STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425324	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - Garden City	9405 Hwy 17 Bypass Garden City, SC 29576

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 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** 50850 Based on observations, interviews, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 1 residents reviewed for respiratory care, Resident (R)70. Findings include: The facility did not provide a policy related to Oxygen Administration. Review of R70's Face Sheet revealed R70 was admitted to the facility on [DATE], with diagnoses including but not limited to: unspecified dementia, moderate, with mood disturbance Note: SEE PSYCH NOTES, solitary pulmonary nodule, basal cell carcinoma of skin of nose, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, chronic kidney disease, stage 3b, hyperlipidemia, hypothyroidism, unspecified osteoarthritis, major depressive disorder, recurrent, anxiety disorder, dysphagia, oropharyngeal phase, insomnia, chronic respiratory failure, unspecified protein-calorie malnutrition, syncope and collapse, and dependence on supplemental oxygen. Review of R70's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/18/24, revealed a Brief Interview for Mental Status (BIMS) was not conducted due to resident being never or rarely understood. Review of R70's Care Plan with a start date of 05/05/22, and a target date of 02/18/25, documented, At Risk for Respiratory Complications r/t H/o Nicotine Dependence, Dx. of Sinus Congestion, Post Nasal Drip. Uses O2 as needed. The documented goal revealed, Will have no unrecognized s/s of Respiratory Distress/Complications daily through next review. Interventions directed staff to, O2 2L via nasal cannula for Sats less than 93% as needed. Further review of the Care Plan with start date of 05/05/22 and target date 02/18/25, documented interventions revealed, Observe respiratory rate and airway effectiveness as needed and report as indicated. Observe tolerance of ADL's and activities. Assess lung sounds as needed and report as indicated. Medications as ordered; observe efficacy and adverse effects; notify MD as needed. Vital signs if symptomatic. Observe for SOB with exertion, at rest or when lying flat. Review of R70's Physician Order with a start date of 11/29/24, revealed, Oxygen Special Instructions: 2L/Min via nasal cannula - mild SOB, 3L/Min via nasal cannula - moderate SOB, 4L/Min via nasal cannula - severe SOB. Every shift, Days, Nights. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/07/25 at 1:29 PM, R70 was lying in bed. R70 was receiving oxygen via nasal cannula at a flow rate of 5 Liters Per Minute (LPM). During an observation on 01/07/25 at 3:37 PM, R70 was receiving oxygen at 5 LPM. During an interview on 01/07/25 at 4:13 PM, Licensed Practical Nurse (LPN)2 verified R70's order for oxygen. LPN2 stated, Oxygen should not be above 4 LPM. LPN2 entered R70's room and verified R70 was receiving oxygen at 5 LPM. LPN2 stated that staff probably bumped the oxygen up due to resident's O2 Sat. LPN2 verified that resident oxygen should not be above 4 LPM. LPN2 lowered R70's oxygen to 4 LPM. During an interview on 01/09/25 at 2:10 PM, the Administrator stated, NHC does not have an Oxygen Administration Policy. The facility just follows doctor's orders. During an interview on 01/09/25 at 4:20 PM, the Director of Nursing revealed, My expectation is that oxygen is provided for the patient per doctor's order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50850 Based on review of facility policy, observations, record review and interviews, the facility failed to ensure a medication administration error rate of less than 5 percent. The facility additionally failed to ensure an ordered medication for Resident (R)526 was administered timely. The medication administration error rate was 12.12 percent. Findings include: Review of the facility policy titled Specific Medication Administration Procedures revised on 01/01/19, documented, Purpose: To administer oral medications in a safe, accurate, and effective manner. Review and confirm medication orders for each individual resident on the Medication Administration Record PRIOR to administering medications to each resident. Pour correct number of tablets or capsules into the medication cup, taking care to avoid touching the tablet or capsule, unless wearing gloves. During an observation of medication pass on 01/08/25 at 7:44 AM, revealed Registered Nurse (RN)1 dropped a pill on the medication cart and picked the pill up with the medication wrapper and put it in the medication cup. The pill was administered to the resident. Further observation revealed RN1 did not administer an order for Bumetanide, Questran, or Voltaren Arthritis Pain Gel. Review of R526's Physican Orders revealed the following orders: Bumetanide 2 mg 1 tablet by mouth at 08:00 AM, Questran 4 Gms by mouth daily at 08:00 AM and Voltaren Arthritis Pain gel 1% apply to bilateral shoulders for pain twice a day at 08:00AM and 08:00 PM. During an observation of medication pass on 01/08/25 at 8:19 AM, revealed Licensed Practical Nurse (LPN)1 did not rinse the resident's mouth with water after administering Fluticasone Propionate Inhaler as directed in the physician order. LPN1 also failed to measure out the appropriate amount of water for administering Miralax. LPN1 did not measure the water and poured the water from a pitcher on the medication cart. During an interview on 01/08/25 at 7:58 AM, RN1 confirmed that she did drop a pill on the cart and pick it up with the medication wrappers and place it in the medication cup for R526. The medication was delivered to the resident and eventually consumed by the resident. RN1 stated that she, did not even think about it. During an interview on 01/08/25 at 8:27 AM, LPN1 was asked how she knew how much water to mix the Miralax powder in. LPN1 looked at the resident's order which did not specify. The nurse read the Miralax bottle which stated mix with 4 to 8 ounces of water. During an interview on 01/08/25 at 8:31 AM, LPN1 was asked why she did not rinse the resident's mouth out with water after she administered the inhaler as noted in the doctor's order. LPN1 stated, Oh my Gosh. I forgot. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 2:32 PM, RN1 stated that R526 Bumetanide 2mg 1 tablet by mouth was not discontinued as she previously stated. RN1 looked in the cart and gave it late at 10:10 AM. Bumetanide 2mg was due at 8:00 AM. RN1 stated that she did give R526's Questran 4 Gms late at 10:10 AM also. RN1 stated that she has not given the resident his Voltaren gel. The Voltaren gel was due at 8:00 AM also. During an interview on 01/09/25 at 4:20 PM, the Director of Nursing revealed that her expectation is that the medications be administered as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on review of the facility policy, observations and interviews, the facility failed to ensure medications and biologicals were properly stored in 3 of 7 medication carts. Findings include: Review of the facility policy titled, Medication Storage In the Facility documented, Policy: Medications and biological's are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. I. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are removed from inventory, disposed of according to procedures for medication disposal. J. Medication storage areas are kept clean, well lit, and free of clutter and extreme temperatures and humidity. K. Medication storage conditions are monitored on a quarterly basis by the consultant pharmacist or pharmacy designee and corrective action taken if problems are identified. During an observation on 01/08/25 at 2:55 PM, of the East Hall middle cart 2 revealed the following: Vitamin B Complex 2 tablets, Manufactured by [NAME] with Lot #36668 was expired on 11/07/2024. One tube of Iodosorb, Manufactured by [NAME] & Nephew with lot #BFA121, expired on 01/01/2025. One Telfa Dressing, STR 2 x 3, 1'8, Manufactured by Covidien with lot #45191 expired on 01/2024. Six Telfa Dressings, STR 2 x 3, 1'8, Manufactured by Covidien with lot #47904 expired on 09/2024. One Acticoat Flex 3 Sterile Dressing, 4 x 4, Manufactured by [NAME] & Nephew with lot #(10)2151 was expired on 10/01/2024. Two Calcium Alginate Wound Dressings with Antibacterial Silver, 4 x 5 in. (10 x 12.5 cm) Ref #EQX9045, GT IN (01) 10888277729292 with lot #83623126339, opened and partially used and no longer sterile was left on the medication cart and labeled as Single Use Only. One Derma Rite 5 x 9 with lot # F-20230313 was open and left on the cart, no longer sterile. One Dermaginate 4 x 5 dressing, open partially used and left on the cart, no longer sterile, lot #F-202404. One 4 x 4 border gauze bandage was removed from the package and had a hand written date of 11/02/2024. One Aquacel Foam dressing, 10 cm x 10 cm - 4 in. x 4 in. with lot #2491713 was expired on 02/2021. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One Aquacel - Convatec, 2 x 45 cm with lot #9M00928, opened on the cart and no longer sterile was expired on 12/01/2024. During an interview on 01/08/25 at approximately 3:00 PM, Licensed Practical Nurse (LPN)1 confirmed the expired, outdated, and opened medications and biologicals and removed them from storage. During an observation on 01/09/25 at 9:38 AM, of the East Hall medication cart 3 revealed the following: Two blunt plastic cannulas with lot#9228512 was expired on 09/30/2024. One 10 milliliter syringe with lot#9323497 was expired on 10/31/2024. During an interview on 01/09/25 at approximately 9:45 AM, LPN2 verified the expired items and removed them from storage. During an observation on 01/09/25 at 10:30 AM, of the East Hall medication cart 2 revealed the following: One packet of lubricating jelly 5 grams, manufactured by [NAME] with lot #CHBA11-02 was expired on 11/28/2024. One open [NAME] Point 3 milliliter needle was opened and unused but left on the medication cart. On 10/09/25 at approximately 10:35 AM, LPN1 verified the expired item and storage of the needle and removed them from storage. During an observation on 01/09/25 at 11:48 AM, of the North Hall medication cart 1 revealed the following: The medication Lasix, Manufactured by Avkare with lot #1257301872 had a use by date of 01/02/25. The medication Levothyroxine 75 micrograms filled on 01/10/2024 and expired on 12/31/2024, remained on the cart and was being administered to a resident. During an interview on 01/09/25 at approximately 11:53 AM, Registered Nurse (RN)2 verified the expired medications and removed them from storage.