STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425323	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angel Oak Nursing and Rehabilitation Center, LLC	4452 Socastee Blvd Myrtle Beach, SC 29588

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 31846 Based on review of facility policy, record reviews and interviews, the facility failed to prevent missappropriation of resident property for Resident (R)2 and R3. Specifically, Licensed Practical Nurse (LPN)1 removed 5 pills from the narcotic locked box, belonging to R2 and R3. LPN1 did not administer the medications to the residents, for 2 of 2 residents reviewed. Findings include: Review of the facility policy titled, Abuse/Neglect/Exploitation/Misappropriation/Mistreatment/Injury, implemented on March 2022 and revised on April 6, 2023, documented, It is the policy of this facility to provide protections for the health, welfare, and the rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, mistreatment, including injuries of unknown sources and misappropriation of resident property. Compliance Guidelines: 2. D. c. Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money without the resident's consent. 3. The facility will provide ongoing oversight and supervision of staff to assure its policies are implemented as written. Review of R2's Face Sheet revealed the facility admitted R2 with diagnoses including, but not limited to: cerebrovascular accident with hemiparesis and hemiplegia, chronic obstructive pulmonary disease, and major depressive disorder. Review of R2's Physician Order revealed an order for Tramadol HCI 50mg 1 po q12 hours prn (as needed). Review of R2's Medication Administration Record (MAR) dated 10/01/24 - 10/31/24, revealed the medication Tramadol 50 milligrams, give 1 tablet every 12 hours as needed for pain. Review of R3's Face Sheet revealed the facility admitted R3 with diagnoses including, but not limited to: a fractured right femur and hemarthrosis of right knee and postpolio syndrome. Review of R3's Physician Order revealed an order for Oxycodone 5-325mg 2 tabs po q6 hours prn. Review of R3's MAR dated 10/01/24 - 10/31/24, revealed the medication Oxycodone 5-325 milligrams, give 2 tablets every 6 hours as needed for pain. (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility's Summary Report of Facility Investigation revealed, On 10/24/24 DON [Director of Nursing] completed a full investigation into the allegation of misappropriation of resident's property by an LPN [Licensed Practical Nurse] in the facility. After viewing video footage of the nurse on shift, it was confirmed that she had taken narcotics out of the narcotic drawer and did not administer them to the residents. In total it was 4 oxycodone 5/325 that belonged to [R3] and 1 Tramadol 50mg that belonged to [R2]. Employee was scheduled to work at 3pm that day. Incident was reported to the local police department, incident was reported to the SC ombudsman, DHEC, and the SC board of Nursing. Residents and residents' families were notified of the incident. The Nurse came in and DON and the Unit Manager both spoke with the nurse and asked her about the incident. LPN showed video footage of her taking the medication and she asked the DON please stop I know that you are showing me She did admit that she took the medication for herself. She stated that she ran out of her pain medication. She was immediately terminated and escorted outside the building. the Employee refused to take a drug test and said that it would come back positive. During review of the video footage, LPN1 was observed on the facility camera, taking Tramadol from the locked narcotic box. LPN1 removed 1 tablet from the blister pack and placed it in a cup. This was observed from the facility video by the director of nursing putting one Tramadol into the medicine cup. Furthermore, LPN1 could be seen removing 4 Oxycodone tablets from the blister pack for R3 and put them in a cup. LPN1 entered a resident room, in which neither of the medications was for. During an observation on 11/04/24 at an unspecified time, R2 was up in his wheelchair watching tv. R2 did not appear to be in distress or experiencing pain. R2 was unable to answer questions. During an interview on 11/04/24 at 11:20 AM, the Unit Manager (UM) stated, I viewed the video and saw her [LPN1] flip through the pages, it made me physically ill, all she said she wanted to do was have a party with her boyfriend. She admitted she took the pills, I walked her out and there was no remorse, what so ever. During multiple observations on 11/19/24, R2 was up and participating in activities and having lunch. R2 did not appear to be in distress or experiencing pain. During an interview on 11/04/24 at 1:06 PM, R3 stated she did not want anymore pain medications because she did not want to be addicted to anything. R3 further stated that she does not remember not getting her pain medications. During an interview on 11/04/24 at 10:40 AM, the DON stated LPN1 had the 5 pills in one cup and took the cup into another resident's room, which neither R2 or R3 resided in. When LPN1 came out of the room she did not have the cup in her hand. The DON stated that LPN1 admitted to taking the medications, and was terminated on 10/24/24. During an interview on 11/04/24 at 10:45 AM, the Administrator stated that she was not working at that time, and the investigation was handled by the DON. Multiple attempts were made to contact LPN1, with no success.

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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. 31846 Based on review of facility policy, observations, interviews and record reviews, the facility failed to ensure a procedure was followed during wound care, to prevent the spread of infection for Resident (R)9, for 1 of 1 residents reviewed for wound care. Findings include: Review of the facility policy titled, Hand Hygiene, dated 06/14/23 and revised on 10/26/23, documents, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. Review of the undated facility policy titled, Dressing Change (clean Technique), states: 9. Wash hands/use sanitizer and apply gloves. 10. Remove the soiled dressing and discard in trash bag at bedside. 11. Remove gloves and discard. 13. Wash hands/use hand sanitizer. 14. Put on gloves. 15. Clean the wound according to order. Clean from the center outward. Linear wounds may be cleansed from top to bottom. 16. Discard soiled gauze or Q-tip used for cleaning. 17. Remove gloves and discard if contaminated during cleaning. 18. Wash hands/use hand sanitizer. 19. Put on gloves. 20. Apply clean dressing as ordered. 21. Remove gloves and discard. 22. Wash hands/use hand sanitizer 23. Document the treatment on the treatment record. Review of R9's Face Sheet revealed the facility admitted R9 with diagnoses including, but not limited to: paraplegia, stage 4 pressure ulcer of the sacral area, neurogenic bladder, and multiple sclerosis. Review of R9's Physician Order revealed, Cleanse the wound with wound cleanser, apply calcium alginate to wound bed. Cover with bordered gauze daily and as needed. During an observation of wound care for R9 on 11/21/24 at 9:50 AM, revealed the following: Registered Nurse (RN)1 was assisted with wound care by RN2. RN1 and RN2 gowned up outside the door, then entered the room and washed their hands and applied gloves. RN2 explained the procedure to the resident then removed the bed sheet from the resident and aided the resident in turning to her left side. RN1 removed the soiled dressing, removed her gloves and washed her hands and then applied gloves, the wound bed is clean, does not have an odor, with some redness around the outside of the wound. RN1 removed her gloves and washed her hands and applied gloves, she had cleaned the scissors and the marker. RN1 opened the supplies and put them on the clean field on the over bed table. She wet a 4x4 with the wound cleanser and cleaned the wound inside out and then folded the 4x4 and and wiped around the outside of the wound. RN1 then took a dry 4x4 and wiped around the outside of the wound to dry it off. RN1 failed to remove her gloves and wash her hands, then cut a piece of the calcium alginate for the wound bed, and took the marker and wrote the date, time and her initials onto the border gauze. She placed the calcium alginate into the wound bed and then covered it with the bordered gauze. She then removed her gloves and washed her hands. The 2 nurses remained in the room to dress the resident for an outing with activities. (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 interview on 11/21/24 at 10:46 AM, RN1 confirmed that she had not removed her gloves and washed her hands after cleaning the wound and proceeded to apply the clean dressing.