STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **425288**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **10/05/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH- RIDGEWAY	**213 TANGLEWOOD COURT RIDGEWAY, SC 29130**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0157 **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 the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to immediately inform the resident's physician and responsible party when there was a significant change in the resident's physical status. Resident #2 was found outside in (MONTH) slumped over and received 2nd and 3rd [MEDICAL CONDITION] skin that was exposed to the sun. There was no documentation of the incident in the resident's medical record the day of the incident. The resident's physician and responsible party were notified the day after the incident. One of three residents reviewed for incidents. The findings included: Review of Resident #2's medical record revealed [DIAGNOSES REDACTED]. The resident discharged from the facility to the hospital on [DATE]. Further review of the medical record revealed the Quarterly Minimum Data Set ((MDS) dated [DATE] and the Quarterly MDS dated [DATE] coded Resident #2 as having a Brief Interview for Mental Status score of 3. The MDS coded the resident as requiring extensive assistance with 1 person assist for locomotion on and off the unit. Review of Resident #2's Nurses' Notes revealed an entry on 6/28/17 and the next entry was on 7/4/17. Review of the Nurses' Notes dated 7/4/17 at 4:00 AM indicated the nurse was called to the room by the Certified Nursing Assistant (CNA). Observed large fluid filled blisters intact that start at knuckles on both hands and go down the fingers on the left hand and on the right hand only the knuckles have the blisters. Also noted fluid on bedsheet and pillow. Noted 2 large blisters that had burst on top of head. Blisters on head cleaned with NSS and applied silver sulfadine to the scalp. The blisters on the hands were sprayed with skin prep. Made wound care nurse aware. The next entry was on 7/5/17 at 6:00 AM and indicated other blisters were beginning to develop on both the resident's arms. Review of the SBAR Communication Form dated 7/4/17 revealed the resident was noted to have intact blisters to hands and one noted to top of head. The physician recommended to apply [MEDICATION NAME] to the top of head and [MEDICATION NAME] gauze to the blisters on hands. The note indicated the resident was outside sitting with the other residents in the courtyard. Resident became too hot and confusion was noted. Resident was brought back inside and cooled down. During the night blisters formed on hands and head. The physician was notified on 7/4/17 with no time noted, the responsible party was notified on 7/4/17 at 8:00 AM. There was no documentation in the medical record that the physician or responsible party were notified on 7/3/17 when the incident occurred. The orders for treatment to the resident's hands and head were written on 7/4/17. Review of the Body Audit Form dated 7/3/17 completed by Licensed Practical Nurse (LPN) #1 (treatment nurse) revealed the top of the resident's head was red, the resident had red small areas noted to bilateral arms. The resident's hands and fingers were red. Temperature of skin was noted to be warm. In an interview with the surveyor on 9/26/17 at approximately 10:00 AM, the administrator stated s/he would have expected LPN #1 to document the resident's change in condition on 7/3/17 at the time on an SBAR. That is their practice to document the change in condition and who was notified.
F 0252 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide a safe, clean, comfortable and homelike environment.** Based on observations and interviews, the facility failed to provide a clean, homelike environment on 3 of 4 units. Units 100, 300 and 400 were noted to have broken tiles, odors, stains and brown build up. The findings included: On 9/25/17 at 1:35 PM during Initial Tour, old elimination odors were noted on front hall of 200, all of 300 hall, and the sitting area on the 400 hall. On 9/25/17 2:45 PM: Unit 100: Room 117- Cracked tiles across floor from door to window. Room 123- Broken floor tile next to air conditioner. Floor around air conditioner observed with bright red/brown rust colored stains. Room 103 observed room smelling of old urine. Air conditioner area observed with broken tiles, rust colored stains on tiles. Corners of the closet were observed with thick brown build up. Air conditioner vents observed with gray dust. The air conditioner unit cover observed with rust. Unit 300: Cracked tiles across hallway in front of doors by rooms 311 and 312. Rooms 301-304 unidentifiable odors. Rooms 303 and 304 cracked tiles across hallway and from room doors to windows. Cracked tiles in hallway by rooms 303 and 304. Hallway outside of rooms 301, 302, 303 and 304 had an unpleasant, unidentifiable odor. Cracked tiles across hallway in front of rooms 305 and 306. Sitting area in front of nurses' station contained old urine odors. Rooms 319- 322 contained unpleasant unidentifiable odors. Brown circular stains on tiles in front of the whirlpool room door. Unit 400: Cracked/broken tiles observed in doorway of dining room and 300 hall doorway. Brown buildup observed in cracks and corners of doorways. Brown/yellow stains on tiles in hallway between rooms 415, 417, 418 and 420. Yellow/orange stains on tiles under and in front of air conditioner unit in hallway by room 422 and room 416. On 9/26/17 the Environmental and Maintenance Directors toured facility with the surveyor. Above environmental issues were pointed out to the Directors. They confirmed the observations. Both of the Directors denied they smelled the odors.
F 0281 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure services provided meet professional standards of quality. Resident #2 was found outside in (MONTH) slumped over and received 2nd and 3rd [MEDICAL CONDITION] skin that was exposed to the sun. There was no documentation of the incident in the resident's medical record the day of the incident. The resident was noted on a body audit to have red areas to the head, arms, and hands on 7/3/17 with no treatment started until 7/4/17. There was no documentation that the wounds were monitored per facility policy for the month of (MONTH) (YEAR). One of three residents reviewed for incidents. The findings included: Review of Resident #2's medical record revealed [DIAGNOSES REDACTED]. The resident discharged from the facility to the

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

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.

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F 0281

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)
hospital on [DATE].
Further review of the medical record revealed the Quarterly Minimum Data Set ((MDS) dated [DATE] and the Quarterly MDS dated [DATE] coded Resident #2 as having a Brief Interview for Mental Status score of 3. The MDS coded the resident as requiring extensive assistance with 1 person assist for locomotion on and off the unit.
Review of Resident #2's Nurses' Notes revealed an entry on 6/28/17 and the next entry was on 7/4/17. Review of the Nurses' Notes dated 7/4/17 at 4:00 AM indicated the nurse was called to the room by the Certified Nurse Assistant (CNA). Observed large fluid filled blisters intact that start at knuckles on both hands and go down the fingers on the left hand and on the right hand only the knuckles have the blisters. Also noted fluid on bedsheet and pillow. Noted 2 large blisters that had burst on top of head. Blisters on head cleaned with NSS and applied silver sulfadine to the scalp. The blisters on the hands were sprayed with skin prep. Made wound care nurse aware. The next entry was on 7/5/17 at 6:00 AM and indicated other blisters were beginning to develop on both the resident's arms.
Review of the SBAR Communication Form dated 7/4/17 revealed the resident was noted to have intact blisters to hands and one noted to top of head. The physician recommended to apply [MEDICATION NAME] to the top of head and [MEDICATION NAME] gauze
to the blisters on hands. The note indicated the resident was outside sitting with the other residents in the courtyard. Resident became too hot and confusion was noted. Resident was brought back inside and cooled down. During the night blisters formed on hands and head. The physician was notified on 7/4/17 with no time noted, the responsible party was notified on 7/4/17 at 8:00 AM. There was no documentation in the medical record that the physician or responsible party were notified on 7/3/17 when the incident occurred. The orders for treatment to the resident's hands and head were written on 7/4/17.
Review of the Physician's Progress Note dated 7/6/17 revealed the resident was exposed to direct sun light on a hot day for an indeterminate period of time. The resident was noted by the staff to be lethargic and confused secondary to the heat experience. In a short period of time it was noted that all areas of direct skin exposure on his/her arms, hands and head have 2nd and 3rd degree blisters on his arms/hand and head.
Review of the Incident Report for 7/3/17 at 4:00 PM indicated Resident #2 was noted to have blisters develop on his hands and top of head after being outside in the courtyard. Interventions put in place included to wear a hat and long sleeves outside, drink plenty of fluids, and avoid direct sunlight.
Review of the Body Audit Form dated 7/3/17 completed by Licensed Practical Nurse (LPN) #1 (treatment nurse) revealed the top of the resident's head was red, the resident had red small areas noted to bilateral arms. The resident's hands and fingers were red. Temperature of skin was noted to be warm.
The surveyor reviewed the resident's Documentation of Wound Observation and Assessment Forms for the top of head, right hand and left hand and noted that all documentation was for (MONTH) (YEAR). There was no documentation that the facility could provide for (MONTH) (YEAR). The forms contained information on location of wounds, wound bed tissue type, wound edges, surrounding skin, and signs of infection.
Review of the Nursing Home to Hospital Transfer Form dated 8/18/17 revealed the skin evaluation included wart on scrotum, sunburn to left hand and head.
Review of the ER Progress Note dated 8/18/17 revealed the resident was sent to the hospital for open [MEDICAL CONDITION] on top of head, left hand, and sacral area. Resident noted to have a very large open wound skin edges on the scalp, left hand has a skin breakdown type lesion.
Registered Nurse (RN) #1's facility-obtained statement dated 9/12/17 indicated on 7/4/17 after the morning meeting LPN #1 asked him/her to look at some blisters that s/he noted on Resident #2 that morning. LPN #1 stated that the day before the resident was outside and s/he did not know how long the resident was outside but s/he did not see any blisters on him. The next day s/he noted blisters to the top of both of his hands. RN #1 went to the resident's room and s/he noticed several fluid filled blisters to the top of both of his hands. While s/he was in the room Resident #2 mumbled something about his head leaking. RN #1 pushed his pillow down to see what he was talking about and that is when s/he noticed that he had a blister to the top of his head that had burst and the skin was pulled back. After s/he left the room, s/he told LPN #1 to notify the director of nursing and the physician of the resident's condition.
In an interview with the surveyor on 9/25/17 at approximately 4:00 PM, LPN #2 stated that Resident #2 was sent out to the hospital because he had areas on his scrotum that looked like warts that had been scratched off. Resident #2 was sent to the hospital because of his head also. LPN #2 was the resident's nurse the day he went out to the hospital. From what s/he was told, he was outside and he had sunburn on top of his head. The area on his head was dark and not healing. Resident #2 would scratch at his head. LPN #2 stated s/he worked with Resident #2 on a regular basis. The resident also had sunburn blisters on both hands. One hand healed and one didn't. LPN #1 was the nurse the day the resident received the sunburn. LPN #1 is the treatment nurse but was working on the floor the day Resident #2 was sunburned. LPN #2 stated Resident #2 was alert with confusion. LPN #2 stated s/he did not like for the resident to go outside by himself because he was a bilateral [MEDICAL CONDITION]. Resident #2 was not able to get inside by himself because someone would have to help push him over the
doorway.
LPN #1's facility-obtained statement dated 7/6/17 indicated Resident #2 was sitting outside with other residents in the courtyard. Staff member that was outside at the time called for him/her to come get the resident. LPN #1 assessed the resident. There was no hypo/[MEDICAL CONDITION] noted after checking the resident's blood glucose. Resident #2 was warm to the touch. They placed the resident in bed and gave him a cool sponge bath and water to drink. Skin was intact and normal in color. Resident #2 had visitors that day that were related to him. Around 3:30 PM the visitors left and took the resident outside in the courtyard where he wanted to go at that time. During the time he was outside other residents were outside as usual. Staff member was getting ready to do the smoke break and called LPN #1 to come get Resident #1.
In an interview with the surveyor on 9/25/17 at approximately 4:05 PM, LPN #1 stated s/he is the treatment nurse. LPN #1 stated s/he was Resident #2's nurse the day he received the sunburn. The resident was visiting with family, when they left they told him/her they were leaving and Resident #2 was outside. It was around 3:30 PM when the family said they were leaving. At the smoke break, around 4:00 PM, another staff member brought the resident in because they thought his blood sugar had dropped. The resident was slumped over, sweating and looked like he was having a hypertensive episode. S/he checked his sugar and it was fine. They gave him something to drink, laid him down and assessed him. At that time, he did not have any signs of sunburn. Throughout the night is when he developed the blisters on his head and hands. From that point on, the blisters were stage 2 blisters. The blisters deteriorated because the resident would remove the dressing and pick at the one on his head and the left hand. The one on the right hand healed because he wasn't picking at that one. LPN #1 stated Resident #2 liked to sit outside in the sun. LPN #1 stated they think the resident's sunburn may be related to some of his medications. He is on medications because he had a renal transplant. LPN #1 stated the resident has been on those medications for a while.
In an interview with the surveyor on 9/26/17 at approximately 10:00 AM, the administrator stated s/he would have expected LPN #1 to document the resident's change in condition on 7/3/17 at the time on an SBAR. That is their practice to document the change in condition and who was notified.
In an interview with the surveyor on 9/26/17 at approximately 11:05 AM, the director of nursing stated they talked with staff from the VA last week. The staff stated Resident #2 was at the burn center and had a debridement done at the burn center.
Housekeeper #1's facility-obtained statement dated 7/6/17 indicated s/he was outside doing the smoke break and Resident #2 started leaning over in his wheelchair and stopped talking normal. Housekeeper #1 called the nurse to come check on the resident.
In a telephone interview with the surveyor on 10/5/17 at approximately 11:20 AM, housekeeper #1 stated s/he was walking by the courtyard around 4:00 PM and saw Resident #2 slumped over. The housekeeper wondered why the resident was outside because it was hot. Resident #2 was sitting in his wheelchair out in the sun. There were no staff or residents outside when the housekeeper saw the resident and the housekeeper didn't remember anyone in the common area overlooking the courtyard at the time. Housekeeper #1 went and got the resident and took him to the resident's nurse.
Prior to exiting the facility on 9/26/17, the administrator confirmed they could not locate any documentation that the resident's wounds were monitored and assessed during the month of (MONTH) (YEAR).
Review of the facility's Wound Observation and Assessment Documentation policy revealed the wound assessment and documentation is completed weekly and when there is significant change using the Documentation of Wound Observation and

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F 0281 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Assessment form. Wound measurements are completed when there is significant change in wound status and weekly by the SIC RN.
F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident received adequate supervision to prevent accidents. Resident #2 was found outside in (MONTH) slumped over and received 2nd and 3rd degree burns to skin that was exposed to the sun. There was no documentation of the incident in the resident's medical record the day of the incident. One of three residents reviewed for incidents. The findings included: Review of Resident #2's medical record revealed [DIAGNOSES REDACTED]. The resident discharged from the facility to the hospital on [DATE]. Further review of the medical record revealed the Quarterly Minimum Data Set ((MDS) dated [DATE] and the Quarterly MDS dated [DATE] coded Resident #2 as having a Brief Interview for Mental Status score of 3. The MDS coded the resident as requiring extensive assistance with 1 person assist for locomotion on and off the unit. Review of Resident #2's Nurses' Notes revealed an entry on 6/28/17 and the next entry was on 7/4/17. Review of the Nurses' Notes dated 7/4/17 at 4:00 AM indicated the nurse was called to the room by the Certified Nursing Assistant (CNA). Observed large fluid filled blisters intact that start at knuckles on both hands and go down the fingers on the left hand and on the right hand only the knuckles have the blisters. Also noted fluid on bedsheet and pillow. Noted 2 large blisters that had burst on top of head. Blisters on head cleaned with NSS and applied silver sulfadine to the scalp. The blisters on the hands were sprayed with skin prep. Made wound care nurse aware. The next entry was on 7/5/17 at 6:00 AM and indicated other blisters were beginning to develop on both the resident's arms. Review of the SBAR Communication Form dated 7/4/17 revealed the resident was noted to have intact blisters to hands and one noted to top of head. The physician recommended to apply silvadene to the top of head and xerofoam gauze to the blisters on hands. The note indicated the resident was outside sitting with the other residents in the courtyard. Resident became too hot and confusion was noted. Resident was brought back inside and cooled down. During the night blisters formed on hands and head. The physician was notified on 7/4/17 with no time noted, the responsible party was notified on 7/4/17 at 8:00 AM. There was no documentation in the medical record that the physician or responsible party were notified on 7/3/17 when the incident occurred. The orders for treatment to the resident's hands and head were written on 7/4/17. Review of the Physician's Progress Note dated 7/6/17 revealed the resident was exposed to direct sun light on a hot day for an indeterminate period of time. The resident was noted by the staff to be lethargic and confused secondary to the heat experience. In a short period of time it was noted that all areas of direct skin exposure on his/her arms, hands and head have 2nd and 3rd degree blisters on his arms/hand and head. Review of the Incident Report for 7/3/17 at 4:00 PM indicated Resident #2 was noted to have blisters develop on his hands and top of head after being outside in the courtyard. Interventions put in place included to wear a hat and long sleeves outside, drink plenty of fluids, and avoid direct sunlight. Review of the Body Audit Form dated 7/3/17 completed by Licensed Practical Nurse (LPN) #1 (treatment nurse) revealed the top of the resident's head was red, the resident had red small areas noted to bilateral arms. The resident's hands and fingers were red. Temperature of skin was noted to be warm. The surveyor reviewed the resident's Documentation of Wound Observation and Assessment Forms for the top of head, right hand and left hand and noted that all documentation was for (MONTH) (YEAR). There was no documentation that the facility could provide for (MONTH) (YEAR). The forms contained information on location of wounds, wound bed tissue type, wound edges, surrounding skin, and signs of infection. Review of the Nursing Home to Hospital Transfer Form dated 8/18/17 revealed the skin evaluation included wart on scrotum, sunburn to left hand and head. Review of the ER Progress Note dated 8/18/17 revealed the resident was sent to the hospital for open lesions on top of head, left hand, and sacral area. Resident noted to have a very large open wound skin edges on the scalp, left hand has a skin breakdown type lesion. Registered Nurse (RN) #1's facility-obtained statement dated 9/12/17 indicated on 7/4/17 after the morning meeting LPN #1 asked him/her to look at some blisters that s/he noted on Resident #2 that morning. LPN #1 stated that the day before the resident was outside and s/he did not know how long the resident was outside but s/he did not see any blisters on him. The next day s/he noted blisters to the top of both of his hands. RN #1 went to the resident's room and s/he noticed several fluid filled blisters to the top of both of his hands. While s/he was in the room Resident #2 mumbled something about his head leaking. RN #1 pushed his pillow down to see what he was talking about and that is when s/he noticed that he had a blister to the top of his head that had burst and the skin was pulled back. After s/he left the room, s/he told LPN #1 to notify the director of nursing and the physician of the resident's condition. 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Resident #2 was not able to get inside by himself because someone would have to help push him over the doorway. LPN #1's facility-obtained statement dated 7/6/17 indicated Resident #2 was sitting outside with other residents in the courtyard. Staff member that was outside at the time called for him/her to come get the resident. LPN #1 assessed the resident. There was no hypo/hyperglycemia noted after checking the resident's blood glucose. Resident #2 was warm to the touch. They placed the resident in bed and gave him a cool sponge bath and water to drink. Skin was intact and normal in color. Resident #2 had visitors that day that were related to him. Around 3:30 PM the visitors left and took the resident outside in the courtyard where he wanted to go at that time. During the time he was outside other residents were outside as usual. Staff member was getting ready to do the smoke break and called LPN #1 to come get Resident #1. In an interview with the surveyor on 9/25/17 at approximately 4:05 PM, LPN #1 stated s/he is the treatment nurse. LPN #1 stated s/he was Resident #2's nurse the day he received the sunburn. The resident was visiting with family, when they left they told him/her they were leaving and Resident #2 was outside. It was around 3:30 PM when the family said they were leaving. At the smoke break, around 4:00 PM, another staff member brought the resident in because they thought his blood sugar had dropped. The resident was slumped over, sweating and looked like he was having a hypertensive episode. S/he checked his sugar and it was fine. They gave him something to drink, laid him down and assessed him. At that time, he did not have any signs of sunburn. Throughout the night is when he developed the blisters on his head and hands. From that point on, the blisters were stage 2 blisters. The blisters deteriorated because the resident would remove the dressing and pick at the one on his head and the left hand. The one on the right hand healed because he wasn't picking at that one. LPN #1 stated Resident #2 liked to sit outside in the sun. LPN #1 stated they think the resident's sunburn may be related to some of his medications. He is on medications because he had a renal transplant. LPN #1 stated the resident has been on those medications for a while. In an interview with the surveyor on 9/26/17 at approximately 10:00 AM, the administrator stated s/he would have expected LPN #1 to document the resident's change in condition on 7/3/17 at the time on an SBAR. That is their practice to document the change in condition and who was notified. In an interview with the surveyor on 9/26/17 at approximately 11:05 AM, the director of nursing stated they talked with staff from the VA last week. The staff stated Resident #2 was at the burn center and had a debridement done at the burn center.

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) Housekeeper #1's facility-obtained statement dated 7/6/17 indicated s/he was outside doing the smoke break and Resident #2 started leaning over in his wheelchair and stopped talking normal. Housekeeper #1 called the nurse to come check on the resident. In a telephone interview with the surveyor on 10/5/17 at approximately 11:20 AM, housekeeper #1 stated s/he was walking by the courtyard around 4:00 PM and saw Resident #2 slumped over. The housekeeper wondered why the resident was outside because it was hot. Resident #2 was sitting in his wheelchair out in the sun. There were no staff or residents outside when the housekeeper saw the resident and the housekeeper didn't remember anyone in the common area overlooking the courtyard at the time. Housekeeper #1 went and got the resident and took him to the resident's nurse.