STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425316	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Operations	82 N Main Street Inman, SC 29349

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on facility policy, observation, record review, and interview, the facility failed to develop a comprehensive care plan for of 2 of 3 residents. (Resident (R)22 and R24). Findings include; Record review of the facility policy dated 2025, titled Comprehensive Care Plan revealed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs . The comprehensive care plan will describe, at a minimum the following: the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. Review of R22's Face Sheet revealed R22 was admitted to the facility on [DATE], with diagnoses including but not limited to acute respiratory failure with hypoxia, hydrocephalus, and mild cognitive impairment. Review of R22's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/04/25, recorded R22 with a Brief Interview for Mental Status (BIMS) score of 9 out 15, indicating R22 had mild cognitive impairment. Review of R22's Physician Order dated 03/03/25, revealed oxygen 2 liters per minute (lpm) via nasal cannula (N/C) to be administered to keep oxygen saturation (oxygen in the blood) above 90% every shift. Review of R22's Care Plan revealed there was no Care Plan related to respiratory concerns, the use of oxygen, or obtaining oxygen saturation to keep above 90%. Further review of the Care Plan revealed a cardiovascular Care Plan, which did not reference the use of oxygen. During an interview on 03/19/25 at 9:43 AM, an interview with Registered Nurse (RN)2 and the Director of Nursing (DON). RN2 stated we remotely update the Care Plans. RN2 confirmed R22 did not have a Care Plan for the use oxygen. The DON confirmed that the Care Plans are updated by the corporate MDS remotely. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R24's Face Sheet revealed R24 was admitted to the facility on [DATE], with diagnoses including but not limited to: Type 2 Diabetes Mellitus, Dementia, emphysema, and abnormal gait. Review of R24's MDS with an ARD of 12/19/24, revealed R24 had a BIMS score of 3 out of 15, indicating R24 had severe cognitive impairment. Review of R24's Progress Notes dated 03/14/25 at 8:52 PM, revealed, Resident arrived to facility via stretcher with emergency medical personnel from hospital at 1320 . Resident left great toe was amputated. Resident surgical amputation site has sutures and is covered with dressing. Dressing dry and intact. There is no redness, draining, or any signs or symptoms of infection to site. Resident has special shoe that is to be worn, and dressing should be left in place until follow up appointment. Review of R24's Care Plan revealed there was no care plan addressing R24's surgical site. During an interview on 03/19/25 at 12:55 PM, with Licensed Practical Nurse (LPN)2, Unit Manager and the Director of Nursing (DON). They stated, the MDS Nurse was not here when she went to the hospital and had the amputation. They verified there was not a Care Plan in place. They further confirmed there should be a Care Plan for amputation in place but we don't have anyone doing them. 50850

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on review of facility policy, observation, record review and interview, the facility failed to complete a dressing change using standards of practice to prevent cross contamination of a pressure ulcer, for 1 of 1 resident, (Resident (R)22), reviewed for pressure ulcers. Findings include: Review of the facility policy dated 2024, titled, Clean Dressing Change stated, It is the policy of this facility to provide wound care in a manner to decrease potential for infection and or cross/contamination. Setup clean field on the overbed table with needed supplies .Place a disposable cloth or linen saver on the overbed table. Place only the supplies to be used per wound on the clean field . Use no touch techniques to remove ointments and creams from their containers (i.e. use of tongue blade or applicator). Review of R22's Face Sheet revealed R22 was admitted to the facility on [DATE], with diagnoses including but not limited to: acute respiratory failure with hypoxia, hydrocephalus, and mild cognitive impairment. Review of R22's Minimum Data sheet (MDS) with an Assessment Reference Date (ARD) of 01/04/25, revealed R22 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating R22 had moderate cognitive impairment. Review of R22's Progress Note dated 03/07/25 at 11:10 PM, reveals a care conference note late entry, Resident reviewed with IDT for skin breakdown to her buttocks. Reported that resident had skin tears to the left and right buttocks. Order written for areas to be cleaned with normal saline and border gauze applied. Will continue to treat resident according to orders and wounds/skin will be assessed weekly until healed. Review of R22's Physician Order dated 03/07/25, revealed the following order: Balsam Peru Castor Oil External Ointment (Balsam Peru Castor Oil), Apply to bilateral buttocks topically every day and night. Discontinued on 03/21/2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview of R22's wound treatment on 03/18/25 at 9:51 AM, with Registered Nurse (RN)2 revealed, upon entering the room, the privacy curtains were pulled and a Certified Nursing Assistant (CNA) was assisting with turning and repositioning, and had R22 turned and prepared for the treatment. RN2 entered the room, sanitized her hands and donned gloves. Sites were almost completely healed, pink. RN2 applied the [NAME] and [NAME] ointment from the tube to both areas, directly from the tube with gloved hands. RN2 held the tube of treatment in her gloved hand and placed the tube on the bed linens. After applying the ointment, she placed the tube in her pocket. She removed the gloves, then picked up a cup in one hand and held the dirty gloves in the other. She exited the room, went to the dining room, discarded the gloves in the trash and gave the cup to the kitchen. RN2 returned to the room, then washed her hands. She removed the cream from her pocket. She walked towards the treatment cart, but gave the Director of Nursing (DON) the tube of ointment and said it needed to be reordered. RN2 stated, the tube was on her night stand in the room. RN2 confirmed it was not sanitary to place it on the bed. When asked about why she didn't wash her hands after the treatment, RN2 stated she returned to the room and washed her hands, but didn't touch anything along the way because she had a cup in one hand and the gloves in the other. On 03/18/25 at 10:06 AM, an interview with Licensed Practical Nurse (LPN)1 revealed she had just placed R22's ointment back into the treatment cart. After discussing observations, she stated, the nurse should have had a barrier and placed the tube there or she could have poured it in a medication cup and left the tube on the cart. The tube was just given to me by my DON. I placed the tube back into the treatment cart. On 03/19/25 at 9:47 AM, an interview with the DON confirmed R22's ointment was given to her to reorder by RN2 and she handed it to LPN1. The DON stated, I expect the nurse to have a barrier for a dressing and items. Use a barrier for the cream or ointment. The nurse should sanitize or wash her hands before exiting the room.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on observation, interview, record review, and facility policy review, the facility failed to provide respiratory care in accordance with professional standards. Specifically, the facility failed to ensure 2 of 2 sampled residents (Resident (R)12 and (R)22), received the correct oxygen flow rate per physician's orders. Findings include: Review of the undated facility policy titled, Oxygen Administration revealed, Policy: Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in cases of emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. Review of R12's Face Sheet revealed R12 was admitted to the facility on [DATE], with diagnoses including but not limited to: paroximal atrial fibrillation, heart failure, long term (current) use of anticoagulants, acute ischemic heart disease, asthma, bipolar disorder, current episode mixed, mild, presence of automatic (implantable) cardiac defibrillator, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertension, gastro-esophageal reflux disease without esophagitis, ventricular tachycardia, pure hypercholesterolemia, and systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction. Review of R12's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/08/25, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R12 had mild cognitive impairment. Review of R12's Care Plan documented, Has oxygen r/t Dyspnea, Asthma. Documented goal indicated, Will have no s/sx of poor oxygen absorption through the review date. Documented intervention directed staff to, OXYGEN SETTINGS: O2 per provider orders. Review of R12's Medication Administration Record dated 03/01/25 - 03/18/25, revealed an order for oxygen at 2 liters with nasal cannula to keep 02 sats above 90%. Check 02 sats every shift. every shift related to ACUTE ISCHEMIC HEART DISEASE, DYSPNEA. Start Date 08/14/24. The document revealed documentation on the following days as noted with nurse initials: 03/17/25. Review of R12's Physician Order with a start date of 08/14/24, documented, O2 at 2 liters with nasal cannula to keep sats above 90%. Check O2 sats every shift. During an observation on 03/17/25 at 10:41 AM, R12 was lying in bed. R12's Oxygen via nasal cannula was set at 2.5 liters per oxygen concentrator. During an observation on 03/17/25 at 2:17 PM, R12 was receiving oxygen via nasal cannula at 2.5 liters per oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/17/25 at 2:22 PM, Registered Nurse (RN)1, verified the oxygen was set to 2.5 liters per minute and it should be on 2 liters per minute. RN1 adjusted to the oxygen to 2 liters per minute. During an interview on 03/19/25 at 9:50 AM, the Director of Nursing (DON) revealed, the nurses should have oxygen orders to get the resident's oxygen saturation. Some of the resident's oxygen rates are based on their saturation rates. The nurses should follow the doctor's orders based on the parameters. If the oxygen is on a different flow rate than the doctor's order specifies, this is a concern. Review of R22's Face Sheet revealed R22 was admitted to the facility on [DATE], with diagnoses that included but not limited to: acute respiratory failure with hypoxia, hydrocephalus, and mild cognitive impairment. Review of R22's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/04/25, revealed R22 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating R22 had mild cognitive impairment. Review of R22's Physicians Orders dated 03/03/25, revealed oxygen 2 liters per minute (lpm) via nasal cannula (N/C) to be administered to keep oxygen saturation (oxygen in the blood) above 90% every shift. During an observation on 03/17/25 at 12:38 PM, revealed R22's oxygen concentrator was set to 1.5 lpm, connected to a nasal cannula. During an observation and interview of R22 on 03/17/25 at 2:18 PM, revealed the oxygen concentrator remained at 1.5 lpm. RN1 verified the oxygen was set at 1.5 lpm, and stated it should be at 2 lpm. RN1 concluded, Someone may have messed with it. I turned it up this morning. During an interview on 03/19/25 at 9:47 AM, the Director of Nursing (DON) stated, If a resident is on oxygen, they should have oxygen orders. We have set parameters, then follow the orders. It is a concern if the oxygen is not at the correct liter. 50850

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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. 50850 Based on review of facility policy, observation, record review and interview, the facility failed to ensure proper handwashing and proper precautions utilizing gloves while removing and reapplying a transdermal patch for Resident (R)5, for 1 of 1 residents observed. Findings include: Review of the facility policy titled, Medication Administration, states, Policy: Policy Explanation and Compliance Guidelines: . 4. Wash hands prior to administering medication per facility protocol and product. 14. Remove medication from source, taking care not to touch medication with bare hand. 19. Wash hands using facility protocol and product. During an observation on 03/18/25 at 8:40 AM, during medication administration revealed, R5 was ordered Rivastigmine 4.6mg/24. Apply transdermal patch everyday. Registered Nurse (RN)1 prepared the medications for R5. RN1 signed the Medication Administration Record (MAR) to indicate the medications had been given. RN1 sanitized her hands, collected the medications and knocked on the door of the resident's room. RN1 placed the medications on the resident's bedside table. All of the by mouth medications were administered to the resident. RN1, with bare hands, removed the old transdermal patch and applied a new transdermal patch to R5's right arm without washing her hands. RN1 did not sanitize her hands or wear gloves before removing the old transdermal patch or before applying the new transdermal patch. During an interview on 03/19/25 at 9:50 AM, the Director of Nursing (DON) revealed that the nurses should wash their hands and wear gloves if needed for that specific medication. The DON stated that the nurses should sanitize their hands before and after medication administration. After utilizing the hand sanitizer three times, the nurse should wash their hands with soap and water. During an interview on 03/19/25 at 6:45 PM, RN1 confirmed that she had not sanitized her hands or worn gloves before removing the old transdermal patch and applying a new patch. RN1 stated, I do not wear gloves because I cannot reach the corner of the old patch to remove it with gloves on. I do not wear gloves to apply the new patch because it gets stuck on the gloves.