

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Presbyterian Communities of South Carolina-Florenc		STREET ADDRESS, CITY, STATE, ZIP CODE 2350 W Lucas Street Florence, SC 29501	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50085</p> <p>Based on review of facility policy, record review, observation, and interview, the facility failed to implement care plan interventions for Resident (R)20's refusal of oxygen, for 1 of 2 residents reviewed.</p> <p>Findings include:</p> <p>Review of the undated facility policy titled Developing and Evaluating Goals and Objectives, Care Plans states, 1. Care plan goals and objective are defined as the desired outcome for a specific resident problem. 2. When goals and objectives are not achieved the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly.</p> <p>Review of R20's Face Sheet revealed R20 was admitted to the facility on [DATE], with diagnoses including, but not limited to: dependence on supplemental oxygen, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, hypertensive heart and chronic kidney disease, thalassemia, dementia, cerebral infarction, and posthemorrhagic anemia.</p> <p>Review of R20's unspecified Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/31/24, revealed R20's Brief Interview for Mental Status (BIMS) score was not notated, resident's cognitive skills are impaired. Further review revealed under section E revealed R20 did not exhibit signs of rejection of care behavior.</p> <p>Review of R20's unspecified MDS with an ARD of 07/08/24, revealed R20's BIMS score was 8 out of 15, indicating R20 had moderate cognitive impairment. Further review revealed under section E revealed R20 did not exhibit signs of rejection of care behavior.</p> <p>Review of R20's Physician Orders revealed R20 has an order for, Oxygen at 2 liters continuous: may remove for short period of time or for transport every day and night shift.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R20's Care Plan revealed, R20 has COPD and shortness of breath. The Goal outlined in this Care Plan indicated that R20 will display optimal breathing patterns daily through review date. The Interventions directed staff to give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. The nursing staff are to monitor for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, somnolence. Monitor/document/report as needed any sign and symptom of respiratory infection: Fever, Chills, increase in sputum, chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing. Oxygen settings are O2 at 2L/min via NC continuous. Further review of the Care Plan revealed, [R20] has oxygen therapy related to COPD. At times removes continuous oxygen. The Goal outlined in this Care Plan indicated that R20 will not have any sign and symptom of poor oxygen absorption through review date. The Interventions directed staff to give medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor for sign and symptoms of respiratory distress and report to physician. Staff to assess as needed R20's respirations, pulse oximetry, increased heart rate (Tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin color. Oxygen settings: oxygen at 2L/min via nasal cannula continuous. Staff to reapply oxygen nasal cannula when noted to be taken off by R20.</p> <p>During an observation on 08/13/24 at 12:06 PM, R20 was not wearing the nasal cannula. Nasal cannula was observed on the recliner chair in the resident's room, with the oxygen concentrator running at 2 liters per minute. R20 was in his wheelchair, leaning in tripod position (physical stance that people may assume when they are out of breath or experiencing respiratory distress. The position involves sitting or standing while leaning forward and supporting the upper body with the hands on the knees or another surface) unable to answer questions in a full sentence without catching his breath. No staff was observed in the resident's room. Licensed Practical Nurse (LPN)1, who was the nurse on the unit, was assisting with lunch trays.</p> <p>During an observation and interview on 08/13/24 at 12:11 PM, LPN1 was informed of the respiratory concerns for R20. LPN1 entered the resident's room and witnessed R20 in the tripod position. LPN1 stated, R20 is noncompliant with oxygen. R20 stated, he did not need oxygen. LPN1 stated, This morning his SPO2 [oxygen saturation, is a percentage that measures the amount of oxygen-carrying hemoglobin in the blood] was 94% around 9 AM and he refused oxygen since earlier this morning. LPN1 states, she has not been able to chart or notify anyone regarding R20's refusal to receive oxygen. LPN1 further states she has not rechecked R20's SPO2 since 9 AM and denied calling a physician or notifying the Nurse Practitioner. LPN1 stated, This is his usual behavior and I've been assisting with passing trays for lunch. I tried to assist [R20] but he refused and at one point was standing up from wheelchair.</p> <p>During an observation and interview on 08/13/24 at 12:16 PM, R20 stated, he refused oxygen because the nasal cannula hurts his nostrils. R20 was unable to state this in a full sentence without needing to catch his breath. LPN1 was still present to witness the conversation with R20. When the interview was completed with R20, LPN1 exited the room and began assisting with lunch trays.</p> <p>During an interview and observation on 08/13/24 at 12:19 PM, this surveyor immediately revealed R20's respiratory concerns to the Director of Nursing (DON). The DON revealed if a patient has been refusing oxygen, the Nurse Practitioner should be contacted and the nurse should do continuous or very frequent oxygen saturation checks, the responsible party should be notified and documentation of the refusal as soon as possible.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/13/24 at 12:29 PM, the DON went to R20's room to observe the location of the nasal cannula and resident concern. The DON assessed R20 immediately. The portable Spirometer (finger) monitor was unable to read R20's SPO2, after multiple attempts. A Hill-Rom [NAME] Allyn Spot Vital Signs 4400 (a machine used to take residents' vital signs) was brought into the room to obtain R20's SPO2. At 12:36 PM, R20's SPO2 reading was 82%-84%. LPN1 was observed still passing lunch trays. The DON requested LPN1 to stop and assist with assessing the resident.</p> <p>During an interview on 08/13/24 at 12:43 PM, the Nurse Practitioner (NP) revealed that she is familiar with the resident and is aware that he has the behavior of not following orders for his diet and oxygen. The NP revealed that she expects the nurse to redirect the patient. If the patient is refusing, the staff should continue to monitor for respiratory distress and notify if there is a condition change. The NP stated, In general, if the SPO2 is 88% or lower and not increasing with or without supplement oxygen, I expect to be notified as soon as possible. I have only been here for a month. I have not been contacted today regarding [R20's] refusal of oxygen or [R20] having a low SPO2.</p> <p>During an interview on 08/13/24 at 2:51 PM, the DON revealed to the Assistant Director of Nursing (ADON) that R20 was in a tripod position and should have been assessed by LPN1. The DON stated she witnessed LPN1 not assisting with the resident. The DON expressed concerns regarding the non-action and presented this surveyor with R20's Care Plan that directed the staff with interventions to be followed when R20 refuses oxygen. The DON stated that the nurse is expected to place priorities on airway, breathing, and circulation of a resident over passing out lunch trays.</p> <p>31846</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25335</p> <p>Based on record review, interviews, and review of facility policy, the facility failed administer medication to Resident (R)26, in a timely manner, for 1 of 6 residents reviewed for unnecessary medications. Specifically, R26 was administered multiple medications late on multiple day.</p> <p>Finding include:</p> <p>Review of a document, provided by the Administrator, undated and titled Medication Pass Statement revealed, PCSC (Presbyterian Communities of South Carolina) Follows a Liberalized Med Pass Structure which states:</p> <p>Daily 7a-11a Evening 3p-8p QHS (bedtime) 8p-12a PPI 5a-6:30a FSBS 6:30a-730a BID 7a-11a and 7p-11p TID 7a-11a and 11a-3p and 7p-11p</p> <p>Review of R26's Face Sheet revealed R26 was admitted to the facility on [DATE], with diagnoses including but not limited to: systolic (congestive) heart failure, atypical flutter and insomnia.</p> <p>During an interview on 08/13/24 at approximately 1:00 PM, R26 stated that for the past several weeks she was being woken up after her normal 9:00 PM bedtime so that medications could be administered.</p> <p>On 08/13/24 at approximately 3:30 PM, a review of R26's Physician Orders and Medication Administration Record (MAR) revealed that medications were being administered at the scheduled time.</p> <p>On 08/13/24 at approximately 4:15 PM, this Surveyor asked the Administrator to provide R26's Medication Administration Audit Report (MAAR) for July 2024, which will show the actual time of administration and not the default time as shown on the MAR for July 2024.</p> <p>On 08/14/24 at approximately 11:55 AM, a copy of R26's July 2024 MAAR was provided by the Director of Nursing (DON) with subsequent review by the Surveyor on 08/14/24 at approximately 12:05 PM, revealing that multiple medications, were being administered late according to the facility's liberalized med pass structure. The medications are listed as follows:</p> <ol style="list-style-type: none"> 1. Digoxin 12.5 mcg (microgram) Give 1 tablet in the evening related to ATYPICAL ATRIAL FLUTTER Hold for pulse less than 60. 1900 (7:00 PM), administered late approximately eighteen (18) times varying between 43 minutes late on 07/18/24 and 4 hours 15 minutes late on 07/5/24, given at 0015 hours (12:15 am) on 07/06/24. 2. Boudreauxs Butt Paste External Ointment 17% (percent) (Zinc Oxide Topical) Apply to sacrum topically every day and night shift for preventive measures. 1900, administered late approximately nineteen (19) times varying between none (zero) being administered on 07/05/24 and 9 hours 16 minutes late on 07/13/24 given at 0516 (5:16 AM) on 07/14/24. 3. Metoprolol Succinate ER (extended release) Oral Tablet Extended Release 24 hour 25 mg (milligram) give 1.5 tablet two times a day relayed to HYPERTENSIVE HEART DISEASE WITH HEART FAILURE. 1900 administered late approximately two (2) times varying between 1 hour 10 minutes and 1 hour 14 minutes. <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Apixaban Oral Tablet 5 mg Given 1 tablet by mouth two times daily related to CHRONIC ATRIAL FIBRILLATION, UNSPECIFIED 1900 administered late approximately one (1) times by 1 hour 10 minutes.</p> <p>5. Mirtazapine Tablet 7.5 mg Give 2 tablet by mouth at bedtime for insomnia and appetite stimulant related to INSOMNIA, UNSPECIFIED. 2000 (8:00 PM), on 07/13/24 administered late on 07/14/24 0007 (12:07 AM).</p> <p>During an interview on 08/14/24 at approximately 1:05 PM, the Director of Nursing reviewed some of the findings and confirmed that multiple medications were being given late.</p>		