STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425381	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - Charleston	2230 Ashley Crossing Drive Charleston, SC 29414

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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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure that Resident (R)24 received medications that had adequate/appropriate indications of use, for 1 of 6 residents reviewed for unnecessary medications. Specifically, the facility administered R24, a resident who does not have a history or diagnosis of blood glucose/sugar complications/diabetes, 10 units of insulin on two separate dates. The facility further failed to ensure that residents' orders were verified appropriately for accuracy and medications had an adequate/appropriate indication of use. R24 reported to facility staff/medical providers that her anxiety had worsened after this medication error, and she now questions every medication she receives from nursing staff at the facility. On 04/02/26 at 1:20 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 03/26/26. The IJ was related to 42 CFR 483.45 - Pharmacy Services.On 04/03/26 at 12:46 PM, the facility provided an acceptable IJ Removal Plan. On 04/03/26 at 1:16 PM, the survey team, validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F757 at a lower scope and severity of D.An Extended Survey was conducted in conjunction with the Recertification Survey for non-compliance at F757, constituting substandard quality of care.Findings include:Review of the facility policy titled Pharmacy Services revealed, The center shall have procedures for pharmaceutical services to meet the needs of each patient. Medication administration and monitoring systems shall be defined to assure maximum benefit from medication(s) ordered and administered, following manufactures' specification and standards of practice. Support center efforts to effectively manage medications, reduce unnecessary medication, and assist in focusing on appropriateness of use and length of therapy for targeted medications. Review of the facility policy titled Nursing Services last revised in May 2025, revealed, The goal of nursing documentation is to provide a timely recording of pertinent information regarding the safe and appropriate treatment, interventions, and responses in the patient's individual medical record. Documentation guidelines related to orders include: the center must ensure that written medical care of each patient is supervised by a physician. Written and verbal orders constitute the attending physician's directions for the treatment of the patient in the center. General polices for orders: all orders should be directly entered into the Electronic Health Record (EHR) upon receipt, or if handwritten by a provider, should be entered into the EHR from the written orders.Review of R24's Face Sheet revealed R24 was admitted to the facility on [DATE], with diagnoses including but not limited to, bacterial pneumonia, primary hypertension, primary insomnia, major depressive disorder single episode, and generalized anxiety disorder. Review of R24's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/17/26, revealed R24 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that R24 was cognitively intact. Review of the Active Diagnosis section revealed R24 was not diagnosed with diabetes mellitus (diabetic retinopathy, nephropathy, and neuropathy) during this assessment period. Further review of the admission MDS revealed in the Medication section, R24 did not receive any type of injection, including but not limited to insulin. During this assessment period, R24 was receiving antianxiety, antidepressant, and antiplatelet medication. Review of R24 Care Plan edited on 03/24/26 revealed, (continued on next page)

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

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[R24] has a diagnosis of anxiety and major depressive disorder, she receives antidepressant/antianxiety medication, which places her at risk for adverse effects of psychotropic drug use. Interventions include, assess resident's functional status prior to initiation of drug use to serve as a baseline; Assess/record effectiveness of drug treatment, monitor and report signs of sedation, hypotension, or anticholinergic symptoms; Pharmacy consultant review. Review of R24's Care Plan revealed that there were no Care Plan problems/interventions related to R24 being diabetic, having diabetic complications, which would indicate the use for insulin. Review of R24's Hospital Discharge summary dated [DATE], revealed, [R24] with a past medical history of asthma, prior history of Mycobacterium Avium Complex (MAC group of bacteria that can cause opportunistic infections), hypertension, chronic left lower lobe bronchiectasis (condition where damage causes the tubes in your lungs (airways) to widen or develop pouches). [R24] presented to the hospital due to worsening generalized weakness/fatigue and shortness of breath. During the duration of R24's hospitalization there was no indication that R24 had interventions/treatments related to diabetic complications. Review of R24's Prescription Order with an order receive date/start date of 03/25/26 and discharge date of 03/25/26, revealed an order description for Lantus Solostar U-100 Insulin (Insulin Glargine), insulin pen; 100 unit/ml (3 mL) amount 10 units subcutaneous (a method of administering medication just under the skin, between the fatty tissue and muscle) once a day at 9:00 AM. Further review revealed there was no diagnosis included for indication of use for this medication. This medication was ordered by Nurse Practitioner (NP)2 and was created and verified by Licensed Practical Nurse (LPN)4. Review of R24's Prescription Order with an order receive date/start date of 03/25/26 and discharge date of 03/30/26, revealed an order description for Insulin Glargine- insulin pen; 100 unit/mL (3 mL) amount 10 units subcutaneous once a day at 9:00 AM. Further review revealed there was no diagnosis included for indication of use for this medication. This medication was ordered by NP2 and was created and verified by Registered Nurse (RN)3. Review of R24's Medication Administration Record (MAR) dated 03/01/26 - 03/31/26, revealed an order for Lantus Solostar U-100 Insulin once a day at 9:00 AM with a start date and end date of 03/25/26. This medication was not administered on 03/25/26 due to the drug/item unavailable; there was no diagnosis or special instruction included for this medication/order. Review of R24's MAR dated 03/01/26 - 03/31/26, revealed an order for Insulin Glargine- 100 unit/mL (3 mL) 10 units subcutaneous once a day at 9:00 AM with a start date of 03/25/26 - 03/31/26. This medication was administered to R24 on 03/26/26 and 03/27/26. The order continued on 03/28/26, 03/29/26, and 03/30/26; however, R24 did not receive additional doses due to R24's refusal. Review of a Pharmacy Consolidated Delivery Sheet dated 03/25/26, revealed an order for Insulin Glargine- U10, 3 mL for R24 that was ordered by Medical Doctor (MD)1. Review of R24's Psychiatric Initial Evaluation dated 03/25/26 at 2:20 PM, by the Psychiatric Nurse Practitioner (NP)3 revealed, [R24] a resident at the facility due to having multiple medical problems, including with her lungs, neuropathy, and rehabilitating from a fall. Patient was referred due to anxiety, and reports feeling overwhelmed; she does not relax easily, asking for Xanax to go to bed/to fall asleep. She has been having depression, anhedonia (reduced ability to experience pleasure or a loss of interest in previously enjoyed activities), decreased appetite, low energy, trouble concentrating, feeling bad about herself, anxiety, restlessness, passive thoughts of not being here, no plan or intention, and denies Auditory Verbal Hallucinations (AVH). [R24] is worried about going home and her health getting better. Patient has a history of mental health care/medications/past therapy attempts about 40 - 50 years ago when getting a divorce. During that time, she suffered from depression/anxiety and took medications for her mental health. Plan for treatment includes generalized anxiety disorder, patient diagnosis with anxiety longer than six months ago, and continues to be treated with anxiety/anxiolytic medication. Moderate diagnosis with depression in the past, still having symptoms, adjustment disorder with emotional disturbance, the patient struggles with her current medical state, which is causing some mood changes, including depression and anxious emotions. Plan of care includes increasing Lexapro 10 mg (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(an antianxiety medication) and tapering off Xanax (an antianxiety medication) due to healthcare risks of dementia and respiratory depression. Take 1/2 of a tablet by mouth daily for two weeks, then stop if the patient struggles with tapering. Try long-acting benzodiazepines (sedative-hypnotic medications that, by increasing GABA neurotransmitter activity, reduce brain activity to treat anxiety, insomnia, and seizures) for tapering. The Psychiatrist Nurse Practitioner reviewed R24's current medications that she is receiving at the facility; there was no indication that the resident was receiving insulin during this review. Review of R24's Nurse Practitioner Progress Note dated 03/26/26 at 1:06 PM, and signed/revised on 04/01/26 at 8:19 AM, revealed, Chief complaint/nature of presenting problems seen today for follow up of cough and urine results. Recent orders and medication profile have been reviewed, . Medication list including dose and frequency is taken from the facility where patients reside and reflects the best information available at the time of the encounter. Several medications were reviewed during this visit including insulin glargine- 100 unit/mL (3 mL) insulin pen Once A Day 10 units, subcutaneous, Once A Day, TI for Lantus 03/25/2026 Active. There was no diagnosis or indication of use for this medication . Updated diagnoses on 03/30/26 at 6:03 AM include bronchiectasis, anxiety, urinary frequency, and primary hypertension. Clinical, correction under medication list disregard insulin glargine 10 units at bedtime at this is not a prescribed medication for this patient, revised on 04/01/26 at 8:19 AM by [NP1].Review of R24's Nurse Practitioner Progress Note dated 03/31/26 at 12:20 PM, revealed, Chief complaint/nature of presenting problem, seen today for follow up of chronic conditions following hospitalization for weakness, shortness of breath, fatigue. Today's visit, patient seen today for ongoing clinical follow-up, recent orders and medication profile have been reviewed, patient found resting in bed. She feels fatigued and doesn't want to do therapy today, . She's upset that she was advertently given insulin, her family is aware and this issue has already been addressed by the Director of Nursing (DON). Review of R24's Psychiatric Follow-up Evaluation dated 04/01/26 at 10:19 PM, revealed, Patient seen for follow-up for Generalized Anxiety Disorder (GAD) for medication monitoring since Lexapro increased . Last visit writer [NP3] ordered the following changes, increased Lexapro to 10 mg daily and taper off Xanax 0.25 mg 1/2 tablet a day. Xanax was not stopped; the patient is taking an increased dose of Lexapro with little relief for her anxiety. Patient is taking an increased dose of Lexapro with little relief for her anxiety at the present time; she is having an increase in anxiety due to recent events. Her anxiety is a eight out of ten on a scale of zero, meaning none and ten being the worst. She is sleeping fine, her blood pressure has been elevated lately as well, she is having some dry mouth and denies suicidal ideations. Provider [NP3] discussed Lexapro recently increased last week and recommended the patient to wait one more week before doing another medication change. Per her daughter, her medications are not working well at this time for anxiety under the circumstances; however, due to Lexapro being increased one week ago, she is willing to wait another week before increasing it again. Plan of care . is to continue current regimen Lexapro 10 mg daily, do not taper off Xanax due to patient being under increased stress and having increased anxiety right now (Xanax was not stopped at last visit), consider increasing Lexapro 20 mg daily next week. Review of R24's MAR dated 03/01/26 - 03/31/26, revealed an order for Alprazolam (generic name for Xanax) 0.25 MG as needed/PRN for anxiety. R24 received this medication on 03/28/26 and 03/30/26, despite her Psychiatric NP requesting this medication be stopped on 03/25/26, due to healthcare risks of dementia and respiratory depressionReview of R24's Social Services Progress Notes dated 04/02/26 at 6:22 PM, revealed, Master Social Worker (MSW) followed up with [R24] related to her anxiety, she was lying in bed with her husband at the bedside. She was first asleep then woke up while speaking with her husband. [R24] began to share about her medications and her anxiety. [MSW] allowed resident to freely share what she was feeling, [MSW] offered her a current medication list and she informed writer she already requested having one. [MSW] also offered her to follow up with medical staff related to her anxiety. [MSW] allowed her to share and offered coping mechanisms to assist with how she was feeling. Resident voiced thankfulness at the time of visit. Writer provided her with a (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	business card and offered her to ask for writer or to call when needed. Resident sent for writer again to share what she was feeling and writer allowed resident to speak openly and freely. Resident shared her family has offered to move her to another facility and writer informed resident of assisting her and her family in their needs. However, resident stated she didn't want to move. [MSW] will follow up with resident again tomorrow.Review of R24's Medical Director (MD) Progress Note dated 04/03/26 at 6:18 PM, revealed, Chief complaint/nature of presenting problem: NHC [NAME] Medical Director visit following an incident, patient is seen in follow-up for MD visit after recent incident. It appears that an erroneous order for Lantus 10 units daily was entered in her record last week, and on both 03/26/26/ and 03/27/26 she received that medication. Realizing that this was not correct, she refused on 03/28/26 and 03/29/26. On 03/30/26, the error was discovered, and the medication was appropriately discontinued. In interviewing [R24] she cannot indicate any symptoms of hypoglycemia that might have occurred, but did say she may have felt peculiar. She also states that she feels peculiar today, clearly with no relation to insulin several days ago. Vital signs monitored regularly during those days disclosed nothing suggestive of the effects of the insulin. When the error was discovered, blood sugars were checked, and there was no hypoglycemia. There were no notes of anything out of the ordinary from her usual by any nurses during the days she received the insulin. There was a concern that the erroneous medication administration made her extremely anxious. However, she has known generalized anxiety disorder and has been seen by the psychiatric NP here with ongoing medication adjustment. She has been followed up on since the incident with no apparent change. In examining the medication administration record it is noted that the Xanax that she had ordered as needed for anxiety was not requested during any of this time. On recent follow-up with a psychiatric NP, the patient preferred to leave the current Lexapro dose where it is, with consideration for an increase later.During an interview on 03/31/26 at 11:03 AM, R24 revealed, A few days ago, I received 2 injections of insulin, but I am not diabetic. At first, I was agreeable to receiving the medication (03/26/26 and 03/27/26) because I was unsure if something had changed with blood sugars, if I had a change of condition. I've been having a lot of other health issues lately, so I didn't question the medication. After receiving the 2nd injection (03/27/26) I felt sleepy and was certain that this was an error. A male nurse attempted to give me two more doses of insulin, but I refused because I didn't want to have another reaction. During the interview with R24, she stated that her anxiety has increased/worsened due to the potential negative impact this could have had on her. R24 was also concerned about the health and well-being of other residents, specifically those who may have dementia/cognitive impairments that would not be able to communicate with staff if they received the wrong medication. R24 finally stated that the Director of Nursing (DON) is aware of this incident, and the resident, along with her Resident Representative, notified the DON of this situation. During an interview on 04/01/26 at 10:45 AM, R24 and her Resident Representative (RR) revealed that the resident received two insulin injections (03/26/26 and 03/27/26). During these injections, the nurse did not check the resident's blood sugar appropriately prior to administration. During the interview with R24 and her RR, both parties were visibly upset about this incident related to R24 inadvertently receiving insulin, R24 and her RR became tearful and frustrated because of this incident by the facility staff. During an interview on 04/01/26 at 11:15 AM, Nurse Practitioner (NP)1 revealed that the process of insulin administration is that providers write the order based on blood sugars, then nurses should check blood sugars and administer the insulin. NP1 is aware of inadvertent insulin medication that R24 was administered. NP1 at this time was only aware of inaccurate administration (03/26/26) but verified through the MAR during interview that the resident received the medication on 03/26/26 and 03/27/26. NP1 further stated that she was informed about this situation by the DON but was not at the facility at this time. NP1 returned to work the following Monday (03/30/26) and was educated on this situation, which revealed that NP2 ordered this medication, but she is not the NP for R24. The original order for R24 should have been Lexapro but was misinterpreted as insulin; Lexapro was recommended/ordered by the Psych NP to increase for Lexapro due to diagnosis of anxiety/ (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	increased anxiety. During an interview on 04/01/26 at 12:08 PM, Licensed Practical Nurse (LPN)4, who is the Computer Order Entry Clerk, revealed that R24's order was left overnight, the night before. Most providers have hand-written orders. LPN4 further stated that she is unable to locate the handwritten order for this resident and further stated that when she put it in, it was for 10 units of Lantus handwritten on 03/24/26. LPN4 concluded that orders are verified several times before they make it to the Order/MAR, which includes verification by the nurse, physician, and pharmacy. During an interview on 04/01/26 at 12:15 PM, the Unit Manager (UM)1 revealed that orders are mostly handwritten by providers on a yellow sheet and are left for the Computer Order Entry Clerk to input into the electronic medical record for residents, orders are then verified by the pharmacy. UM1 stated that she was working the cart that day (03/26/26 and 03/27/26) and was the nurse that administered the insulin to the resident. UM1 stated, I remember asking [R24], I didn't know you were a diabetic, but [R24] never replied or corrected me. UM1 further stated that she did not check the resident's blood sugar prior to administering because sometimes insulin is used for a off-brand reason, [UM1] also stated that she did not observe [R24] have any side effect/negative impacts from this. UM1 finally stated that the facility administration is about to change the process of order entry into the electronic medical record and will now have providers putting in orders, UM1 was unsure about when this change will take effect and stated providers still have to be educated on the new process. An attempted interview on 04/01/26 at 3:26 PM, with LPN5 (Male Nurse Identified by R24) was unsuccessful; a voicemail message was attempted, but the mailbox was full/unable to leave a message. During an interview on 04/01/26 at 3:31 PM, the DON revealed that she was made aware of this incident on Monday (03/30/26) and began the investigation process by interviewing the resident and the nurses that were assigned to her and gave the resident insulin, along with the Computer Order Entry Clerk. The DON stated that they were unable to locate the physical handwritten order related to the insulin, but stated that the facility is changing the process on how orders are put into the medical record. The facility will now implement providers putting the orders into the record. During a phone interview on 04/01/26 at 4:44 PM, the Medical Director (MD) revealed that he was notified about R24 inadvertent administration of insulin this morning (04/01/26) and was notified by the residents Nurse Practitioner. The NP was made aware of this incident on Monday (03/30/26). They were informed that the order was written by a different NP, NP2. The MD further stated that the resident had a low risk for developing a negative side effect due to the low amount of insulin that she received but some potential side effects could be hypoglycemia/low blood sugar. The MD stated the resident's psycho-social status was discussed due to the resident's increased anxiety after this incident and he stated he was unsure if the resident was being followed by psychiatric services. During a follow phone interview with the MD on 04/02/26 at 8:58 AM, revealed that typically when there is a medication error, if the providers are the person to recognize the error, then they notify me about the medication. If it is a nurse that observes an error then they expect them to notify the DON which should then be relayed to the resident/resident representative, along with the MD, and any other responsible provider. The MD further stated that this incident is still being investigated by the facility Administration but the process moving forward beginning on 04/01/26, are for the providers to input the order into the electronic medical record. The MD finally stated that he would have expected for the facility Administration to notify him of the resident's change sooner but feels that they may have delayed the notification due to the resident not having a serious adverse reaction to the insulin. The notification may have also been delayed because the investigation is still ongoing about the staff member that ordered the insulin. During an interview on 04/02/26 at 10:17 AM, NP2 revealed that they were informed by Certified Nursing Assistant (CNA)1 that the resident had concerns about receiving insulin inappropriately. NP2 went to verify the order because the resident's NP, NP1, was not in house at this time. At that point, NP2 discovered that the order was written in her name, she then went to ask the Computer Order Entry Clerk (COEC) about how this happened and COEC admitted she made a mistake and entered Lantus instead of Lexapro that was ordered by the resident psych NP, NP3. NP2 (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	further stated that this incident should have been caught by the pharmacy when they verified the order and changed the order from Lantus to insulin glargine- insulin pen; 100 unit/mL (3 mL); amt: 10 units; subcutaneous. NP2 finally stated the facility now is having providers put in their own orders, and this was in the process prior to this incident, but initiated on 04/01/26. During a phone interview on 04/02/26 at 11:09 AM, the Psychiatric Nurse Practitioner (NP)3 stated that the resident has a history of anxiety but since being administered the incorrect medication, her anxiety has increased. NP3 met with the resident yesterday, 04/01/26, and spoke with her about this incident.During an interview on 04/02/26 at 11:14 AM, CNA1 revealed that they were the first staff member that R24 reported this incident to, CNA1 further stated that she reported it to NP2 which prompted the investigation. CNA1 stated that the resident has been stating that she is anxious about this incident and overall care at the facility. During an interview on 04/02/26 at 11:41 AM, LPN3 revealed that she works at the facility on Thursdays during the day and on Sunday nights overnight. LPN3 stated that R24 is a very anxious resident but is alert and oriented times 3, very sharp. LPN3 further stated that she did not administer any insulin to R24 and is unsure why her name is signed off on the MAR for 03/30/26 at 9:00 AM for insulin medication that R24 refused when she clocked out of the facility at 7:02 AM. LPN3 provided copy of timeclock which confirmed she had already left the facility when the MAR was signed off. During an interview on 04/03/26 at 9:40 AM, the DON stated the facility realized that there is an error with the EMR. There is currently a glitch that is causing nurses sign off, they are not fully logging out which will cause the oncoming nurse to chart under the prior nurses' name. On 03/30/26, scheduled at 9:00 AM charted for 03/30/26 at 10:09 AM, LPN3 verified that she clocked out at 7:02 AM. DON confirmed today that this date refusal was completed by UM1 on 03/30/26. On 04/03/26 at 12:46 PM, the facility provided an acceptable IJ Removal Plan, which included the following: . Identification of Root CauseFollowing internal review, the facility determined that the event was the result of a breakdown in the medication order entry and verification process, specifically related to ensuring that orders are supported by a clearly identified source and accurately attributed to the appropriate provider prior to entry and administration.Identification of Other Residents at RiskOn March 30, 2026, the facility conducted a targeted audit of all residents in certified beds with active insulin orders to verify appropriate clinical indication. A total of 18 or 18 residents receiving insulin were reviewed, and 100% were confirmed to have a documented diagnosis of diabetes supporting the use on insulin therapy .Additionally, on April 2, 2026, consulting pharmacists initiated a 100% audit of all active medication orders to ensure accuracy and appropriate indication. As of April 3, 2026, no additional residents were identified as having received medications without appropriate indication.Systemic Corrective ActionsOn April 2, 2026, the facility initiated corrective actions to address the identified process gap. All licensed nursing staff were in-serviced by the DON on revised expectations for medication order verification, including the requirement to confirm the accuracy of all newly entered orders, validate clinical indication, and obtain clarification from the provider when any order is unclear prior to administration.On April 2, 2026, providers were notified by the DON and re-educated regarding expectations for order entry and authentication, including the requirement to ensure all orders are accurate, clearly intended, and appropriately attributed prior to signing.Additionally, the facility implemented enhanced controls requiring that all medication orders originate either directly from the provider or from clearly verified source documentation.Monitoring PlanBeginning April 2, 2026, the facility initiated a 100% audit of all newly entered medication orders for a period of seven days. This will be followed by weekly audits for four weeks and ongoing monitoring through the facility's Quality Assurance and Performance Improvement (QAPI) program to ensure sustained compliance. The audits will be conducted by the DON or designee.IJ RemovalIJ Removal Summary:The medication was discontinued on March 30, 2026 following provider evaluationThe resident remained clinically stable with no evidence of serious harmObjective clinical data, including a blood glucose of 166 mg/dL obtained on March 28, 2026, confirms that the resident was not experiencing and was not trending toward hypoglycemia or (continued on next page)

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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. Based on observation, record review, interview, facility policy review, manufacturer and pharmacy labeling review, the facility failed to ensure that drugs and biologicals were properly stored in 2 of 2 medication rooms.Findings include: Review of the facility policy titled MEDICATION STORAGE IN THE FACILITY revised on 2/25/2025, states, Medications and biologicals are stored safely, securely and properly, following manufacturer's recommendations or those of the supplier . All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. During observation on 03/31/2026 at approximately 10:55 AM, of the 200 Hall Medication Room refrigerator revealed the following:- 2 bottles of Augmentin 400mg (milligram)/5 ml (milliliter) Susp (Suspension) in active storage and labeled by pharmacy Do No Use After 3/28/26 and Do Not Use After 3/27/26- 1 opened vial of Purified Protein Derivative/Aplisol 5 TU (test units) /1 ml (10 tests) approximately 20% (percent) full and undated when opened with manufacturer labeling stating: Once entered discard after 30 days. During an interview on 03/31/2026 at approximately 11:06 AM, Registered Nurse (RN)1 verified that the opened vial of Aplisol had not been dated when opened and that the bottles of Augmentin were expired. During an observation on 03/31/2026 at approximately 3:05 PM, of the Hall 100 Medication Room revealed:- 8 Fecal Occult Blood Tests Lab Kits Enhanced Readability by Consult Diagnostics Lot 0822192 with an expiration date of 12/03/2025, located on the 2nd shelf of the shelving unit to left of the refrigerator. During an interview on 03/31/2026 at approximately 3:16 PM, Licensed Practical Nurse (LPN)1 verified that the fecal occult blood tests had expired on 12/03/2025. During an interview on 04/01/2026 at approximately 5:21 PM, the medication storage findings were reviewed with the Director of Nursing (DON) who stated those things should not be left in active storage and that Aplisol should have been dated when opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425381	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - Charleston	2230 Ashley Crossing Drive Charleston, SC 29414

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and review of facility policy, the facility failed to ensure Resident (R)9's dignity was protected for 1 of 1 residents observed with catheter bag. Specifically, R9's catheter bag was not covered.Findings include: Review of the facility's policy titled Administrative Procedures Manual . Establishing a Customer Satisfaction Culture revised 2-1-2011 states, Respect your privacy, dignity, and confidentiality. During an observation on 03/31/2026 at approximately 11:11 AM, during the 200 Hall initial tour, a Certified Nursing Assistant (CNA) rolled R9 in his wheelchair to a table in the common area opposite the nursing station and walked away leaving him at the table. Further observation revealed a fully visible and uncovered urinary bag approximately 3/4 full, was hanging beneath R9's wheelchair. During an observation on 03/31/2026 at approximately 11:25 AM, R9 was observed sitting at the same table, with the urinary bag beneath his wheelchair, still uncovered and visible. Further observation revealed multiple staff members, other residents, and a visitor were in the immediate area. During an interview on 03/31/2026 at approximately 11:28 AM, Registered Nurse (RN)2, who was standing at the nursing station, viewed R9 and his wheelchair and confirmed that his urinary bag was not covered and stated it should be covered. During an interview on 04/01/2026 at approximately 5:23 PM, the Director of Nursing stated that urinary bags should be covered to protect resident's dignity.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure that Resident (R)24's Medical Doctor/Director was informed in a timely manner of an inadvertent administration of a medication, for 1 of 3 residents reviewed.Cross reference F757 Findings include:Review of the facility policy titled Policies and Procedures Regarding Change in Patient Status last revised in 2025 revealed, The patient or patient representative is encouraged to be involved in all decision-making regarding changes in the plan of care. Notification of the patient representative, charge nurse on duty is notified immediately of any change in a patient's condition. The charge nurse will then assess the patient's condition and notify the physician or physician extender and the patient's representative. When a significant change in medical condition has occurred, or the patient is assessed to be critically ill, the attending physician will be notified immediately. Should the attending physician or physician extender not be available, the alternate physician will be notified. When a medical condition is identified and the attending/alternate physician in unavailable, the charge nurse will take the steps necessary to assure appropriate medical care is provided, including but not limited to, contacting the center's Medical Director. Review of R24's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses including but not limited to, bacterial pneumonia, primary hypertension, primary insomnia, major depressive disorder single episode, and generalized anxiety disorder. Review of R24's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/17/26, revealed that R24 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that R24 was cognitively intact. Review of the Active Diagnosis section of the MDS revealed R24 was not diagnosed with diabetes mellitus (diabetic retinopathy, nephropathy, and neuropathy) during this assessment period. Further review of the admission MDS revealed R24 did not receive any type of injection, including but not limited to insulin. During this assessment period, R24 was receiving antianxiety, antidepressant, and antiplatelet medication. Review of R24's Medication Administration Record (MAR) dated 03/01/26 - 03/31/26, revealed an order for Insulin Glargine-100 unit/mL (3 mL) 10 units subcutaneous once a day at 9:00 AM with a start date of 03/25/26 - 03/31/26. Further review of the MAR revealed this medication was administered to R24 on 03/26/26 and 03/27/26. The order continued on 03/28/26, 03/29/26, and 03/30/26; however, R24 did not receive additional doses due to refusal.Review of R24's Nurse Practitioner Progress Note dated 03/26/26 at 1:06 PM and signed/revised on 04/01/26 at 8:19 AM, revealed, Chief complaint/nature of presenting problems seen today for follow up of cough and urine results. Recent orders and medication profile have been reviewed, . Medication list including dose and frequency is taken from the facility where patients reside and reflects the best information available at the time of the encounter. Several medications were reviewed during this visit including insulin glargine-100 unit/mL (3 mL) insulin pen Once A Day 10 units, subcutaneous, Once A Day, TI for Lantus 03/25/2026 Active. There was no diagnosis or indication of use for this medication . Updated diagnoses on 03/30/26 at 6:03 AM include bronchiectasis, anxiety, urinary frequency, and primary hypertension. Clinical, correction under medication list disregard insulin glargine 10 units at bedtime at this is not a prescribed medication for this patient, revised on 04/01/26 at 8:19 AM by [NP1].Review of R24's Nurse Practitioner Progress Note dated 03/31/26 at 12:20 PM, revealed, Chief complaint/nature of presenting problem, seen today for follow up of chronic conditions following hospitalization for weakness, shortness of breath, fatigue. Today's visit, patient seen today for ongoing clinical follow-up, recent orders and medication profile have been reviewed, patient found resting in bed. She feels fatigued and doesn't want to do therapy today, . She's upset that she was advertently given insulin, her family is aware and this issue has already been addressed by the Director of Nursing (DON). Review of R24 Medical Director (MD) Progress Note dated 04/03/26 at 6:18 PM, revealed, (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Chief complaint/nature of presenting problem: NHC [NAME] Medical Director visit following an incident, patient is seen in follow-up for MD visit after recent incident. It appears that an erroneous order for Lantus 10 units daily was entered in her record last week, and on both 03/26/26 and 03/27/26 she received that medication. Realizing that this was not correct, she refused on 03/28/26 and 03/29/26. On 03/30/26, the error was discovered, and the medication was appropriately discontinued .During a phone interview on 04/01/26 at 4:44 PM, the Medical Director (MD) revealed that he was notified about R24's inadvertent administration of insulin this morning (04/01/26) and was notified by the residents Nurse Practitioner. The NP was made aware of this incident on Monday (03/30/26). The MD further stated that he would have expected to be notified sooner about this incident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments for 4 of 4 residents listed on the Missing Obra Assessment Report were corrected, completed and transmitted in a timely manner.Findings include: Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0, revealed, Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Review of the Missing OBRA Assessment report provided by the State Agency included 4 residents with missing assessments. Review of the missing assessments revealed the 4 assessments were coded as completed by the MDS Coordinator but not submitted after the completion. During an interview on 04/02/2026 at 2:50 PM, the MDS Coordinator and the Assistant Regional Nurse confirmed that the missing OBRA assessments were completed and not sent to the state agency timely. They were showing in their computer system as completed but not transmitted.