communication form for 04/17/26 and if the vital signs were not in the dialysis binder, she documented them in the electronic medical record. She stated that when she checked the resident's blood sugar level, she documented that under the vitals section in the electronic medical record and then she put it on the communication form. She stated she knew she had filled out the form on 04/17/26. She stated that there was a lot going on that day. She reviewed the progress notes and stated she did not do a progress note for that day after dialysis. LPN2 stated that there was only one dialysis binder for the resident. She stated the post dialysis vital signs would not be in the electronic medical record because they were from the dialysis center. She stated that if there was a concern from the dialysis center, staff followed up on it and brought it to the doctor's or nurse practitioner's attention and made a progress note. During an interview on 04/30/26 at 12:06 PM, LPN7 stated nurses were to check vital signs and follow any parameters for medications and filled out the communication form prior to dialysis. She stated that R28 did not have parameters for holding medications prior to dialysis. She stated the pre-dialysis information on the communication form dated 04/22/26 by the dialysis center was the pre-dialysis information for 04/20/26 that she had completed. She stated the form was placed in the wrong order in the dialysis binder, and the dialysis center staff dated the form as 04/22/26. She stated that when a resident went to dialysis, staff filled out the communication form, and she thought there might be a parameter in the electronic medical record to make a progress note. She stated that if there were no parameters, it would be best practice to make a progress note. LPN7 stated that they completed a post-dialysis assessment of the resident with vital signs and checked the catheter for excessive bleeding, bruit, and thrill. She stated staff should document that in the progress notes. During an interview on 04/30/26 at 11:05 AM,ˆLPN5 stated that prior to R28's dialysis appointment, she administered the resident's insulin and medication and checked the resident's blood sugar level. She stated she completed the information on the communication form in the dialysis binder and added the blood sugar level, so the dialysis center knew what the levels were. She reviewed the communication forms in R28's dialysis binder and confirmed that there were multiple undated forms. She stated that of the ones she filled out, one for Wednesday (04/29/26) had no date on it, and she was not sure why she did not date it. She stated that the communication form dated 04/24/26 was signed by her. She stated the dialysis center filled out their part on the form, and if there were any order changes, the dialysis center staff put that on the form. She stated that she checked the dialysis binder when R28 returned. She stated that she checked the resident's port for thrill and bruit and if there was any bleeding, and that it was on the treatment administration record (TAR) to check off. She stated that if the dialysis center did not fill out the communication form, she let the UM know. She stated she just filled out the communication form, and she did not document a pre-dialysis or post-dialysis progress note. She stated she left the communication forms in the binder so the nurses could all see them. During a phone interview on 04/30/26 at 8:03 AM, LPN8 stated the process she followed prior to a (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis appointment was to obtain the resident's vital signs and document them in the dialysis binder on the communication form. She stated that she put a progress note in the electronic medical record when the resident returned from dialysis. She stated she usually just put a note that indicated when the resident came back from dialysis, and if something changed, they wrote that information on the communication forms in the dialysis binder. During an interview on 04/30/26 at 5:10 PM, the UM stated that for a dialysis resident, staff were to make sure medications were taken, and an assessment was completed prior to going to a dialysis appointment. She stated that the nurse was to get the dialysis binder together and enter everything needed for the pre-dialysis documentation and make sure the communication form was filled out. She stated the nurse was to make sure to document the resident's vital signs, if medications were held, and stated that the assessment was documented in the progress notes in the electronic medical record. She stated that when the resident came back from dialysis, the nurse was to do a full assessment and check vital signs and make sure the communication form was filled out. She stated that if the communication form was not filled out, the nurse was to call the dialysis center. She stated the nurse was to document all of that (communication, assessments, vital signs, abnormalities, pain) in a progress note. She stated that the management team monitored to ensure progress notes and communication forms were completed, which included her, the Assistant Director of Nursing (ADON), the MDS Coordinator, and the Director of Nursing (DON). She stated the management team should be reviewing the progress notes and communication forms for R28, but they did not have the time. During an interview on 05/01/26 at 4:54 PM, the DON stated that the staff needed to make sure there was a progress note. He stated that when the patient arrived back from dialysis, staff completed their assessment of the patient and completed a progress note. He stated that prior to leaving and when a patient returned, there should be an assessment of the patient. He stated that the communication form should be uploaded in the electronic chart at a minimum. He stated that the nurse was responsible for ensuring the progress notes were completed and that the communication forms were completed. He stated the UM should review the progress notes and communication forms daily, and he would assist if needed. He stated that he expected the UM to bring concerns to his attention if anything was needed. During an interview on 05/01/26 at 4:36 PM, the Nursing Home Administrator stated that her expectation was for the nurses to follow the procedures that were in the dialysis binder, and to follow up on care that would have taken place at the dialysis center, when necessary, if there were any questions or concerns. She stated that documentation in the progress notes of the resident's record and the communication forms was important to show updated information from the resident's appointment/visit at the dialysis center. She stated that should the information from the dialysis center be unclear or not on the form, the nurse should call them and ask what was done.

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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 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. Based on facility policy review, facility document review, observation, and interview, the facility failed to ensure expired medications were not available for resident use in 1 (Medication Cart #3) of 3 medication carts. Specifically, observations revealed a bottle of naproxen (medication used for pain) and a bottle of Orajel 2X Medicated Toothache Rinse had past the manufacturer's expiration date and were available for resident administration. Findings included: A facility policy titled, Storage of Medications, revised 11/01/2015, indicated, XII. Expired, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without closures are promptly destroyed according to facility procedures, and a replacement is ordered from the pharmacy. XIV. Medication storage conditions are monitored routinely and corrective action taken if problems are identified. A facility policy titled, Medication Labeling and Storage, revised 02/2023, indicated, Medication Storage 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The policy further indicated, Medication Labeling 5. Multi-dose vials that have been opened or accessed (e.g., [exempli gratia or for example] needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. A facility Weekly Medication Cart Audit for Hall 400 dated 04/03/26, 04/10/26, 04/17/26, 04/24/26, and 04/27/26, revealed staff documented that there were no expired medications in the medication cart. During an observation of Medication Cart #3 (utilized for Hall 300 and 400) with Licensed Practical Nurse (LPN)6 on 04/29/26 at 2:51 PM the following medications were in the cart available for resident use beyond their expiration date: - a bottle of naproxen 220 milligrams (mg) with an opened dated of 04/29/26 (date of the observation) and a manufacturer's expiration date of 03/26 - a half empty bottle of Orajel 2X Medicated Toothache Rinse with an expiration date of 10/2024. LPN6 stated that the naproxen and Orajel were house stock medications and confirmed that both medications were expired. LPN6 stated it was important not to give expired medications to residents as they were not effective. During an interview on 04/29/26 at 3:08 PM, LPN5 stated that the Unit Manager (UM) and the Assistant Director of Nursing (ADON) audited medication carts for expired medications at least once per week. LPN5 stated that if nurses found expired or undated medications, they reported to the UM or Director of Nursing (DON) to have the medications destroyed. LPN5 stated expired medications were not effective. During an interview on 04/29/26 at 3:26 PM, LPN2 stated that expired medications were not effective. LPN2 stated that the UM audited medication carts weekly to check for expired medications and completed an audit form. During an interview on 04/29/26 4:03 PM, the UM stated she was responsible for completing weekly medication cart audits and completing an audit form, which was then submitted to the DON. The UM stated expired medications were destroyed. The UM stated she bought the bottle of naproxen that day and had brought it into the facility, but she did not check the expiration date on the bottle. During an interview on 04/30/26 at 4:17 PM, the Administrator (ADM) stated that the UM should have checked the naproxen before placing it into the medication cart. During an interview on 05/01/26 at 2:37 PM, the DON stated that he expected medication carts to be free of expired medications. He stated that expired medications would not be effective. During an interview on 05/01/26 at 2:50 PM, the ADM stated expired medications had to be disposed of and should not have been inside any medication cart.