STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425368	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johns Island Post Acute	3647 Maybank Highway Johns Island, SC 29455

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, and interview, the facility failed to check vital signs (VS) for Resident (R)1 and R2, according to the physician's order, for 2 of 3 residents reviewed. Findings include:Review of the facility policy, Medication and Treatment Orders with a revision date of 06/2016, revealed, Order for medications and treatments will be consistent with principles of safe and effective order writing. 1. Review of Resident (R)1's Face Sheet revealed he was admitted to the facility on [DATE], with diagnoses including, but not limited to, metabolic encephalopathy (brain dysfunction due to chemical imbalances in the body), urinary tract infection, diabetes, hemiplegia and hemiparesis (paralysis and weakness on one side of the body), dementia, and acute kidney failure. Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/17/26, revealed he had a Brief Interview for Mental Status (BIMS) score of 09 out of 15, which indicated he had moderate cognitive impairment. Review of R1's Care Plan revealed he exhibited cognitive loss due to dementia. His goal stated avoiding complications, such as falls, injury, impaired nutrition/hydration, and decline in Activities of Daily Living (ADL). Another focus was for R1's urinary tract infection (UTI). His goal stated the UTI would resolve without complications. Another focus stated R1 was at risk for impaired cardiac function and complications. His goal was to have no signs of cardiac distress.Review of R1's Orders revealed an order for R1's vital signs to be checked every shift. Review of R1's Oxygen Saturation (O2 Sat) Summary revealed no O2 Sat entries for 05/27/26, 06/02/26, 06/28/26. Only one entry per day was found for 05/28/26, 05/29/26, 05/30/26, 05/31/26, 06/01/26, 06/03/26, 06/04/26, 06/09/26, and 06/11/26. Review of R1's Pulse Summary revealed no pulse entries for 05/21/26, 05/23/26, and 05/27/26. Only one entry per day was found for 05/14/26, 05/17/26, 05/24/26, 05/26/26, 05/30/26, 05/31/26, 06/01/26, 06/02/26, 06/03/26, 06/04/26, 06/08/26, 06/09/26, and 06/11/26. Review of R1's Respirations Summary revealed no respiration entries for 05/23/26, 05/27/26, 06/02/26, 06/08/26. Only one entry per day was found for 05/14/26, 05/17/26, 05/21/26, 05/24/26, 05/25/26, 05/26/26, 05/30/26, 05/31/26, 06/01/26, 06/03/26, 06/04/26, 06/07/26, 06/09/26, and 06/11/26. Review of R1's Temperature Summary revealed no temperature entries for 05/21/26, 05/23/26, 05/27/26, 06/08/26. Only one entry per day was found for 05/14/26, 05/15/26, 05/17/26, 05/18/26, 05/24/26, 05/26/26, 05/29/26, 05/30/26, 05/31/26, 06/01/26, 06/02/26, 06/03/26, 06/04/26, 06/09/26, and 06/11/26.Review of R1's Blood Pressure (BP) Summary revealed no BP entries for 05/21/26, 05/23/26, and 05/27/26. Only one entry per day was found for 05/14/26, 05/17/26, 05/18/26, 05/24/26, 05/26/26, 05/30/26, 05/31/26, 06/01/26, 06/02/26, 06/03/26, 06/04/26, 06/08/26, 06/09/26, and 06/11/26. 2. Review of R2's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses including but not limited to, hemiplegia and hemiparesis, transient ischemic attack (mini-stroke), hypertension (high blood pressure), chronic kidney disease, heart failure, and acute cystitis (bladder infection). Review of R2's admission MDS with an ARD of 06/18/26, revealed she had a BIMS score of 12 out of 15, which indicated she had moderate cognitive impairment. Review of R2's Care Plan revealed a focus on ADL and mobility decline requiring R2 to need assistance related to hemiplegia and heart failure. Her goal included to have needs anticipated and met by staff. Another focus stated R2 had a risk of impaired (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitive function. Her goal was to communicate basic needs on a daily basis. Another focus revealed R2 was at risk for impaired cardiac function and complications. Her goal stated R2 will have no signs of cardiac distress. Review of R2's Orders revealed an order for R2's vital signs to be taken every shift. Review of R2's O2 Sat Summary revealed no O2 Sat entries for 06/13/26, 06/14/26, and 06/27/26. Only one entry per day was found for 06/19/26, 06/20/26, 06/22/26, 06/23/26, 06/24/26, 06/28/26, 06/29/26, and 06/30/26. Review of R2's Pulse Summary revealed no pulse entries for 06/27/26. Only one entry per day was found for 06/13/26, 06/14/26, 06/19/26, 06/20/26, 06/22/26, 06/24/26, 06/28/26, 06/29/26, and 06/30/26.Review of R2's Respirations Summary revealed no respiration entries for 06/13/26, 06/14/26, 06/20/26, 06/24/26, and 06/27/26. Only one entry per day was found for 06/19/26, 06/22/26, 06/29/26, and 06/30/26. Review of R2's Temperature Summary revealed no temperature entries for 06/13/26 and 06/27/26. Only one entry per day was found for 06/14/26, 06/15/26, 06/16/26, 06/17/26, 06/18/26, 06/19/26, 06/20/26, 06/21/26, 06/22/26, 06/23/26, and 06/29/26. Review of R2's BP Summary revealed no entries for 06/27/26. Only one entry per day was found for 06/13/26, 06/14/26, 06/15/26, 06/16/26, 06/19/26, 06/20/26, 06/21/26, 06/22/26, 06/28/26, and 06/29/26. During an interview on 07/01/26 at 10:50 AM, R1's family member revealed R1 was discharged from the hospital yesterday after being taken directly there, when R1 was discharged from the facility on 07/12/26. She stated he was in the hospital for 2 weeks. She revealed the hospital doctors indicated he was severely dehydrated, his sodium level was very high, and he had a UTI. The family member stated she spoke with the Director of Nursing (DON) and let her know that she was dissatisfied with the care her husband received. She again stated the hospital doctor said he was severely dehydrated, and she is very upset because R1 was a feeder. She revealed he relied on staff members to give him fluids throughout the day because he was not able to do it himself. She revealed she had been a Certified Nursing Assistant (CNA) for 20 years, and she knew her job. She stated she was an old-school CNA and knew what is supposed to be done for residents. During an interview on 07/01/26 at 2:45 PM, Licensed Practical Nurse (LPN)1 revealed R1 needed total assistance with his care, and he needed to be fed. She stated vital signs are usually the CNA's responsibility. However, if the resident is brittle, the nurse may take them instead. She stated the nurse is not supposed to use the previous shift's VS readings if the order is for VS to be taken every shift. She revealed she always knew to get the VS on her shift, and if the VS were taken on the previous shift just before shift change, she would wait to get the VS until later in her shift.During an interview on 07/01/26 at approximately 3:45 PM, the DON revealed when the nurses document in Point Click Care (electronic medical system), the system will prepopulate the vital signs from the last set taken. If the last set taken was on a previous shift, PCC will populate those results. She stated some Agency staff may be unaware of this when they are writing their notes. She revealed her expectation is if VS are ordered to be taken every shift, then VS need to be documented every shift.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility policy review, record review, and interview, the facility failed to ensure proper infection control measures were followed for Resident (R)4, for 1 of 1 resident reviewed on Contact Precautions.Findings include:Review of the facility policy, Isolation - Categories of Transmission-Based Precautions with a revision date of 09/2022, revealed, Contract Precautions . 7. Staff and visitors wear gloves (clean, non-sterile) when entering the room. b. Gloves are removed and hand hygiene performed before leaving the room. 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room.Review of Resident (R)4's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses including but not limited to, osteomyelitis of vertebra (infection in the bones of the spine), osteomyelitis of the left ankle and foot, extended spectrum beta-lactamase (ESBL) resistance (multi-drug resistant organism), and senile degeneration of the brain. Review of R4's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/15/26, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated she had moderate cognitive impairment. According to the MDS R4 did not show any physical or verbal behaviors directed towards others. She was dependent on others for all Activities of Daily Living (ADL) except eating. She was non-ambulatory. Review of R4's Care Plan revealed a focus related to, Isolation Precautions: Resident requires contact, single room isolation precautions due to ESBL Infection, VRE Infection (multi-drug-resistant organisms). Her goal included, Isolation using contact, single room precautions will be maintained while medically necessary. Interventions included maintaining isolation using contact, single room precautions, performing hand washing after completing care and leaving room, and using personal protective equipment as recommended for the type of infection R4 had. Review of R4's Order Recap revealed an order for, Strict Single room isolation with: contact precautions related to Extended-Spectrum Beta-Lactamases (ESBL) and Vancomycin-Resistant Enterococci (VRE) every shift. This order started on 06/25/26. During a random observation on 07/01/26 at 3:00 PM, revealed a Contact Precautions sign on R4's door indicating that all staff must put on gloves and a gown prior to entering the room. Gloves and gown supplies were noted to be hanging on R4's door. Further observation revealed Certified Nursing Assistant (CNA)1 entering the room of R4 with no gloves or gown on. Additionally, CNA1 did not sanitize her hands prior to going into room. While in the room, CNA1 spoke with R4. CNA1 was observed placing her hands on the side of R4's bed sheet. CNA1 was not observed sanitizing hands after leaving the room.During an interview on 07/01/26 at 3:00 PM, CNA1 revealed all staff are supposed to put on gloves and a gown prior to entering the room due to Contact Precautions. CNA1 stated she was also supposed to sanitize her hands prior to entering R4's room and when leaving the room. CNA1 revealed she had just gone in R4's room to check if the resident needed anything. She stated she was not in the room to provide care and had not realized she touched R4's bed sheet. She revealed she works part time at the facility and just recently started.During an interview on 07/01/26 at approximately 3:45 PM, the Director of Nursing (DON) revealed when a resident is on Contact Precautions, the staff must put on gloves and a gown prior to providing care. She stated if they are just going in the room to ask a question, they don't need to put on gloves and a gown as long as they do not touch anything or provide care. The DON stated CNA1 should not have touched R4's bed sheet when in the room without gloves and a gown on.