STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425140	A. Building B. Wing	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Moncks Corner	505 South Live Oak Drive Moncks Corner, SC 29461

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015 Based on interviews, record review, and policy review, the facility failed to ensure a safe environment for 1 Resident (R)77) of 3 residents reviewed for accidents. Specifically, R77 ingested unsecured medications of another resident, risperidone (antipsychotic), buspirone (anti-anxiety), and gabapentin (anti-convulsant), which were left unsupervised on the top of the medication cart. The practice of lack of supervision of residents, and unsecured medications resulted in the resident experiencing a medical emergency that required the resident to be transferred to the emergency room (ER). Findings include: Review of the facility's policy titled Medication Administration: Oral Medications dated 12/10/21, revealed it is the policy of (facility name) that oral medications are administered in an organized and safe manner. Review of the facility's policy titled Medication Discrepancies and Adverse Reactions dated 06/22/22, revealed, Definitions: Medication Discrepancy: An inappropriate or incorrect medication prescribed for, dispensed for, or given to a patient/resident. It is also an omission of a vital due to a prescribing, dispensing, or administration error. Adverse Medication Reaction: An undesirable or unintended harmful effect occurring as a result of a medication (e.g., heavy sedation .) .In the event of a medication discrepancy or adverse medication reaction, immediate action is taken, as necessary, to protect the patient/resident's safety and welfare. The attending physician is notified promptly of the error or significant adverse medication reaction. The physician's orders are implemented, and the patient/resident is monitored closely for 24 to 72 hours or as directed. Review of R77's undated Face Sheet located in the EMR under Face Sheet tab, indicated the resident was admitted on [DATE], with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, anxiety disorder, cognitive communication deficit, major depressive disorder, and altered mental status. Review of R77's quarterly Minimum Data Set (MDS), located in R77's EMR under the MDS tab, with an Assessment Review Date (ARD) of 09/05/22, revealed R77's Brief Interview for Mental Status (BIMS) score was 1 out of 15, indicating R77's cognition was severely impaired. R77 was assessed as wandering daily. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R77's Care Plan dated 10/13/21, located in R77's EMR under the Care Plan tab, indicates R77 presents a risk for elopement as evidenced by exit seeking behaviors, asking for money to catch the bus. Approaches include provide discuss with resident/family risks of elopement and wandering, observe unit for possible safety hazards, provide increased supervision during periods of increased wandering and agitation, re-direct, provide diversional activities, wander guard on wrist. Review of R77's Progress Notes dated 04/14/22, located in R77's EMR under Progress Notes tab, revealed Behavior Note: Resident is wandering on and off units. Insists that she is allowed to go home, tried all doors to see if she could go out of them .Insisted that her w/c [wheelchair] was not her own, walked all the way to the fire doors from her room . Review of R77's Progress Notes dated 04/16/22 at 11:38 PM, located in R77's EMR under the Progress Notes, revealed the Director of Nursing (DON), who was R77's night shift nurse, documented upon arriving for nurse shift, resident lying in reclining chair at nurses' station, lethargic appearing. During report, nurse LPN [Licensed Practical Nurse] 2 reports med [medication] error regarding resident. NP [nurse practitioner] notified per nurse [LPN2], who orders to monitor resident's vital signs. Vital signs obtained. 92% (oxygen saturations) on room air oxygen, 12 respirations, 65/30 (blood pressure), and 65 heart rates. 911 called. Director of Nursing notified; RP [Responsible Party] notified via phone. Review of R77's Progress Notes dated 04/17/22 at 12:46 AM, located in R77's EMR under Progress Notes tab, the DON documented Resident is in the ER, RP notified of this . Review of R77's Event Information dated 04/17/22, located in R77's EMR under the Event tab, revealed on 04/16/22 at 9:00 PM, R77 took medicine that was crushed in a cup that was not hers. Medications included risperidone (antipsychotic), buspirone (anti-anxiety), and gabapentin (anti-convulsant). R77 was sent to hospital for further evaluation due to blood pressure lowering. Review of the emergency room Provider Documentation dated 04/16/22, revealed Diagnoses: hypotensive episode, hyperglycemia, and accidental overdose. Per ER provider notes, inadvertently given essentially double her p.m. (evening) medications. Staff apparently had called the nursing home physician who did not think that this was a significant overdose. EMS [emergency medical services)] states that initial blood pressure was in the 70s, they gave her about 600 milliliters of fluids. A request was made to the Administrator and Director of Nursing on 10/05/22 for documentation related to vital signs and monitoring of R77 from the date/time of incident on 04/16/22 at 9:00 PM until the on-coming nurse at 11:38 PM. The facility was unable to provide this information. During an interview conducted with the Administrator on 10/04/22 at 4:16 PM, the Administrator was questioned concerning R77's medication event on 04/16/22. The Administrator responded that LPN2 was an agency nurse, who crushed a resident's medications and left them on top of the medication cart. R77 took the medications sitting on-top of the medication cart. The on-coming nurse noticed something different about R77 and LPN2 informed her of the medication error. The resident was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the DON on 10/05/22 at 9:38 AM, the DON was questioned concerning the incident with R77 on 04/16/22. The DON responded that she had come in for the 11PM to 7 AM shift, and asked LPN2 what was wrong with R77. LPN2 told her that she had mixed medicine for another resident, sat the medications onto the cart, and walked away. When LPN2 came back, R77 was eating the medicine that had been mixed in pudding. LPN2 notified the NP and was instructed to monitor vital signs. The DON was asked to describe R77's condition when she had arrived. The DON responded that she obtained R77's vital signs and her blood pressure and it was something like 60/30 and resident was very lethargic. The DON stated she called the NP and sent R77 to the ER. During an interview conducted with Certified Nurse Aide (CNA)1 on 10/05/22 at 10:05 AM, CNA1 responded that R77 usually wanders around in her wheelchair but will stand up and walk with the wheelchair. During an interview conducted on 10/05/22 at 10:30 AM, the NP responded that LPN2 had called and reported to her that R77 ingested someone else's medication. The NP gave orders to monitor vital signs every 15 minutes for two hours, and if the blood pressure drops below 90/60 to send to hospital. The NP added that R77's vital signs improved when the EMS (Emergency Medical Services) gave her a liter of fluid. During an interview on 10/05/22 at 12:10 PM, LPN2 revealed that she had crushed another resident's medications, mixed the medications in some pudding, and left the pudding with the medications on top of the medication cart and walked away to answer a call light. When LPN2 returned to the medication cart, R77 was eating the pudding with medications in it. LPN2 added there was no one around cart when she left the medication on it; however, R77 wanders a lot in her wheelchair and can also stand up and walk.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015 Based on interview, record review, review of the Centers for Disease and Prevention (CDC) guidelines, and facility policy review, the facility failed to ensure that 2 Residents (R)1 and R84) of 5 residents sampled for immunization reviews, were offered, and given the option to receive or decline pneumonia vaccine. Findings include: Review of the CDC guidelines located at https://cdc.gov/vaccines/vpd/pnuemo/hcp/recommendations , CDC recommends, PCV15 or PCV20 for: Adults 65 or older . Review of the facility's policy titled, Pneumococcal Vaccinations, revised 12/10/21, revealed All patients/residents who reside in this healthcare center are to receive the pneumococcal vaccine(s) within the current CDC guidelines unless contraindicated by their physician or refused by the patient/resident or patient/resident's family. If the patient/resident is cognitively impaired as evidenced by scoring on the MDS, the responsible party will be contacted and their wishes will be followed in this matter . The admission process will include determining whether the patient/resident has received pneumococcal vaccine in the past. This will be the responsibility of the Director of Health Services or designee. Every effort will be made to obtain documentation of the date of prior immunization and what type of vaccine, Pneumovax (PPSV23), Pneumococcal 2}-valent Conjugate Vaccine 20 (PCV20), Pneumococcal l5-valent Conjugate Vaccine (PCVI5) or Pneumococcal 13-valent Conjugate Vaccine (PCV13), was administered. If reliable documentation of previous immunization is obtained, the date should be entered on the Immunization Record and made a part of the clinical record . Administration: Adults [AGE] years of age or older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive a pneumococcal conjugate vaccine (either PCV20 or PCV15). If PCV15 is used, this should be followed by a dose of PPSV23. 1. Review of R1's undated Face Sheet located in R1's electronic medical record (EMR) under the Face Sheet tab, indicated R1 was [AGE] years old and admitted to the facility on [DATE], with diagnoses including cerebral infarction (stroke), peripheral vascular disease, and hypertension. Review of R1's undated Pneumococcal Vaccines located in R1's EMR under the Preventative Health Care tab, indicated R1's PPSV23 (Pneumococcal polysaccharide vaccine) and Prevnar (Pneumococcal conjugate vaccine) administration was unknown. 2. Review of R84's undated Face Sheet located in R84's EMR under the Face Sheet tab, indicates R84 is [AGE] years old and was admitted to the facility on [DATE], with diagnoses including hypertension, acute respiratory disease, and intellectual disabilities. Review of R84's undated Pneumococcal Vaccines located in R1's EMR under the Preventative Health Care tab, indicated R84's PPSV23 is unknown and Prevnar13 vaccine administration was prior to admission. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted with the Infection Control Preventionist (ICP) on 10/05/22 at 3:01 PM, the ICP stated confirmed that the ICP stated that the Administrator and she reviewed these two residents charts and all the facility's documentation and they could not find anything related to these two residents receiving/refusing or declining the