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	02/25/2026

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

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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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, and interviews, the facility failed to ensure Resident (R)137 was discharged from the facility to a safe environment.Per a phone interview with R137 and the Local Ombudsman, R137 revealed he was discharged from the facility on 01/22/26 to a home without utilities (water/electricity).R137 indicated this failure has caused his health to decline due to lack of adequate Durable Medical Equipment (DME-devices and supplies that are intended for repeated use and are essential for managing health conditions at home) and appropriate community services (Home Health), for 1 of 2 residents, reviewed for discharge. The Administrator and Director of Nursing (DON) were notified on 02/24/26 at 12:41 PM of an Immediate Jeopardy (IJ) at F627 at a Scope and Severity (S/S) of J in the area of Transfer and Discharge, specifically, appropriate discharge procedures. The IJ was determined to exist on 01/22/26 when the facility discharged Resident (R)137 to a home without adequate utilities (water/electricity). An acceptable IJ Plan of Removal was provided on 02/24/26 at 4:25 PM and was validated by the survey team on 02/25/26 at 12:28 PM. After the removal of the Immediate Jeopardy, the deficient practice remained at a scope and severity (S/S) of a D. Findings include:Review of facility policy titled Discharge Summary and Plan last revised September 2012, revealed, When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. Policy interpretation and Implementation include, when the facility anticipates a resident's discharge to a private residence, another nursing care facility, a discharge summary and post-discharge plan will be developed which will assist the resident to adjust to his/her new living environment. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's .special treatments or procedures (treatments and procedures that are not part of the basic services provided). The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his/her family. The resident or representative should provide the facility with a minimum of seventy-two (72) hour notice of a discharge to ensure that an adequate discharge plan can be developed. The Social Services Department will review the plan with the resident and family twenty-four (24) hours before the discharge is to take place.Review of R137's Face Sheet revealed he was admitted to the facility on [DATE] with diagnoses, including but not limited to; burn of third degree on right hand, encounter for surgical aftercare following surgery on the skin, burn of third degree of buttock, burn of third degree of abdominal wall, chronic pain, and need for assistance with personal care. Review of R137's Discharge with Return Not Anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/22/26 revealed that R137 has the Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicates that he is cognitively intact. Further review of the Discharge MDS in the Participation in Assessment and Goal Setting revealed active discharge (yes); has referral been made to the local contact agency (yes). Review of R137's Hospital (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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Discharge Summary with a Date of Service Date of 01/12/26 at 10:46 AM revealed R137 with a Past Medical History (PHM) significant for hypertension who presents with burns to the right hand, bilateral buttocks, bilateral posterior thighs, and right flank (side region of the torso between the lower ribs and the top of the hip bone, also known as the lumbar region). The patient states that the burn occurred this morning around 10 AM when he was turning his back to a propane-fueled heater and accidentally cut himself on fire. He states that he presented to an outside emergency department for evaluation, given the severity of his burns. He was subsequently transferred to MUSC for a higher level of care. He is a relatively poor historian and states his only medical problems are chronic pain and high blood pressure. Family history: history reviewed, no pertinent family history. Hospital Course: R137 presenting with a flame burn to the right hand, buttocks, bilateral thighs, and right flank that occurred on 12/07/25 by when his clothes caught on fire after backing into a propane heater, patient admitted to Burn Surgery Service for further evaluation and management of burn wounds .Patient not willing to go to neighbor for assistance, accepted to Skilled Nursing Facility.Review of R137's Discharge Planning Form with an effective date of 01/14/26 at 8:34 PM revealed Tentative discharge date : [DATE] discharge plan includes, resident's goal is to regain strength and endurance and heal his wounds. Home environment: lives alone, concerns about returning to home, four steps to enter home. Does the resident have family or a support network to provide assistance post-discharge: unknown. Primary caregiver for resident: self. Potential barriers to discharge: pending his progress in therapy, will discuss alternate discharge placement. Services/DME Needed After Discharge; will identify resources needed from resident and send referrals, DME needed after discharge: to be discussed, currently has a cane and walker, IDT to assist with discharge plans. Review of R137's Discharge Summary and Post-Care Instructions with an Effective Date of 01/19/26 at 2:12 PM revealed Social Services Discharge Notice, you are being discharged and his document is intended to inform you or your representative about the reason for your discharge and your next destination. Our goal is to provide you with the necessary information to help you prepare for a smooth transition to the greatest extent possible. Discharge information includes, date and time (01/22/26 at 12:00 PM). Reason for discharge: resident health has improved sufficiently so the resident no longer needs the services provided by the facility. Mode of transportation: other/NA; Home health services, no. Durable Medical Equipment (DME): wheelchair, DME ordered agency name and contact information: Home Medical 415 [NAME] Street [NAME] Corner SC 29461.Community Support Services: Salvation Army, Habitat for Humanities. Physical Functioning and Structural Problems, patient has made gains since working for therapy and contact guard for most physical function, patient remains a fall risk. Special Treatments, Devices and Procedures include dialysis (hemodialysis) and wound care. These Discharge Summary and Post Care Instructions were developed and reviewed by the Physician and Interdisciplinary Team (IDT) in coordination and participation with the resident and/or representative. This information was reviewed with a copy provided to the resident. This document was signed by Unit Manager (UM)1. Review of R137's Social Services Note dated 01/14/26 at 9:33 PM revealed admission Note, R137 was admitted on [DATE] from the Hospital, where he was being treated for extensive burns. He is alert and verbal and can make his needs known to staff. He scored a 15 out of 15 on his BIMS score and a 6 on his mood score, which indicates he has mild depression noted. Prior Level of Function (PLOF) was discussed, and he wishes to return to home on discharge with community resources. Prior to admission, he was able to do all self-care activities. His Mother (Resident Representative (RR)1) and neighbor (RR2) are available to assist if needed. Discussed R137 Primary Care Provider (PCP) and preferred Pharmacy, DME at home is a cane and walker, therapy will evaluate and treat to determine if any other DME is needed to return home safely. Copy of grievance policy and Ombudsman contact was provided to the resident. Review of R137's Social Services Note dated 01/21/26 at 10:32 AM revealed On the marginal date, Social Services talked with R137 regarding his living arrangements. R137 stated that he resides in his mother's house (RR1), which does not have electricity. R137 stated that the house has not had electricity in about five (5) years. (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R137 also mentioned how he would be able to get Social Security Disability. Review of R137's Onsite Primary Care Discharge Note dated 01/21/26 at 7:00 PM revealed Discharge Summary: Date of admit: [DATE], Estimated Date of discharge: [DATE]. R137 is discharging home today, patient has progress with therapy during his stay. Patent seen in wheelchair, awake, alert, and oriented times x4 (highest level of orientation). Patient is discharging home today and has progressed with therapy during his stay. Discharge instructions include please follow up with your primary care provider within one (1) to two (2) weeks for continued medication management and lab monitoring. New Equipment, DME, or Service Needs: cane: The patient has impaired mobility and gait instability related to recent injury and functional limitations. Patient requires the use of a cane to safely ambulate and perform activities of daily living. The cane is medically necessary to provide additional support, improve balance, and reduce the risk of falls. The patient is able to safely use the cane as instructed. Use of a cane will significantly enhance her mobility and safety within the home and community. Home Health Services: Home health for Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Home Health Aide (HHA), and Nursing for medication and disease management and education. This is a face-to-face visit. This patient is at a significantly increased risk due to acute/subacute issues on top of their underlying chronic conditions, which are also severe. They will require very close monitoring and frequent follow-up to avoid further complications if even possible. Home Health: The patient will need home health services due to due to homebound status. Homebound status is met due to the inability to tolerate any prolonged activity without requiring frequent resting, inability to tolerate prolonged ambulation, unsteady gait, inability to adequately ambulate on uneven terrain, and the need for general improvement, assistance, and strengthening. The patient also needs nursing for medication, disease management, and education.Review of a Progress Note dated 02/23/26 at 10:03 AM revealed, On the marginal date Social Worker (SW) received a telephone call from the Ombudsman regarding concerns from R137. R137 revealed he has not received his wheelchair, the remaining medications, the remaining of his wound care supplies, and home health. SW contacted R137 and revealed that Home Care came out to his house on Saturday. He is still waiting for his wheelchair. SW will follow up and return his call.A phone interview before the Recertification on 02/20/26 at 3:31 PM with the local Ombudsman revealed that they received a call from R137 stating the facility discharged him to an unsafe environment without running water or electricity. A phone interview on 02/23/26 at 2:39 PM with R137's RR1 revealed that they are currently residing in a skilled nursing facility and is non-interviewable. A phone interview on 02/23/26 at 2:41 PM with R137's RR2 revealed that R137 was admitted to the facility from the hospital after he accidentally set himself on fire. RR2 further stated that the resident is currently living in an unsafe environment that does not have electricity or running water, and the house is currently caving in (has structural issues). RR2 further stated that she is unsure if the resident left Against Medical Advice (AMA) or not, but stated that if he had been discharged appropriately, R137 would have called her to pick him up.A phone interview with R137 on 02/23/26 at 3:03 PM revealed R137 stated that he went through the proper procedure when it was time for him to discharge and spoke with the SW about his discharge and was told that he would have home health come to his house for services. R137 stated that no one has been to his house since he left the facility, and he still needs a wheelchair. R137 was able to find his discharge paperwork from the facility and stated that he signed the discharge summary and has a paper about post-care instructions. R137 further stated that the home that he is currently living in does not have running water or electricity. He stated, Before I had my accident and had to go to the hospital, I used to go to a nearby park to wash up and charge my phone, but now, I can barely walk, and I've been having a lot of falls. I also have been having a lot of pain with my wounds/scars.A follow-up interview with the local Ombudsman on 02/23/26 at 3:21 PM revealed that she spoke with the facility's SW related to R137 discharge. Ombudsman further stated that the SW wasn't able to find an exact date when she referred the resident to home health services, but Home Health visited the resident on 02/21/26. The Ombudsman finally stated that she spoke with the facility's Administrator about her concerns with (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R137 on last Wednesday, 02/18/26.A follow-up phone interview on 02/23/26 at 4:23 PM with R137 revealed that he did not go to his appointment with the burn clinic but was able to visit his PCP recently, and that is the provider who referred Home Health Services to visit him on 02/21/26. A phone interview with the Wound Care Nurse on 02/23/26 at 5:15 PM revealed that she was unable to recall R137 specifically, but was able to explain the facility's discharge process. She stated, Once rehabilitation coverage or insurance coverage ends, Social Services becomes involved to coordinate discharge planning. She stated that Social Services attempts to address any needs before discharge, including arranging home health services or assisting with housing if needed. She stated residents are provided a discharge packet, medications are explained, paperwork is signed, and residents generally provide their own transportation. An interview with the Unit Manager (UM)1 revealed that she explained the facility discharge process and stated that residents are typically sent home with two (2) to three (3) days worth of wound care supplies, if applicable. Residents are informed of the plan, including who will assist them, and staff communicate with residents throughout the stay. Home Health services and necessary DME should be arranged before discharge. She stated that family members are involved in reviewing the discharge paperwork at the bedside when appropriate. UM1 further stated that she was familiar with R137 and could recall him discharging from the facility. UM1 finally stated that she was unaware that the resident discharged to a home without running electricity and this information was brought to the IDT prior to R137 discharging from the facility. On 02/23/26 at 8:42 PM, a report was filed with the South Carolina Department of Social Services related to R137 being a vulnerable adult, living in an unsafe environment, without basic utility services. An interview on 02/25/26 with the facility's SW revealed that a few days prior from discharging from the facility, R137 reported to her that his current home did not have electricity and had been without electricity for the past five (5) years. The SW further stated that she made a referral to Salvation Army because they have services that assist with utility bills. The SW stated that the Ombudsman contacted her recently (02/18/26) because R137 reached out to the Ombudsman's Office due to still not receiving DME equipment/referral for Home Health services. The SW finally stated that she was unsure if she had communicated/updated R137's home background to the IDT team. A phone interview with the Home Health Company that was referred to R137 by his PCP on 02/25/26 at 10:30 AM revealed that Home Health attempted to provide services to R137 on 02/18/26 but was unable to accept him as a patient for caseload due to the condition of his home. The Company further stated that the nurse who went to visit the resident assisted him with wound care for his burns and provided him with canned groceries, such as soup and canned vegetables, so that the resident could have a few meals for a while. An interview with the Administrator and Director of Nursing on 02/25/26 at 1:02 PM revealed that they were not updated by the facility's SW on the condition of R137's home status and the lack of adequate utilities. A phone interview after the Recertification Survey with the local Ombudsman on 03/02/26 at 2:03 PM revealed that the resident still has not received adequate DME at this time and is still in need of Home Health Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** Based on review of the facility policy, observations, and interviews, the facility failed to ensure medications and biologicals were not expired, were properly stored, and were properly maintained for four (4) of six (6) medication carts reviewed and one (1) of one (1) wound care supply closet. Findings Include:Review of the facility policy titled, Storage of Medications last revised November 2020 revealed Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.Observations conducted on 02/23/26 and 02/24/26 of medication storage areas revealed there was one (1) wound care supply closet and three (3) units: Angel Oak Unit, [NAME] Unit, and [NAME] Unit. Each unit maintained two (2) medication carts (A and B) for a total of six (6) medication carts reviewed. The following discrepancies were identified:02/23/26 at 1:20 PM on the Angel Oak Unit (Medication Cart B) with Licensed Practical Nurse (LPN)1: -Glucagon Injection 1mg (milligram)/2ml (milliliter) expired August 202502/23/26 at 1:30 PM on the [NAME] Unit (Medication Cart A) with LPN4: -COVID-19 Antigen Testing Kit expired November 4, 2025 -Amber/orange pill bottle with mixed pills labeled Rosuvastatin 10mg tabs.02/23/26 at 1:45 PM, on the [NAME] Unit (Wound Care Supply Closet) with LPN5: -Packing Strip Iodoform, Lot #C22184, expired March 2024. -Cotton-Tipped Applicators, Lot #21623060003, expired June 30, 2023. -Lemon Glycerin Swab sticks (Triple Pack), Lot #612211220080, expired December 2024. -Skintegrity Eco Paraben-Free Hydrogel (Single Patient Use), Lot #27923100005, expired October 2025; package appeared opened/used with no tamper-evident seal intact in-spite of single-patient use labeling. -Lidocaine 4% Topical Anesthetic Cream, Lot #112211A, expired November 2024. -Povidone-Iodine Prep Pads 10%, Lot #61222040061, expired April 2025 (three boxes). -COVID-19 AccessBio Test, Lot #CP23B20, expired November 6, 2024.The Director of Nursing (DON) observed and confirmed all the expired medications and biologicals collected from the Angel Oak Unit, [NAME] Unit, and the Wound Care Supply Closet during an interview on 02/23/26 at 4:15 PM.All expired medications and biologicals reviewed on 02/23/26 were returned to the Assistant Director of Nursing (ADON) on 02/23/26 at approximately 5:00 PM.Observations on 02/24/26 revealed the following:2/24/26 at 12:34 PM on the [NAME] Unit (Medication Cart A) with LPN3: -Ondansetron 4 mg tablets labeled Discard After January 27, 2026 was expired at the time of review.02/24/26 at 2:43 PM on the Angel Oak Unit (Medication Cart A) with LPN2: - Povidone-Iodine Prep Pads 10%, 2-Ply, Lot# 61222040061, expired April 2025 (100 count box with 37 remaining).All expired medications and biologicals pulled on 02/24/26 from the [NAME] and Angel Oak Units were reviewed, confirmed expired, and returned to the DON during an exit interview on 02/24/26 at approximately 4:15 PM.

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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 observation, interview and record review, the facility failed to provide necessary care and services to prevent a sheering injury for Resident (R)133, for 1 of 2 residents reviewed for quality of care. Findings Include:Review of R133's Face Sheet revealed she was admitted to the facility on [DATE] with diagnoses including, aftercare following joint replacement surgery, presence of right artificial hip, systemic lupus erythematosus, Sjogren syndrome, mild intellectual disabilities, depression and urinary tract infection.Review of R133's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/20/26 revealed R133 is dependent with toileting hygiene and personal hygiene.Review of R133's Brief Interview of Mental Status (BIMS) performed on 02/20/26 revealed a score of 12 of 15, indicating moderate cognitive impairment.Review of R133's Baseline Care Plan dated 02/15/26 revealed that R133 is at risk for a decline in Activities of Daily Living/mobility and requires assistance to avoid significant decline. The Care Plan also states that R133 is incontinent and requires staff assistance and the use of pads and briefs for incontinent needs.During an interview with R133 on 02/22/26 at 11:46 AM revealed, They put diapers on me that were too tight and now I have a sore place. During an interview on 02/22/26 at 12:15 PM with R133's Power of Attorney revealed, She was forced to wear a brief that was too small for three to four days after she was admitted , which resulted in an open area that is bleeding in her right groin. The brief they have on her now is too big and they are pulling the brief too tight, which is causing pressure on that open area making it worse.An observation on 02/22/26 at 03:30 PM revealed an area to R133's right groin. There was an open area, approximately three inches in length, with a small amount of bright red drainage noted on the brief. R133 stated, The area is painful.On 02/25/26 at 10:08 AM, an interview with Wound Nurse/Infection Control Nurse revealed, To be honest, I think that she got that area from sheering from a diaper that was too tight. It is not that bad; it should heal up pretty quick. I am using a combination of a zinc cream with collagen mixed together with every brief change. I see her once a day to make sure it is there. Staff is good about letting me know when they run out. Residents are measured via their girth to determine sizing on briefing. The nurse or the CNA can do the measuring. I do not know if she has been measured. The brief that she has on now appears to be the appropriate size. She had no open areas when I saw her on 02/16/26. I see all new admissions the day after they are admitted . If the resident is admitted on a weekend, I will see them on Monday. I started treating her right hip/groin on 02/18/26. The abrasion is improving.On 02/25/26 at 10:30 AM, an interview with Licensed Practical Nurse (LPN)5 revealed all nurses and CNAs are trained to measure residents for the appropriate size brief on admission.On 02/25/26 at 10:35 AM, an interview with Unit Manager (UM)1 revealed, We measure the girth of all residents on admission, regardless of the day of the week, or the time of day that the resident is admitted . R133 has not been measured yet. I will get on that right now and we will measure her.On 02/25/26 at 10:40 AM, an interview with the Director of Nursing (DON) revealed, Staff does a great job measuring resident's girth on admission to determine the appropriate brief size.On 02/25/26 at 10:50 AM, a second with the DON revealed, We also determine the correct size brief by using the resident's weight. I know that she had an agency CNA when she was admitted . I answered her call light on 02/13/26. The resident said her briefs were too tight. She told me what kind of briefs that she wears, and I went and got them. I asked staff to change her. I put the pack of briefs that I got for her in her closet.On 02/25/26 at 11:15 AM, the DON revealed, she was unable to locate a policy regarding measuring residents for appropriate brief size.On 02/25/26 at 11:40 AM, a second interview with UM1 revealed there is nothing pertaining to a resident's weight being utilized to determine the size brief that a resident wears. UM1 showed the surveyor a brief package, and it referenced measuring a resident's girth to determine the correct brief size for a resident.On 02/25/26 at 02:35 PM, the DON revealed that there is not a generalized Quality of Care Policy.

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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 review of the facility policy, record review, observations, and interviews, the facility failed to follow the infection control policy by providing hand hygiene and usage of gloves, while providing resident care for Resident (R) 69. This failure had the potential to place R69 at risk for infection for the improper use of gloves while providing catheter care, for 1 of 4 residents reviewed for infection control.Findings include:Review of the facility policy titled, Handwashing/Hand Hygiene with a revision date of 2001 stated, All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene is indicated: immediately before touching a resident; before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); after touching a resident; after touching the resident's environment; immediately after glove removal. The following equipment and supplies are necessary for hand hygiene: Non-sterile gloves.Review of R69's face sheet revealed she was admitted to the facility on [DATE]. Her diagnoses included, but were not limited to, retention of urine, non-Alzheimer's Dementia, and vesicoureteral reflux with reflux nephropathy and bilateral hydroureter.Review of R69's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/04/26 revealed R69 had a Brief Interview for Mental Status (BIMS) score of 04 out of 15, which indicated R69 had severe cognitive impairment. The MDS also reveals R69 has an indwelling catheter, and the urinary continence is not rated.Review of R69's care plan, with an initiation date of 12/10/25, revealed R69 has an indwelling catheter with interventions including provide catheter care every shift. Further review of the care plan, with an initiation date of 07/25/23, revealed bladder incontinence: has mixed bladder incontinence and is related to dementia, diuretic use, difficulty with interventions to provide incontinence care on rounds, upon request and as needed.Review of R69's physician orders, dated 02/17/26, revealed resident requires enhanced barrier precautions during high contact resident care activities due to the presence of a foley. During an observation on 02/22/26 at 2:56 PM, R69's catheter was observed above her hip and clothes were wet, due to urine. She was sitting in the sitting area on her hall. During an observation on 02/23/26 at 8:51 AM, R69 was observed sitting in her chair, inside her room with her pants down, she removed her catheter bag, and it was sitting on the bedside table in front of her. Registered Nurse (RN)1 was observed touching R69's door and moving the bedside table with her gloved hands, before she helped R69 with the same gloves.During an observation on 02/25/26 at 8:51 AM, R69 was observed sitting in the chair in her room, appeared neat and clean and her catheter bag was positioned on her right leg.During an interview on 02/23/26 at 8:58 AM, RN1 revealed she put fresh gloves on prior to coming down the hall and entering the resident's room. She stated she is allergic to the gloves the facility supplies, so she has her own special gloves that she keeps on her cart. She also included she had just put her gloves on before going to the resident's room. RN1 stated she's never been told she couldn't put gloves on before entering the room to provide resident care. RN1 stated she receives yearly training on infection control, the most current training was October 2025.During an interview on 02/25/26 at 8:53 AM, R69 stated that she doesn't like her catheter bag and doesn't know what the bag is there for. She doesn't like wearing it and is aware she's not supposed to take it off, but does it anyway because it makes her uncomfortable.During an interview on 02/25/26 at 9:53 AM with the Infection Control Preventionist (ICP), she stated she recently completed random spot checks with staff related to hand hygiene. Staff receive annual training on hand hygiene and Personal Protective Equipment (PPE). She provides additional education and spot checks when she observes an infraction or identifies a need for improvement. The ICP reported that Evidence-Based Practice (EBP) training is provided regularly, including catheter care. Step-by-step instructions are posted outside residents' rooms to guide staff (continued on next page)

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	02/25/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on proper handwashing, glove use, and care tasks. She stated that staff are not allowed to put on gloves in the hallway. Gloves must be applied inside the resident's room after performing hand hygiene and removed inside the room. Gloves applied in the hallway are considered contaminated. Staff are expected to wash their hands before donning clean gloves upon entering a resident's room. When changing a catheter bag, staff should remove gloves, wash their hands, apply a new pair of gloves, complete the task, remove gloves, and wash their hands again. Failure to follow these steps may increase the risk of infection. The ICP further stated that staff should not carry gloves in their pockets, but instead bring needed supplies into the resident's room and apply gloves after performing hand hygiene.During an interview on 02/25/26 at 11:12 AM with the Director of Nursing (DON), she stated her expectation is that staff follow infection control protocols to prevent the spread of infection. Staff receive training on PPE at least annually and as needed. Staff also receive annual training on skilled catheter care, with additional education provided if concerns are identified. The DON reported that on 02/24/26, she reminded staff not to put on gloves in the hallway and to perform hand hygiene between glove use. When a nurse was identified as not following proper practice, she provided one-on-one education. The DON stated infections can occur during catheter bag changes if proper procedures are not followed. She stated gloves and necessary supplies are available, and staff are expected to bring supplies into the room and apply gloves after performing hand hygiene to maintain infection control standards.