STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425391	A. BUILDING _____ B. WING _____	**04/28/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AGAPE REHABILITATION OF CONWAY	**2320 HIGHWAY 378 CONWAY, SC 29527**

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 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 reviews, interviews, and review of the facility policy titled, Notification, Physician or Responsible Party, the facility failed to notify the physician of Resident #100 refusing [MEDICAL TREATMENT] and fingerstick blood sugars not done as ordered for 1 of 1 resident reviewed for [MEDICAL TREATMENT]. The facility failed to notify the physician of the unavailability of ordered medications for Resident #8. The facility further failed to notify the physician of missed doses of medications for Resident #186 for 2 of 5 residents reviewed for unnecessary medications. The findings included: The facility admitted Resident #8 with [DIAGNOSES REDACTED]. Review on 4/20/2016 at approximately 10:49 AM of the Medication Administration Record [REDACTED]. Review of the MAR indicated [REDACTED]. Further review on 4/20/2016 at approximately 10:49 AM of the MAR for February 2016 revealed K-Phos No 2 tablet 350-700 mg to be administered at 9:00 AM on 2/15/2016, 2/16/2016, 2/17/2016, 2/18/2016 and 2/19/2016 was not given. The 1:00 PM dose of this medication was not administered on 2/16/2016, 2/17/2016, 2/18/2016 and 2/19/2016. The 5:00 PM dose was not administered for 2/17/2016, 2/18/2016 and 2/19/2016. The 9:00 PM dose on 2/19/2017 was not administered. During even further review of the MARs on 4/20/2016 at approximately 10:55 AM revealed a MAR indicated [REDACTED]. Review on 4/20/2016 at approximately 2:00 PM of the nurses notes dated 2/06/2016 and 2/8/2016 states,[MEDICATION NAME] 1 mg, not available from pharmacy. The nurses notes dated 2/15/2016 states the K-Phos No 2 Tablet is not available from pharmacy. On 2/16/2016 the nurses note states, pharmacy will fill, and not available from pharmacy. On 2/17/2016 and 2/18/2016 the nurses note states, medication not available. On 2/19/2017 the nurses note states, not available, will call pharmacy again. Further review of the nurses notes on 4/20/2016 at approximately 2:00 PM revealed a note on 3/7/2016 that states, [MEDICATION NAME] not available, request refill, The nurses note on 3/22/2016 states, Daily Vitamin Tablet - medication not available from pharmacy. No documentation could be found in Resident #8's medical record to ensure the physician was notified of the above missed medications. The facility admitted Resident #100 with [DIAGNOSES REDACTED]. Review on 4/21/2016 at approximately 2:01 PM of the medical record for Resident #100 revealed a Physician's order dated 2/25/2016 at 4:38 PM for Accucheck blood sugar checks before meals and at bedtime. Further review of Resident #100's medical record on 4/21/2016 at approximately 2:05 PM revealed a Medication Administration Record [REDACTED]. Review of the MAR for March 2016 revealed no blood sugars taken on 3/1/2016 at 11:30 AM , 3/08/2016 at 11:30 AM, 3/10/2016 at 11:30 AM, 3/14/2016 at 9:00 PM, 3/15//2016 at 11:30 AM, 3/17/2016 at 11:30 AM, 3/24/2016 at 11:30 AM and 3/31/2016 at 11:30 AM and 4:30 PM. No documentation could be found to ensure the physician was notified of missed blood sugar checks. Review on 4/21/2016 at approximately 2:05 PM of the nurses notes dated 4/20/2016 at 7:12 AM revealed a note which stated, resident states that he/she is not going to [MEDICAL TREATMENT] today, oncoming nurse notified. No documentation could be found where the physician was notified. During an interview on 4/21/2016 at approximately 2:10 PM with the Director of Nursing (DON), he/she stated, I was not aware that the physician was not notified of the missed blood sugars and that Resident #100 had refused to go to [MEDICAL TREATMENT]. The facility admitted Resident # 186 with [DIAGNOSES REDACTED]. Review of the current MAR indicated [REDACTED]. On 4/12/2016 at 6:30 AM, 11:30 AM, 4:30 PM and 9:00 PM the blood sugars were not documented as done. The blood sugar reading to be done on 4/14/2016 at 4:30 PM was not documented as done. The medication [MEDICATION NAME] 25 mg to be given by mouth at 6:30 AM that was ordered on [DATE] was not available on 4/9/16 for the 6:30 AM Dose per the nurses notes. Review of the nurses note dated 4/9/2016 at 6:44 AM states the medication is not available. No documentation could be found in Resident #186's medical record to ensure the physician was notified of the missed blood sugar readings or the missed [MEDICATION NAME]. During an interview on 4/22/2016 at 10:27 AM with the DON concerning the missed medication and the blood sugars not done, she stated she did not know why but she would look into it. He/she went on to say that the staff was not allowed to open the Talyst System to retrieve medications, that this is only done by the pharmacists, Review on 4/22/2016 at approximately 3:35 PM of the facility policy titled, Notification, Physician or Responsible Party, states under Procedures: number 1D. The resident repeatedly refuses treatment or medications. And 1F states, Deemed necessary or appropriate in the best interest of the resident.
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and facility files, the facility failed to protect residents from abuse for one of one resident's (#178) coerced without an investigation or report to state agencies. One of one resident (resident #69) with misappropriation of funds, without a thorough investigation and 2 residents with allegations of abuse that were not reported to state agency. It was determined on 4/21/16 at approximately 4:20 PM Immediate Jeopardy and/or Substandard Quality of Care existed in the facility as of 3/17/2016. The findings included: During the Recertification and Complaint Survey, on 4/21/16 the Department of Health and Environmental Control (DHEC) Certification State Agency office received an additional eight (8) allegations of abuse/neglect. Review of the allegations revealed the facility had identified a concern related to the allegation that involved resident # 178. The facility admitted resident # 178 with [DIAGNOSES REDACTED]. The resident had a Brief Interview for Mental Status Score of 15. S/he was alert and oriented and able to make decisions regarding his/her ability to make decisions regarding activities of daily living. Review of the additional allegations revealed an allegation of 3/16/16 related to resident

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) #178. Per the allegation, the resident had complained that a nurse had snatched off a neck brace. Review of the facility's grievance files revealed a grievance of the allegation. Through the facility investigation of the allegation, the resident had stated the nurse had startled him/her when removing the neck brace and was not abused. The Administrator, Director of Nursing (DON), Director of Nursing in Training (DON in training), and Social Services (SS) were interviewed by the surveyor on 4/21/16 at approximately 11:30 AM. During the interview the Administrator and DON stated that a note was left under the administrator's door, signed by the resident. The administrator provided the note for review. The note stated, I will (sic) like to speak to the Patient Advocate about my collar being snatched off by male nurse. Please call them for me, thanks for asking about my care. I was informed S/he is Ombudsman ---- (name of person). The administrator went to the resident and was told by the resident that someone had come in his/her room at 3:00 AM, wearing a hoodie and had him/her sign a paper. The resident did not know who the person was or what was on the paper that s/he signed. The resident stated s/he did not write the note and did not want to talk to the patient advocate. The DON stated the same person seen in Resident #178's room was seen on the same night by staff members copying resident charts. The DON stated when s/he came in, the person had already left the facility. During the interview the Administrator and DON and DON in training stated the person that had entered the facility during the night was an employee, a Licensed Practical Nurse (LPN), who worked the 7A-7P shift. The employee was out on medical leave at the time of the survey. The DON in training stated that they had been informed the LPN had been observed sitting outside of other staff member's homes, in a car. The Administrator was asked by the surveyor, what had been done to protect the residents from unknown persons entering the building in the middle of the night, coercing the residents. The Director of Nursing stated the County Sheriff's Department had been asked by the facility to be placed on their security patrol route. The DON did not know how often the police would patrol the facility at night. S/he did not know what medical records had been allegedly copied by the person. The DON and DON-in-training were unable to provide an investigation into the incident with resident #178, regarding the night visitor nor any information regarding the copied medical records. The DON in training repeatedly stated the employee was just doing what s/he thought was right. The facility was aware of the middle of the night entrance into the building by an off duty employee. The resident informed them of an unknown person dressed in a hoodie coercing him/her to sign a note that the resident did not write. The resident did not know who the person was or what was written on the note. They were also aware of the allegation of medical records being copied and removed from the facility. There was no investigation, no preventive measures put into place to protect the residents, or the facility medical records. There was no documentation that the Sheriff's Department was contacted, or how often they would patrol the facility. There was no documentation the alleged perpetrator had been investigated regarding the medical records. On 4/21/16 at approximately 3:00 PM the Administrator provided a facility document of communications with corporate personnel. The document was a time line related to the incident of 3/16/16. 3/16- LPN was called into the office for inappropriate comments and insubordinate attitude toward the Assistant Director of Nursing (ADON) . The LPN was highly defensive, and aggressive toward myself and ADON when I tried to speak with him/her .Within 30 minutes the LPN brought back an allegation of abuse toward the ADON which stemmed from an incident that happened 14 days prior. I immediately investigated the complaint and interviewed the following: (Resident #178) S/he said that s/he was nervous for them to take the neck brace off, and that s/he got scared. S/he said it felt rough when they had to pull the velcro collar to undo it. S/he said it was rough but said s/h didn't think it was abusive in anyway. The ADON, Certified Nursing Assistant (CNA) and X-ray Tech state that the resident was alert and aware of what was going on. That the ADON was not rough with the resident, nor did s/he jerk or snatch the collar off the resident. 3/17/16- The LPN called myself (administrator) at 6:00 AM to tell me s/he was sick and wasn't coming into work for his/her shift at 7:00 AM; ADON worked his/her shift. The LPN called and texted multiple staff, all day to the point where one staff member called---- for being harassed by him/her. That night the LPN was seen and reported in the building after Midnight- s/he told staff that s/he was here to work on his/her charting. The staff said they found it weird but let him/her continue. 1 staff member said s/he saw the LPN copy papers from a chart, not on his/her normal hallway and take the papers with him/her. 2 staff members said that while the LPN was there she made threats of physical violence toward a CNA, who had just left the building a few hours prior .The LPN was also seen going down the 200 hall, and coming back to the 100 Hall later. 3/18/16- A letter was found signed by resident (#178)that said s/he wanted to speak to the Ombudsman about the neck. The writing on the letter, and the resident's signature were two different styles of writing, We spoke to the resident regarding the letter and s/he said that someone (s/he couldn't tell who, they had a hoodie on s/he thinks) woke him/her fro his/her sleep around 2-3 am and made him/her sign a letter. S/he said s/he was told not to talk to anyone about the letter and not to tell anyone that someone came to visit him. We asked if s/he needed the Ombudsman, and s/he said that s/he didn't request him/her, because s/he did not write the letter. The resident stated he did not sign his/her name the way it was on the letter. So s/he knows s/he was out of it If s/he signed a letter with his /her legal name. The facility admitted resident #69 with [DIAGNOSES REDACTED]. Idiopathic Peripheral [MEDICAL CONDITIONS], Infected Sebaceous Cyst, Fatigue, Adult Failure to Thrive and Open Wound of Toe. 4/20/16 8:00 AM Review of the Medical Record revealed a Quarterly Minimum Data Set ((MDS) dated [DATE]: The resident had a Brief Interview for Mental Status (BIMS) score of 13. S/he had no mood or behaviors. Nurses Notes reviewed from 1/21/16 through 4/19/16. Nurses Notes revealed resident was alert and oriented with periods of confusion. S/He had weakness with unsteady gait and balance. During an interview with the resident on 4/18/16, the resident stated CNA #1 had taken his/her bank card. I gave it to her/him to get my girlfriend a Valentine's present. I told her/him s/he could use it but if s/he did, to let me know. S/he used it but did not let me know. S/he did not bring it back to me. I called the bank to check on my account and I was missing money. It was money I did not spend. I reported it. S/he (CNA) does not work here any more. I heard I was not the only one s/he did that to. Review of the facility investigation of the incident revealed the resident complained to a CNA on 2/29/16 that CNA #1 had his/her card and the resident was missing money from his/her account. The resident had called the bank and found out the money was missing. The facility called the police. The police investigated the incident. The CNA also had the resident's vehicle. The resident reported the missing money to CNA #2. The CNA was interviewed by the surveyor on 4/20/16 at approximately 11:00 AM. The CNA stated the resident had reported to him/her that CNA #1 had the resident's bank card and s/he had missing money from his/her account. The resident said s/he had some money missing and s/he did not authorize it. I asked him/her where the bank card was. S/he stated CNA #1 had it. S/he said s/he would just keep the card and if s/he (resident) needed something s/he could call him/her and s/he would get it with the debit card. S/he authorized the CNA to get cleaning supplies and pay anyone that helped her. I went and told the Administrator everything I told you. The resident told me that the CNA had his/her car at their place. Review of the facility investigation revealed a thorough investigation had not been conducted. The facility had not interviewed any residents that could have been affected with missing money or items. No statement was taken from the resident. There were no staff statements obtained. Following the interview with CNA #2, two staff statements were provided to the surveyor. CNA #2 was asked when s/he had written the statement. The CNA stated s/he had written the statement that morning. Review of the Police Department Reports revealed the police had four warrants out for the CNA. The bank confirmed there were $1,500.00 of unauthorized usage of the resident's bank account. Based on full and/or limited record reviews, interviews and review of the facility's policies, it was determined on 4/21/16 at approximately 4:20 PM Immediate Jeopardy and/or Substandard Quality of Care existed in the following area as of 3/17/2016: CFR 483.13(c) F-224 Prohibit Mistreatment/neglect/misappropriation was identified at a scope and severity level of (L). The facility failed to protect Resident #69 and Resident #178 from allegations of abuse. The facility Administrator, Director of Nursing, and Director of Nursing in Training were informed of the Immediate Jeopardy on 4/21/16 at approximately 5:20 PM. The facility provided an Allegation of Compliance (AOC) that was acceptable on 4/28/16 at 2:05 PM. Observation, record review and interview provided evidence to the survey team prior to exit the AOC had been implemented by the facility and the Immediate Jeopardy at F-224 was removed, but the citation remained at a lower scope and

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) severity of F. The AOC included the following: AOC: It has been alleged in the context of the pending survey process that the Facility's response to events allegedly occurring on or around March 17th-20th, was insufficient. In an effort to demonstrate and achieve substantial compliance with applicable and involved regulations, the Facility proposes and has initiated implementation of the following plan of correction: * Resident Security- 1. In an effort to put immediate corrective action in place, Resident #1 was asked by the Administrator to inform Facility Administration in the event there is a recurrence of uninvited or unwanted visitors entering (his/her) room (employees or otherwise). Further, the Resident was reminded of (his/her) right to speak with the Department of Health or the Ombudsman should (he/she) ever have questions or concerns, or should (he/her) require additional information on any topic affecting (his/her) Facility admission. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has conducted an investigation into the subject events which included interviews of all residents. Specifically, each resident has been asked if they have ever been visited by people they did not recognize, and where applicable, the time, dates are being investigated to determine the nature of the visit. Further, on 4/22/16, the Facility has provided each current resident with a flyer containing the phone numbers of the South Carolina Department of Health and Environmental Control, and the local Ombudsman. Going forward, this same flyer will be distributed to incoming residents on admission. Additionally, the codes have been changed at each pedestrian entrance door. (4/23/16) 3. The following measures have been put in place to ensure the deficient practice will not reoccur: * A sign-in log was placed at the front desk. All visitors (which includes employees who are in the Facility for reasons other than working a scheduled shift) will be required to sign in at the front desk, and indicate their purpose in visiting the Facility. If a visitor is there to see a resident, the name and room number of the Resident must be indicated on the sign-in log. * All employees have been informed via in-service that they should not be present on Facility premises unless they are assigned to work, or have other work-related business at that time Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * The following information has been inserviced: Abuse, Neglect, Misappropriation, and timely reporting of an allegation Resident Rights, and timely reporting of any violations Door code change for security, an sensitivity of code. * All employees have been trained (4/23/16) that in the event any employee is seen entering the Facility at hours not typically worked by that employee, they are obligated to report such unusual activity to Facility management. Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * Signs have been posted at or near each door leading in to the Facility, instructing all visitors to sign in at the front desk (4/25/16). * The code to all exit doors was changed on 4/21/16. All active employees, and resident responsible parties were notified of the code change. * Protection of Private Health Information 1. In an effort to put immediate corrective action in place, Resident #1 was informed by the Administrator that an employee of Compass Post-Acute Care is alleged to have collected private information about (him/her) outside the scope of (his/her) employment. Our guidance to (him/her) reflected the information we have to date and the possibility that (his/her) protected health information may have ben accessed for reasons unrelated to (his/her) treatment, payment or other healthcare purpose. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has invited members of our Compliance Department to come and evaluate our existing practices. All employees have been re-educated (4/27/16) regarding their obligations under HIPAA, and all new employees (and agency if necessary) will receive the more comprehensive training upon hire via a web-based module [MEDICATION NAME] approximately 45 minutes. 3. In addition to the physical security items listed above, the following measures have been put in place to ensure the deficient practice will not reoccur: * Any time a chart is removed temporarily from the nursing station, the employee doing so must note the removal in the log created to capture this information. The employee will need to log the date, time of removal, time of return, and purpose associated with the temporary removal. * Employees who remove medical records from the Facility or who access the chart for reasons inconsistent with Federal and State Privacy Laws will be disciplined up to and including the possibility of termination. * A video surveillance system is to be installed and contractors have been contacted. The system will provide remote visualization of each door leading in to the Facility, and will also show activity in public or shared areas including but not limited to hallways, nursing stations, dining rooms, etc.). * Resident rooms will not be included in the areas capable of being viewed by the cameras. The Department should also be aware that the employee whose conduct is at issue has been suspended pending the results of our investigation. (He/she) has not worked in the Facility or had contact with any Facility resident since. We allege compliance as of this day (4/27/16).
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and facility files, the facility failed to follow their policy to complete a thorough investigation and report immediately to state agencies any allegations of abuse, neglect and misappropriation of funds. The facility failed to conduct a thorough investigation for 1 of 1 allegations of misappropriation of funds (resident #69). The facility failed to conduct a thorough investigation, ensure protection of a resident (Resident #178) and report allegations of abuse for 2 of 2 residents (Resident #178 and #211) with identified concerns. It was determined on 4/21/16 at approximately 4:20 PM Immediate Jeopardy and/or Substandard Quality of Care existed in the facility as of 3/17/2016. The findings included: Cross refer to F 224 as it relates to preventing, investigating and reporting allegations of abuse, neglect and misappropriation of funds/personal property. Resident #178 reported someone had entered their room in the middle of the night and had him/her sign a paper. The resident did not know who the person was or what was on the paper. The resident was told not to mention the letter and not to tell anyone that the resident had a visitor. The facility also received reports the person that entered the building in the middle of the night made copies of medical records. No investigation had been conducted nor were the allegations reported to the state agencies. A plan had not been put in place to prevent a re-occurrence Resident # 69 reported to the facility that a Certified Nursing Assistant (CNA) had his/her bank card and had used the card without the resident's authorization. The CNA had the resident's car as well. The facility did not have a thorough investigation of the allegations. The facility's investigation did not include an official statement from the resident. There were no interviews/statements of other resident's that may have been affected by the CNA's practice. There were no statements obtained from the staff. During the Recertification/Complaint Survey, the facility Administration was notified by the surveyor of two allegations of abuse the facility was not aware. The facility Administration stated they would do an investigation. No reports were received by the state agency of the allegations.

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) The facility admitted Resident #211 with [DIAGNOSES REDACTED]. During an individual interview on 4/19/16 at 10:49 AM, Resident #211 stated staff were not nice to her. He/she continued by stating after asking for assistance, the nurse slammed his/her hands down on the counter and asked don't I always help you? He/she continued by stating the Administrator had been informed of the event. Record review on 4/20/16 of the nurse's notes and the social services notes did not reflect the incident. Investigation of the incident was requested on 4/19/16. A grievance form had been completed on 4/17/16 which stated the resident did not feel the nurse provided enough assistance in helping the resident go to the bathroom. Per the findings of the investigation, the nurse felt he/she was trying to help the resident maintain her independence and felt he/she was professional and thorough with the resident's activities of daily living. After the investigation, it was determined the resident did not feel comfortable with the nurse. The action taken was the nurse would not be assigned to the resident. After reviewing the grievance, the facility was asked if they were aware of the nurse allegedly slamming her hands down on the desk when the resident was speaking to him/her. The facility did not have knowledge of the incident. On 4/20/16, an initial 24-hour report was completed and sent to the State Survey Agency. The incident was described as verbal abuse as an employee was overheard yelling and cursing at Resident #211. A witness statement was obtained with a date of 4/16/16 which alleged the nurse in question had cursed at the resident. During an interview with the Administrator on 4/23/16 at 10:59 AM, he/she had no explanation as to why the date on the witness statement was 4/16/16 and no explanation why this was not reported at the time of the incident. Review of the facility policy titled Abuse Policy and Procedure revealed under Section III-A Reporting the following: Any person observing(or hearing a complaint of) mistreatment, neglect, abuse or misappropriation of resident property should immediately report it to the Administrator, Social Services Director, Director of Nursing or other department head. CFR 483.13(c) F-226 Develop/Implement Abuse/Neglect, etc Policies was identified at a scope and severity level of (L). The facility failed to follow and implement policies related to investigation, preventing and reporting of allegations of abuse for Residents #69, #178 and #211. The facility Administrator, Director of Nursing, and Director of Nursing in Training were informed of the Immediate Jeopardy on 4/21/16 at approximately 5:20 PM. The facility provided an Allegation of Compliance (AOC) that was acceptable on 4/28/16 at 2:05 PM. Observation, record review and interview provided evidence to the survey team prior to exit the AOC had been implemented by the facility and the Immediate Jeopardy at F-226 was removed, but the citation remained at a lower scope and severity of F. The AOC included the following: AOC: It has been alleged in the context of the pending survey process that the Facility's response to events allegedly occurring on or around March 17th-20th, was insufficient. In an effort to demonstrate and achieve substantial compliance with applicable and involved regulations, the Facility proposes and has initiated implementation of the following plan of correction: * Resident Security- 1. In an effort to put immediate corrective action in place, Resident #1 was asked by the Administrator to inform Facility Administration in the event there is a recurrence of uninvited or unwanted visitors entering (his/her) room (employees or otherwise). Further, the Resident was reminded of (his/her) right to speak with the Department of Health or the Ombudsman should (he/she) ever have questions or concerns, or should (he/her) require additional information on any topic affecting (his/her) Facility admission. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has conducted an investigation into the subject events which included interviews of all residents. Specifically, each resident has been asked if they have ever been visited by people they did not recognize, and where applicable, the time, dates are being investigated to determine the nature of the visit. Further, on 4/22/16, the Facility has provided each current resident with a flyer containing the phone numbers of the South Carolina Department of Health and Environmental Control, and the local Ombudsman. Going forward, this same flyer will be distributed to incoming residents on admission. Additionally, the codes have been changed at each pedestrian entrance door. (4/23/16) 3. The following measures have been put in place to ensure the deficient practice will not reoccur: * A sign-in log was placed at the front desk. All visitors (which includes employees who are in the Facility for reasons other than working a scheduled shift) will be required to sign in at the front desk, and indicate their purpose in visiting the Facility. If a visitor is there to see a resident, the name and room number of the Resident must be indicated on the sign-in log. * All employees have been informed via in-service that they should not be present on Facility premises unless they are assigned to work, or have other work-related business at that time Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * The following information has been inserviced: Abuse, Neglect, Misappropriation, and timely reporting of an allegation Resident Rights, and timely reporting of any violations Door code change for security, an sensitivity of code. * All employees have been trained (4/23/16) that in the event any employee is seen entering the Facility at hours not typically worked by that employee, they are obligated to report such unusual activity to Facility management. Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * Signs have been posted at or near each door leading in to the Facility, instructing all visitors to sign in at the front desk (4/25/16). * The code to all exit doors was changed on 4/21/16. All active employees, and resident responsible parties were notified of the code change. * Protection of Private Health Information 1. In an effort to put immediate corrective action in place, Resident #1 was informed by the Administrator that an employee of Compass Post-Acute Care is alleged to have collected private information about (him/her) outside the scope of (his/her) employment. Our guidance to (him/her) reflected the information we have to date and the possibility that (his/her) protected health information may have ben accessed for reasons unrelated to (his/her) treatment, payment or other healthcare purpose. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has invited members of our Compliance Department to come and evaluate our existing practices. All employees have been re-educated (4/27/16) regarding their obligations under HIPAA, and all new employees (and agency if necessary) will receive the more comprehensive training upon hire via a web-based module [MEDICATION NAME] approximately 45 minutes. 3. In addition to the physical security items listed above, the following measures have been put in place to ensure the deficient practice will not reoccur: * Any time a chart is removed temporarily from the nursing station, the employee doing so must note the removal in the log created to capture this information. The employee will need to log the date, time of removal, time of return, and purpose associated with the temporary removal. * Employees who remove medical records from the Facility or who access the chart for reasons inconsistent with Federal and State Privacy Laws will be disciplined up to and including the possibility of termination. * A video surveillance system is to be installed and contractors have been contacted. The system will provide remote visualization of each door leading in to the Facility, and will also show activity in public or shared areas including but not limited to hallways, nursing stations, dining rooms, etc.). * Resident rooms will not be included in the areas capable of being viewed by the cameras. The Department should also be aware that the employee whose conduct is at issue has been suspended pending the results of our investigation. (He/she) has not worked in the Facility or had contact with any Facility resident since. We allege compliance as of this day (4/27/16).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425391	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AGAPE REHABILITATION OF CONWAY	2320 HIGHWAY 378 CONWAY, SC 29527

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 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 4)
F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interview and review of activity attendance sheets, the facility failed to provide an ongoing program of activities designed to meet the interests, and the physical, mental and psychosocial well being for Resident #2 for 1 of 3 residents reviewed for activities. The findings included: The facility admitted Resident #2 with [DIAGNOSES REDACTED]. Observations made on the first 2 days of the survey, 4/11/2016 and 4/12/2016 revealed the resident in his/her room with no activities to meet his/her interest. Review on 4/22/2016 at approximately 3:15 PM of the Activity - Admission Evaluation revealed current activity interest for Resident #2 that includes games such as cards, word trivia and bingo. He/she also enjoys puzzles, exercise groups, television sports and music. He/she enjoys reading, Spiritual and Religious activities with groups and enjoys trips, gardening, and going out of doors. He/she also enjoys pets and socializing. No documentation could be found where Resident #2 was offered any of the activities of his/her interest or encouraged to attend any activities at all. Review on 4/22/2016 at approximately 5:00 PM of the Comprehensive Plan of Care did not include activities of any kind for Resident #2. Review on 4/22/2016 at approximately 5:00 PM of the activity attendance sheets included the dates from 1/29/2016 through 2/3/2016 but none from the current admission for Resident #2. During an interview on 4/22/2016 at approximately 5:10 PM with the Activity Director he/she stated, he/she has not attended any out of room activities since the readmission. We are doing in room activities for this resident. The activity director could not provide documentation for any in room activities.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to develop a Comprehensive Plan of Care with goals and interventions for an ongoing program of activities to meet the interest, and the physical, mental and psychosocial well being of each resident. Resident #2 was not provided activities of interest for 1 of 3 residents reviewed for activities. The findings included: The facility admitted Resident #2 with [DIAGNOSES REDACTED]. Observations made on the first 2 days of the survey, 4/11/2016 and 4/12/2016 revealed Resident in his/her room with no activities to meet his/her interest. Review on 4/22/2016 at approximately 3:15 PM of the Activity - Admission Evaluation revealed current activity interest for Resident #2 that includes games such as cards, word trivia and bingo. He/she also enjoys puzzles, exercise groups, television sports and music. He/she enjoys reading, Spiritual and Religious activities with groups. He/she enjoys trips, gardening, and going out of doors. He/she also enjoys pets and socializing. No documentation could be found where Resident #2 was offered any of the activities of his/her interest or encouraged to attend any activities at all. Review on 4/22/2016 at approximately 5:00 PM of the Comprehensive Plan of Care did not include activities of any kind for Resident #2. During an interview on 4/22/2016 at approximately 5:30 PM with the Care Plan Coordinator/Director of Nursing in training, verified that the Comprehensive Plan of Care did not include activities for Resident #2.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to afford the opportunity to the resident and/or responsible party to participate in the care plan process for 2 of 3 residents reviewed for care plan participation.(Residents #211 & #197) The findings included: The facility admitted Resident #211 with [DIAGNOSES REDACTED]. During an individual interview with Resident #211, on 4/19/16 at 1:58 PM, he/she stated a care plan meeting was conducted and he/she was not invited which made the resident feet left out. During an interview with the Care Plan Coordinator (CPC) on 4/23/16 at 11:49 AM, the CPC stated a 72 hour meeting had been scheduled and the resident's parents did not want him/her in attendance. On 4/23/16 at 11:59 AM, during an interview with Social Services (SS), SS stated during a 72 hour meeting items such as discharge planning, applying for Medicaid and insurance is discussed. SS further stated the resident's parents did not want the resident to attend this meeting. No documentation could be provided related to the parents wishes for the resident not to attend the meeting. During the survey process, a policy was not provided related to invitation to care plan meetings and the care plan process. The facility admitted Resident #197 with [DIAGNOSES REDACTED]. During an interview on 4/18/2016, Resident # 197 reported that he/she was not included in decisions concerning his/her medications, therapy or other treatments. Resident #197 also reported at that time that he/she had not been invited to attend or participate in a Care Planning Conference. During an interview on 4/23/2016 at approximately 10:46 AM with the Care Plan Coordinator/Director of Nursing in training, he/she stated, if a resident is short term they are included in a care plan conference along with the family. The meeting is arranged by the receptionist and the meeting is called a 72 hour meeting. No documentation could be found that Resident #197 nor his/her family had been invited or included in a care planning conference. During an interview on 4/23/2016 at approximately 12:00 noon with the Social Service Director (SSD), he/she stated, a care plan meeting was not held for this resident. The SSD went on to say that, a call to the family was attempted but he/she had spoken with them in the facility hallway. No mention was made that Resident #197 had been invited or encouraged to attend a care plan conference. No documentation could be found to ensure the family was spoken to nor Resident #197 concerning his/her care planning.
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to follow the Comprehensive Plan of Care related to ensuring a 1200 milliliter daily fluid restriction was followed. The facility further failed to monitor the input and output for Resident #100 for 1 of 1 residents reviewed for [MEDICAL TREATMENT]. The findings included: The facility admitted Resident #100 with [DIAGNOSES REDACTED]. Review on 4/19/2016 at approximately 7:00 PM of the physician telephone orders revealed an order dated 2/22/2016 which read, Fluid restriction 1200 milliliters (mls), daily for End Stage [MEDICAL CONDITION]. During an interview on 4/19/2016 at approximately 7:00 PM Licensed Practical Nurse # 1 confirmed that the fluid restriction was not being followed per the physician's orders [REDACTED].#100 was taking in more than the ordered 1200 mls daily. Review on 4/20/2016 at approximately 4:05 PM of the Comprehensive Plan of Care dated 2/23/2016 and revised on 3/20/2016 and included interventions to encourage to follow fluid restriction as ordered 1200 mls daily. Also included on the care plan was an intervention to, Monitor intake and output. No documentation could be found to ensure the fluid restriction was being followed nor documentation for the correct input and output.

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F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5)
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and review of the facility policy titled, Encouraging and Restricting Fluids, the facility failed to ensure a 1200 milliliter daily fluid restriction was followed per a physician's order. The facility further failed to monitor the input and output for Resident #100 for 1 of 1 resident reviewed for [MEDICAL TREATMENT]. The findings included: The facility admitted Resident #100 with [DIAGNOSES REDACTED]. Review on 4/19/2016 at approximately 7:00 PM of the physician telephone orders revealed an order dated 2/22/2016 which read, Fluid restriction 1200 milliliters (mls), daily for End Stage [MEDICAL CONDITION]. During an interview on 4/19/2016 at approximately 7:00 PM Licensed Practical Nurse # 1 confirmed that the fluid restriction was not being followed per the physician's order and confirmed that Resident #100 was taking in more that the ordered 1200 mls daily. Review on 4/19/2016 at approximately 7:08 PM of the Medication Administration Record [REDACTED]. The fluid intake on 4/5/2016 was 1650 mls, 4/6/2016 the intake was 1650, on 4/7/2016 the intake was 1320 and on 4/10/2016 the fluid intake was 1400 mls. Further review on 4/19/2016 at approximately 7:08 PM revealed a MAR for March 2016. On 3/28/2016 the intake of fluid was recorded as 3060 mls and 1740 mls on 3/29/2016. The MAR for February revealed on 2/24/2016 the intake of fluid was 1625 mls and on 2/25/2016 the intake of fluid was 2050 mls. No measurements of urine could be found in the medical record for Resident #100, just continent episodes. Review on 4/20/2016 at approximately 7:15 PM of the guidelines for fluid restrictions of 1200 mls per day revealed breakfast 240 mls, Lunch 240 mls and Supper 240 mls. During medication administration Resident #100 could consume 150 mls with the 7 to 3 shift, 120 mls with the 3 to 11 shift and 120 mls with the 11 to 7 shift. The guidelines also stated that the resident may have 3 ounces/90 mls of fluids per shift in addition to meals and medications. Review on 4/20/2016 at approximately 7:15 PM of the facility policy titled, Encouraging and Restricting Fluids, states, The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Under, General Guidelines, number 1. states, Follow specific instructions concerning fluid intake or restrictions. 2. states, Be accurate when recording fluid intake. Number 3. states, Record fluid intake on the intake side of the intake and output record, Number 4. states, Be supportive of the resident's fluid intake. Encourage the resident to follow specific instructions.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**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 interviews, the facility failed to provide supervision for the safety of the residents. Resident #178 was visited in the middle of the night by someone s/he did not know, and instructed to sign a paper. The resident was told to not tell anyone about the paper and not to tell anyone about the visit. The facility was made aware of the incident early that same AM and failed to address the incident to ensure not just the safety of Resident #178, but all residents in the building. It was determined on 4/21/16 at approximately 4:20 PM Immediate Jeopardy and/or Substandard Quality of Care existed in the facility as of 3/17/2016. The findings included: Cross refer to F224 and F226 as it relates to prevention, investigation and reporting abuse/neglect and misappropriation of funds and implementing abuse policies as applicable to ensure resident well being. The facility admitted resident # 178 with [DIAGNOSES REDACTED]. The resident had a Brief Interview for Mental Status Score of 15. S/he was alert and oriented and able to make decisions regarding his/her ability to make decisions regarding activities of daily living. Review of the additional allegations revealed an allegation of 3/16/16 related to resident #178. Per the allegation, the resident had complained that a nurse had snatched off a neck brace. Review of the facility's grievance files revealed a grievance of the allegation. Through the facility investigation of the allegation, the resident had stated the nurse had startled him/her when removing the neck brace and was not abused. The Administrator, Director of Nursing (DON), Director of Nursing in Training (DON in training), and Social Services (SS) were interviewed by the surveyor on 4/21/16 at approximately 11:30 AM. During the interview the Administrator and DON stated that a note was left under the administrator's door, signed by the Resident #178. The administrator provided the note for review. The note stated, I will (sic) like to speak to the Patient Advocate about my collar being snatched off by male nurse. Please call them for me, thanks for asking about my care. I was informed S/he is Ombudsman ---- (name of person). The administrator went to the resident and was told by the resident that someone had come in his/her room at 3:00 AM, wearing a hoodie and had him/her sign a paper. The resident did not know who the person was or what was on the paper that s/he signed. The resident stated s/he did not write the note and did not want to talk to the patient advocate. The DON stated the person was seen by staff members copying resident charts. The DON stated when s/he came in, the person had already left the facility. During the interview the Administrator and DON and DON in training stated the person that had entered the facility during the night was an employee, a Licensed Practical Nurse (LPN), who worked the 7A-7P shift. The employee was out on medical leave at the time of the survey. The DON in training stated that they had been informed the LPN had been observed sitting outside of other staff member's homes, in a car. The Administrator was asked by the surveyor, what had been done to protect the residents from unknown persons entering the building in the middle of the night, coercing the residents. The Director of Nursing stated the County Sheriff's Department had been asked for the facility to be placed on their security patrol route. The DON did not know how often the police would patrol the facility at night. S/he did not know what medical records had been allegedly copied by the person. The DON and DON-in-training were unable to provide an investigation into the incident with resident #178, regarding the night visitor nor any information regarding the copied medical records. The DON in training repeatedly stated, the employee was just doing what s/he thought was right. The facility was aware of the middle of the night entrance into the building by an off duty employee. The resident informed them of an unknown person dressed in a hoodie coercing him/her to sign a note that the resident did not write. The resident did not know who the person was or what was written on the note. They were also aware of the allegation of medical records being copied and removed from the facility. There was no investigation, no preventive measures put into place to protect the residents, or the facility medical records. There was no documentation that the Sheriff's Department was contacted, or how often they would patrol the facility. There was no documentation the alleged perpetrator had been investigated regarding the medical records. On 4/21/16 at approximately 3:00 PM the Administrator provided a facility document of communications with corporate personnel. The document was a time line related to the incident of 3/16/16. 3/16- LPN was called into the office for inappropriate comments and insubordinate attitude toward the Assistant Director of Nursing (ADON) . The LPN was highly defensive, and aggressive toward myself and ADON when I tried to speak with him/her .Within 30 minutes the LPN brought back an allegation of abuse toward the ADON which stemmed from an incident that happened 14 days prior. I immediately investigated the complaint and interviewed the following: (Resident #178) S/he said that s/he was nervous for them to take the neck brace off, and that s/he got scared. S/he said it felt rough when they had to pull the velcro collar to undo it. S/he said it was rough but said s/h didn't think it was abusive in anyway. The ADON, Certified Nursing Assistant (CNA) and X-ray Tech state that the resident was alert and aware of what was going on. That the ADON was not rough with the resident, nor did s/he jerk or snatch the collar off the resident. 3/17/16- The LPN called myself (administrator) at 6:00 AM to tell me s/he was sick and wasn't coming into work for his/her shift at 7:00 AM; ADON worked his/her shift. The LPN called and texted multiple staff, all day to the point where one staff member called---- for being harassed by him/her. That night the LPN was seen and reported in the building after Midnight- s/he told staff that s/he was here to work on his/her charting. The staff said they found it weird but let him/her

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 6) continue. 1 staff member said s/he saw the LPN copy papers from a chart, not on his/her normal hallway and take the papers with him/her. 2 staff members said that while the LPN was there she made threats of physical violence toward a CNA, who had just left the building a few hours prior .The LPN was also seen going down the 200 hall, and coming back to the 100 Hall later. 3/18/16- A letter was found signed by resident (#178) that said s/he wanted to speak to the Ombudsman about the neck. The writing on the letter, and the resident's signature were two different styles of writing, We spoke to the resident regarding the letter and s/he said that someone (s/he couldn't tell who, they had a hoodie on s/he thinks) woke him/her from his/her sleep around 2-3 am and made him/her sign a letter. S/he said s/he was told not to talk to anyone about the letter and not to tell anyone that someone came to visit him. We asked if s/he needed the Ombudsman, and s/he said that s/he didn't request him/her, because s/he did not write the letter. The resident stated he did not sign his/her name the way it was on the letter. So s/he knows s/he was out of it If s/he signed a letter with his /her legal name. CFR 483.25(h) F-323 Free of Accident Hazards/supervision/devices was identified at a scope and severity level of (L). The facility failed to provide supervision for the safety of Resident #178 and all facility residents. The facility Administrator, Director of Nursing, and Director of Nursing in Training were informed of the Immediate Jeopardy on 4/21/16 at approximately 5:20 PM. The facility provided an Allegation of Compliance (AOC) that was acceptable on 4/28/16 at 2:05 PM. Observation, record review and interview provided evidence to the survey team prior to exit the AOC had been implemented by the facility and the Immediate Jeopardy at F-323 was removed, but the citation remained at a lower scope and severity of F. The AOC included the following: AOC: It has been alleged in the context of the pending survey process that the Facility's response to events allegedly occurring on or around March 17th-20th, was insufficient. In an effort to demonstrate and achieve substantial compliance with applicable and involved regulations, the Facility proposes and has initiated implementation of the following plan of correction: * Resident Security- 1. In an effort to put immediate corrective action in place, Resident #1 was asked by the Administrator to inform Facility Administration in the event there is a recurrence of uninvited or unwanted visitors entering (his/her) room (employees or otherwise). Further, the Resident was reminded of (his/her) right to speak with the Department of Health or the Ombudsman should (he/she) ever have questions or concerns, or should (he/her) require additional information on any topic affecting (his/her) Facility admission. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has conducted an investigation into the subject events which included interviews of all residents. Specifically, each resident has been asked if they have ever been visited by people they did not recognize, and where applicable, the time, dates are being investigated to determine the nature of the visit. Further, on 4/22/16, the Facility has provided each current resident with a flyer containing the phone numbers of the South Carolina Department of Health and Environmental Control, and the local Ombudsman. Going forward, this same flyer will be distributed to incoming residents on admission. Additionally, the codes have been changed at each pedestrian entrance door. (4/23/16) 3. The following measures have been put in place to ensure the deficient practice will not reoccur: * A sign-in log was placed at the front desk. All visitors (which includes employees who are in the Facility for reasons other than working a scheduled shift) will be required to sign in at the front desk, and indicate their purpose in visiting the Facility. If a visitor is there to see a resident, the name and room number of the Resident must be indicated on the sign-in log. * All employees have been informed via in-service that they should not be present on Facility premises unless they are assigned to work, or have other work-related business at that time Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * The following information has been inserviced: Abuse, Neglect, Misappropriation, and timely reporting of an allegation Resident Rights, and timely reporting of any violations Door code change for security, an sensitivity of code. * All employees have been trained (4/23/16) that in the event any employee is seen entering the Facility at hours not typically worked by that employee, they are obligated to report such unusual activity to Facility management. Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * Signs have been posted at or near each door leading in to the Facility, instructing all visitors to sign in at the front desk (4/25/16). * The code to all exit doors was changed on 4/21/16. All active employees, and resident responsible parties were notified of the code change. * Protection of Private Health Information 1. In an effort to put immediate corrective action in place, Resident #1 was informed by the Administrator that an employee of Compass Post-Acute Care is alleged to have collected private information about (him/her) outside the scope of (his/her) employment. Our guidance to (him/her) reflected the information we have to date and the possibility that (his/her) protected health information may have ben accessed for reasons unrelated to (his/her) treatment, payment or other healthcare purpose. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has invited members of our Compliance Department to come and evaluate our existing practices. All employees have been re-educated (4/27/16) regarding their obligations under HIPAA, and all new employees (and agency if necessary) will receive the more comprehensive training upon hire via a web-based module lasting approximately 45 minutes. 3. In addition to the physical security items listed above, the following measures have been put in place to ensure the deficient practice will not reoccur: * Any time a chart is removed temporarily from the nursing station, the employee doing so must note the removal in the log created to capture this information. The employee will need to log the date, time of removal, time of return, and purpose associated with the temporary removal. * Employees who remove medical records from the Facility or who access the chart for reasons inconsistent with Federal and State Privacy Laws will be disciplined up to and including the possibility of termination. * A video surveillance system is to be installed and contractors have been contacted. The system will provide remote visualization of each door leading in to the Facility, and will also show activity in public or shared areas including but not limited to hallways, nursing stations, dining rooms, etc.). * Resident rooms will not be included in the areas capable of being viewed by the cameras. The Department should also be aware that the employee whose conduct is at issue has been suspended pending the results of our investigation. (He/she) has not worked in the Facility or had contact with any Facility resident since. We allege compliance as of this day (4/27/16).
F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review, the facility failed to ensure residents received the proper treatment and care for 3 of 3 residents reviewed for respiratory services. (Resident #5, Resident #117, and Resident #160) The findings included:

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F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) The facility admitted Resident #5 with [DIAGNOSES REDACTED]. Review of the medical record revealed a physician's orders [REDACTED].in the evening every Sun . Observation on 4/18/16 at approximately 11:00 AM revealed the oxygen concentrator was in use. Further observation revealed that the filter on the left side of the concentrator was missing, and the filter on the right side of the oxygen concentrator was heavily soiled with a white-colored substance on the surface of the filter. Further observations on 4/19/16 at approximately 4:00 PM and 4/20/16 at approximately 10:30 AM revealed the same findings. Review of the Medication Administration Record [REDACTED]. The Director of Nursing in Training confirmed these findings with the surveyor on 4/23/16 at approximately 11:00 AM. The surveyor informed the staff member that these findings were first observed upon entry to the facility on [DATE]. The facility admitted Resident #117 with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Observation on 4/18/16 at approximately 1:00 PM revealed Resident #117 resting in bed with the oxygen concentrator in use. Further observation revealed the filters on both sides of the oxygen concentrator were heavily soiled with a white-colored substance. Additional observations on 4/19/16 at approximately 11:00 AM and 4/20/16 at approximately 10:30 AM revealed the same findings. The Director of Nursing in Training confirmed these findings with the surveyor on 4/23/16 at approximately 11:00 AM. The surveyor informed the staff member that these findings were first observed upon entry to the facility on [DATE]. The facility admitted Resident #160 with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Observation on 4/18/16 at approximately 11:00 AM revealed the filters on the oxygen concentrator in Resident #160's room were covered with a white residue. Further observations on 4/19/16 at approximately 10:00 AM and 4/20/16 at approximately 10:30 AM revealed the same findings. The oxygen concentrator was not in use during these observations. The Director of Nursing in Training confirmed these findings with the surveyor on 4/23/16 at approximately 11:00 AM. The surveyor informed the staff member that these findings were first observed upon entry to the facility on [DATE].
F 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the facility policies titled Administering Medications, Insulin Pen Delivery Device for Diabetes Care and Crushing Medications, the facility failed to maintain a medication error rate of less than 5 percent. There were 6 errors out of 26 opportunities for error resulting in a medication error rate of 23.07%. The findings included: Error #1 The facility admitted Resident #116 with [DIAGNOSES REDACTED]. On 4/21/16 at approximately 10:45 AM, during medication administration to Resident #116, Registered Nurse(RN)#1 was observed to administer [MEDICATION NAME] 800 milligrams(mgs). Record review revealed [MEDICATION NAME] was to be administered four times a day 9 AM, 1 PM, 5 PM and 9 PM. Resident #116 received the medication 1 hour and 45 minutes past the standard time frame of administration. Error #2 The facility admitted Resident #56 with [DIAGNOSES REDACTED]. On 4/21/16 at 11:17 AM, during medication administration to Resident #56, RN#3 administered Humalog 5 units via [MEDICATION NAME]. Prior to administration, RN#3 was asked was there anything to be done to the pen prior to administration in which he/she answered no. Prior to the administration of the insulin, RN #3 did not prime the pen nor did he/she leave the pen needle in for 6-10 seconds as required. Error #3-6 The facility admitted Resident #186 with [DIAGNOSES REDACTED]. On 4/22/16 at 9:02 AM, during medication administration to Resident #186, Licensed Practical Nurse #4 crushed the am medications to be administered which included [MEDICATION NAME] 5 mg delayed release, [MEDICATION NAME] Succ. ER 200 mg, [MEDICATION NAME] 67 mg and Dilitiazem ER 180 mg. Prior to crushing the medications, LPN#4 stated due to the resident having Dementia, all medications were crushed. Review of the facility policy titled Administering Medications revealed under item #4 the following: Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified(for example, before and after meal orders). Review of the facility policy titled Insulin Pen Delivery Device for Diabetes Care revealed under items #8 and #9 the following: #8-The insulin pen is to be primed prior to each use to prevent the collection of air in the insulin reservoir. #9-To verify that all insulin is injected, keep the pen needle in the subcutaneous fat layer for 6-10 seconds after the injection with the thumb remaining on the push/button plunger. Review of the facility policy titled Crushing Medications revealed under items #2 and #3 a the following: #2-The nursing staff and/or Consultant Pharmacist shall notify any Attending Physician who gives an order to crush a drug that the manufacturer states should not be crushed(for example, long-acting or [MEDICATION NAME] coated medications). The Attending Physician or Consultant Pharmacist must identify an alternative or the Attending Physician must document(or provide the nurses with a clinically pertinent reason to document) why crushing the medication will not adversely affect the resident. #3 a-The Medication Administration Record [REDACTED].
F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the facility policies titled Administering Medications, Insulin Pen Delivery Device for Diabetes Care and Crushing Medications, the facility failed to ensure that it was free of significant medication errors. There was six significant medication errors out of 26 opportunities for error observed during medication pass. The findings included: The facility admitted Resident #116 with [DIAGNOSES REDACTED]. On 4/21/16 at approximately 10:45 AM, during medication administration to Resident #116, Registered Nurse(RN)#1 was observed to administer [MEDICATION NAME] 800 milligrams(mgs). Record review revealed [MEDICATION NAME] was to be administered four times a day 9 AM, 1 PM, 5 PM and 9 PM . Resident #116 received the medication 1 hour and 45 minutes past the standard time frame of administration. ii The facility admitted Resident #56 with [DIAGNOSES REDACTED]. On 4/21/16 at 11:17 AM, during medication administration to Resident #56, RN#3 administered Humalog 5 units via [MEDICATION NAME]. Prior to administration, RN#3 was asked was there anything to be done to the pen prior to administration in which he/she answered no. Prior to the administration of the insulin, RN #3 did not prime the pen nor did he/she leave the pen needle in for 6-10 seconds as required. The facility admitted Resident #186 with [DIAGNOSES REDACTED]. On 4/22/16 at 9:02 AM, during medication administration to Resident #186, Licensed Practical Nurse #4 crushed the am medications to be administered which included [MEDICATION NAME] 5 mg delayed release, [MEDICATION NAME] Succ. ER 200 mg, [MEDICATION NAME] 67 mg and Dilitiazem ER 180 mg. Prior to crushing the medications, LPN#4 stated due to the resident having Dementia, all medications were crushed. Review of the facility policy titled Administering Medications revealed under item #4 the following: Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified(for example, before and after meal orders). Review of the facility policy titled Insulin Pen Delivery Device for Diabetes Care revealed under items #8 and #9 the following: #8-The insulin pen is to be primed prior to each use to prevent the collection of air in the insulin reservoir. #9-To verify that all insulin is injected, keep the pen needle in the subcutaneous fat layer for 6-10 seconds after the injection with the thumb remaining on the push/button plunger. Review of the facility policy titled Crushing Medications revealed under items #2 and #3 a the following: #2-The nursing staff and/or Consultant Pharmacist shall notify any Attending Physician who gives an order to crush a drug that the

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F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) manufacturer states should not be crushed(for example, long-acting or [MEDICATION NAME] coated medications). The Attending Physician or Consultant Pharmacist must identify an alternative or the Attending Physician must document(or provide the nurses with a clinically pertinent reason to document) why crushing the medication will not adversely affect the resident. #3 a-The Medication Administration Record [REDACTED].
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Store, cook, and serve food in a safe and clean way** Based on observations, interviews and review of the facility policy titled, Temperature Regulations Made Practical and Infection Control Policy and Procedure, for the Dietary Department, the facility failed to prepare, distribute and serve food under sanitary conditions in 1 of 1 kitchen and has the potential to effect all residents eating meals prepared in the facility kitchen. The findings included: During initial tour of the kitchen on 4/18/2016 at approximately 8:50 AM revealed the following: 1. The robo coupe was soiled with dried food and debris. 2. The stand mixer was covered and confirmed not used had a pink thin liquid in the bottom of the bowl. 3. The ice machine had a grease build up on the front, outside of the machine. 4. A large amount of cut-up chicken was observed in the stainless steel sink with a trickle of water running from the faucet. The chicken was thawed, laying directly in the sink, there was an odor coming from the chicken and a light brown color was noted on the lean portion of the chicken. During an interview on 4/18/2016 at approximately 8:50 AM with the Dietary Manager he/she stated that the chicken was removed from the freezer at around 8:00 AM. This surveyor asked for a temperature of the raw meat and it was taken by the Dietary Manager and was 69 degrees. The thawed chicken was removed from the sink and discarded in the trash. All of the above findings were confirmed at this time by the Dietary Manager. During initial tour on 4/18/2016 at approximately 9:15 AM of the nutrition room on the 100 hall revealed a bottle of Uti-Stat Cranberry supplement had expired on 1/2016. During an interview with Licensed Practical Nurse #5 verified the findings. Review of the facility policy titled, Temperature Regulations Made Practical, on 4/18/2016 at approximately 10:30 AM states under, Time and Temperature Principle, The failure to adequately control food temperatures is the one of two factors most commonly implicated in outbreaks of foodborne illness. The second most frequently implicated is cross-contamination. Since disease-causing bacteria are capable of rapidly multiplying at temperature from 41 degrees to 140 degrees this is know as the Temperature Danger Zone, An observation on 4/22/2016 at approximately 11:30 AM revealed a male dietary staff member preparing food in the kitchen and not wearing a beard protector. The staff member member confirmed that he was not wearing a beard protector and then proceeded to apply one. Review on 4/22/2016 at approximately 1:30 PM of the facility policy titled, Infection Control Policy/Procedure - Dietary Department, under, Procedures, Personnel Requirements, number 6. states, Wear a mustache and or a beard covering.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews and review of the facility agreement with the Pharmacy, and the Consultant Pharmacy Services Agreement, the Pharmacy failed to ensure medications ordered by the physician were available and accessible for Residents #8 in a timely manner for 1 of 5 residents reviewed for unnecessary medications. The findings included: The facility admitted Resident #8 with [DIAGNOSES REDACTED]. Review on 4/20/2016 at approximately 10:49 AM of the Medication Administration Record [REDACTED]. Review of the MAR indicated [REDACTED]. Further review on 4/20/2016 at approximately 10:49 AM of the MAR for February 2016 revealed K-Phos No 2 tablet 350-700 mg to be administered at 9:00 AM on 2/15/2016, 2/16/2016, 2/17/2016, 2/18/2016 and 2/19/2016 was not given. The 1:00 PM dose of this medication was not administered on 2/16/2016, 2/17/2016, 2/18/2016 and 2/19/2016. The 5:00 PM dose was not administered for 2/17/2016, 2/18/2016 and 2/19/2016. The 9:00 PM dose on 2/19/2017 was not administered. During even further review of the MARs on 4/20/2016 at approximately 10:55 AM revealed a MAR indicated [REDACTED]. Review on 4/20/2016 at approximately 2:00 PM of the nurses notes dated 2/06/2016 and 2/8/2016 states,Alprazolam 1 mg, not available from pharmacy. The nurses notes dated 2/15/2016 states the K-Phos No 2 Tablet is not available from pharmacy. On 2/16/2016 the nurses note states, pharmacy will fill, and not available from pharmacy. On 2/17/2016 and 2/18/2016 the nurses note states, medication not available. On 2/19/2017 the nurses note states, not available, will call pharmacy again. Further review of the nurses notes on 4/20/2016 at approximately 2:00 PM reveled a note on 3/7/2016 that states, Cymbalta not available, request refill, The nurses note on 3/22/2016 states, Daily Vitamin Tablet - medication not available from pharmacy. No documentation could be found in Resident #8's medical record to ensure the physician was notified of the above missed medications. During an interview on 4/23/2016 at approximately 10:39 AM with the Director of Nursing (DON) stated, the medications come in in a tote for the Talyst and the staff cannot get into the totes to get the medications. He/she went on to say, staff cannot get into the Talyst to reload the medications, sometimes the medications are jammed in the machine or they are not available at times. During an interview on 4/23/2016 at approximately 11:30 AM with Licensed Practical Nurse #2 he/she confirmed by stating, if a resident is admitted in the morning or the afternoon the medications are not delivered until 9:00 or 10:00 PM that night and are only the punch cards. Review on 4/23/2016 at approximately 12:00 noon of the, Consultant Pharmacy Services, states, The consultant pharmacist will be responsible for the following: #9.Monitoring drug inventory and control system of the emergency and interim drug boxes, medication cart and medication room including the medication refrigerator. The form titled, Daily Order and Delivery of Medications, states, Agape delivers medications daily. All incoming patient orders should be faxed as soon as they are dictated so we can assure timely delivery of medications.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on record review, observation, interview and review of the facility policy titled Storage of Medications, the facility failed to maintain appropriate refrigerator temperatures on 2 of 2 units. In addition, the facility failed to secure the medication keys for the medication cart and medication room for 1 of 2 units. The findings included: Observation of the 100 Unit medication refrigerator on 4/22/16 at 6:50 PM revealed a temperature of 28 degrees Fahrenheit. At the time of the observation, Licensed Practical Nurse (LPN)#2 stated the correct temperature should be between 36-41 degrees. He/she stated they were unaware of the facility procedure if the refrigerator range was incorrect. At the time of the observation, no liquid medication was frozen. A recheck on 4/23/16 of the refrigerator revealed the temperature was 32 degrees Fahrenheit.

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F 0431 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 9) On 4/22/16 at 2:24 PM, the 200 Unit refrigerator temperature reading was 32 degrees. At the time of the observation, no liquid medications were frozen. A recheck of the refrigerator on 4/22/16 at 6:55 PM revealed the a temperature reading of 36 degrees and on 4/23/16 at 10:49 AM a reading of 41 degrees. Review of the refrigerator log sheet for the 100 Unit revealed on 4/19/16 at 6 AM a temperature reading was 33 degrees; 7 PM-34 degrees; 4/20/16 at 6 AM-34 degrees; 7 PM-33 degrees; 4/21/16 at 6 AM-32 degrees; and 6 PM 33 degrees; and 4/22/16 at 12 PM 33 degrees. Review of the refrigerator log sheet for the 200 Unit revealed on 4/21/16 a temperature reading of 35 degrees and on 4/22/16 at 6:30 PM a temperature reading of 31 degrees. On 4/22/16 at 11:45 AM, Registered Nurse(RN) #2 was asked to unlock the Unit 2, medication cart 2. RN #2 reached into an unlocked desk drawer and obtained the medication keys which unlocked the medication room, the pixus room and the Unit 2, medication cart 2. At the time of the observation, RN #2 stated keeping the keys in an unlocked drawer was not the normal procedure. He/she continued by stating the keys were not on his/her person, so he/she assumed the keys were somewhere and that is why he/she looked in the drawer in the desk. On 4/22/16 at 12:02 PM, the Director of Nursing was notified of the unsecured medication keys. Further review of the temperature logs revealed instructions the temperature of the refrigerators should be between 36-46 degrees Fahrenheit. Review of the facility policy on 4/23/16 titled Storage of Medications revealed the following under #7: Compartments(including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility files and interviews, the facility failed to Administer in a way to maintain safety of residents named in allegations of abuse/neglect misappropriation of funds. It was determined on 4/21/16 at approximately 4:20 PM Immediate Jeopardy and/or Substandard Quality of Care existed in the facility as of 3/17/2016. The findings included: Cross refer to F224- Prevent, investigate and report allegations of abuse/neglect, misappropriation of funds Cross Refer to F226: Developing Policies and Procedures for Abuse/Neglect and Misappropriation of funds/personal property. Cross refer to F323: Supervision to prevent accidents/incidents. Supervision not provided to prevent unknown person entering facility and resident's rooms when sleeping. During the Recertification and Complaint Survey, on 4/21/16 the Department of Health and Environmental Control (DHEC) Certification State Agency office received an additional eight (8) allegations of abuse/neglect. Review of the allegations revealed the facility had identified a concern related to the allegation that involved resident # 178. The facility admitted resident # 178 with [DIAGNOSES REDACTED]. The resident had a Brief Interview for Mental Status Score of 15. S/he was alert and oriented and able to make decisions regarding his/her ability to make decisions regarding activities of daily living. Review of the additional allegations revealed an allegation of 3/16/16 related to resident #178. Per the allegation, the resident had complained that a nurse had snatched off a neck brace. Review of the facility's grievance files revealed a grievance of the allegation. Through the facility investigation of the allegation, the resident had stated the nurse had startled him/her when removing the neck brace and was not abused. The Administrator, Director of Nursing (DON), Director of Nursing in Training (DON in training), and Social Services (SS) were interviewed by the surveyor on 4/21/16 at approximately 11:30 AM. During the interview the Administrator and DON stated that a note was left under the administrator's door, signed by the resident. The administrator provided the note for review. The note stated, I will (sic) like to speak to the Patient Advocate about my collar being snatched off by male nurse. Please call them for me, thanks for asking about my care. I was informed S/he is Ombudsman ---- (name of person). The administrator went to the resident and was told by the resident that someone had come in his/her room at 3:00 AM, wearing a hoodie and had him/her sign a paper. The resident did not know who the person was or what was on the paper that s/he signed. The resident stated s/he did not write the note and did not want to talk to the patient advocate. The DON stated the same person seen in Resident #178's room was seen on the same night by staff members copying resident charts. The DON stated when s/he came in, the person had already left the facility. During the interview the Administrator and DON and DON in training stated the person that had entered the facility during the night was an employee, a Licensed Practical Nurse (LPN), who worked the 7A-7P shift. The employee was out on medical leave at the time of the survey. The DON in training stated that they had been informed the LPN had been observed sitting outside of other staff member's homes, in a car. The Administrator was asked by the surveyor, what had been done to protect the residents from unknown persons entering the building in the middle of the night, coercing the residents. The Director of Nursing stated the County Sheriff's Department had been asked by the facility to be placed on their security patrol route. The DON did not know how often the police would patrol the facility at night. S/he did not know what medical records had been allegedly copied by the person. The DON and DON-in-training were unable to provide an investigation into the incident with resident #178, regarding the night visitor nor any information regarding the copied medical records. The DON in training repeatedly stated the employee was just doing what s/he thought was right. The facility was aware of the middle of the night entrance into the building by an off duty employee. The resident informed them of an unknown person dressed in a hoodie coercing him/her to sign a note that the resident did not write. The resident did not know who the person was or what was written on the note. They were also aware of the allegation of medical records being copied and removed from the facility. There was no investigation, no preventive measures put into place to protect the residents, or the facility medical records. There was no documentation that the Sheriff's Department was contacted, or how often they would patrol the facility. There was no documentation the alleged perpetrator had been investigated regarding the medical records. CFR 483.75 F-490 Effective Administration resident well-being was identified at a scope and severity level of (L). The facility administration failed to ensure appropriate policies and procedures were implemented to protect residents from Abuse/Neglect and failed to provide supervision for the safety of all residents. The failure of the facility to ensure implementation of these policies placed all residents at risk for serious harm. The facility Administrator, Director of Nursing, and Director of Nursing in Training were informed of the Immediate Jeopardy on 4/21/16 at approximately 5:20 PM. The facility provided an Allegation of Compliance (AOC) that was acceptable on 4/28/16 at 2:05 PM. Observation, record review and interview provided evidence to the survey team prior to exit the AOC had been implemented by the facility and the Immediate Jeopardy at F-490 was removed, but the citation remained at a lower scope and severity of F. The AOC included the following: AOC: It has been alleged in the context of the pending survey process that the Facility's response to events allegedly occurring on or around March 17th-20th, was insufficient. In an effort to demonstrate and achieve substantial compliance with applicable and involved regulations, the Facility proposes and has initiated implementation of the following plan of correction: * Resident Security- 1. In an effort to put immediate corrective action in place, Resident #1 was asked by the Administrator to inform Facility Administration in the event there is a recurrence of uninvited or unwanted visitors entering (his/her) room (employees or otherwise). Further, the Resident was reminded of (his/her) right to speak with the Department of Health or the Ombudsman should (he/she) ever have questions or concerns, or should (he/her) require additional information on any topic affecting (his/her) Facility admission. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has conducted an investigation into the subject events which included interviews of all residents. Specifically, each resident has been asked if they have ever been visited by people they did not recognize, and where applicable, the time, dates are being investigated to determine the nature of the visit. Further, on 4/22/16, the Facility has provided each current resident with a flyer containing the phone numbers of the South

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F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 10) Carolina Department of Health and Environmental Control, and the local Ombudsman. Going forward, this same flyer will be distributed to incoming residents on admission. Additionally, the codes have been changed at each pedestrian entrance door. (4/23/16) 3. The following measures have been put in place to ensure the deficient practice will not reoccur: * A sign-in log was placed at the front desk. All visitors (which includes employees who are in the Facility for reasons other than working a scheduled shift) will be required to sign in at the front desk, and indicate their purpose in visiting the Facility. If a visitor is there to see a resident, the name and room number of the Resident must be indicated on the sign-in log. * All employees have been informed via in-service that they should not be present on Facility premises unless they are assigned to work, or have other work-related business at that time Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * The following information has been inserviced: Abuse, Neglect, Misappropriation, and timely reporting of an allegation Resident Rights, and timely reporting of any violations Door code change for security, an sensitivity of code. * All employees have been trained (4/23/16) that in the event any employee is seen entering the Facility at hours not typically worked by that employee, they are obligated to report such unusual activity to Facility management. Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * Signs have been posted at or near each door leading in to the Facility, instructing all visitors to sign in at the front desk (4/25/16). * The code to all exit doors was changed on 4/21/16. All active employees, and resident responsible parties were notified of the code change. * Protection of Private Health Information 1. In an effort to put immediate corrective action in place, Resident #1 was informed by the Administrator that an employee of Compass Post-Acute Care is alleged to have collected private information about (him/her) outside the scope of (his/her) employment. Our guidance to (him/her) reflected the information we have to date and the possibility that (his/her) protected health information may have ben accessed for reasons unrelated to (his/her) treatment, payment or other healthcare purpose. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has invited members of our Compliance Department to come and evaluate our existing practices. All employees have been re-educated (4/27/16) regarding their obligations under HIPAA, and all new employees (and agency if necessary) will receive the more comprehensive training upon hire via a web-based module [MEDICATION NAME] approximately 45 minutes. 3. In addition to the physical security items listed above, the following measures have been put in place to ensure the deficient practice will not reoccur: * Any time a chart is removed temporarily from the nursing station, the employee doing so must note the removal in the log created to capture this information. The employee will need to log the date, time of removal, time of return, and purpose associated with the temporary removal. * Employees who remove medical records from the Facility or who access the chart for reasons inconsistent with Federal and State Privacy Laws will be disciplined up to and including the possibility of termination. * A video surveillance system is to be installed and contractors have been contacted. The system will provide remote visualization of each door leading in to the Facility, and will also show activity in public or shared areas including but not limited to hallways, nursing stations, dining rooms, etc.). * Resident rooms will not be included in the areas capable of being viewed by the cameras. The Department should also be aware that the employee whose conduct is at issue has been suspended pending the results of our investigation. (He/she) has not worked in the Facility or had contact with any Facility resident since. We allege compliance as of this day (4/27/16).
F 0496 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Receive registry verification that a nurse aide has met the required training and skills that the State requires; and 2) ensure nurse aides receive the required retraining after 24 months if nursing related services were not provided for monetary compensation** Based on record review and interview, the facility failed to ensure registry verification was done prior to hire for 1 of 10 Certified Nurses Aides (CNA) reviewed for registry verification. (CNA #3) The findings included: Review of employee files during the Extended Survey revealed that the hire date for CNA #3 was 2/13/15. Further review of the employee file revealed that the facility had not obtained registry verification for CNA #3 until 2/16/15. This information was confirmed by Administrative Staff #1 on 4/28/16.
F 0497 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Review the work of each nurse aide every year; and 2) give regular in-service training based upon these reviews.** Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required 12 hours of in-service training per year based on employment date. The findings included: A review of nurse aide in-service education during the Extended Survey on 4/28/16 revealed the facility was unable to provide documentation of nurse aide in-service training prior to 1/1/16. Administrative Staff #1 confirmed this finding and confirmed that the information provided related to in-service training failed to verify that the facility's CNAs received the required 12 hours of training based on hire date.
F 0500 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Employ or obtain outside professional resources providing services in the nursing home that meet professional standards.** Based on record review and interview during the Extended Survey, the facility failed to have outside resources for all needed areas. The findings included: Record review during the Extended Survey revealed a Dental contract and AMS Ambulance contract had not been signed. During an interview with the Administrator on 4/28/16 at 4:43 PM, he/she could not provide signed contract agreements for the above entities. ii
F 0516 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Keep clinical record information safe, so that it will not be lost, destroyed or used by the wrong person.**

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AGAPE REHABILITATION OF CONWAY	**2320 HIGHWAY 378 CONWAY, SC 29527**

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 0516 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 11) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain the safety and confidentiality of resident records and failed to safeguard clinical record information against unauthorized use. It was determined on 4/21/16 at approximately 4:20 PM Immediate Jeopardy and/or Substandard Quality of Care existed in the facility as of 3/17/2016. The findings included: Cross refer to F224- Prevent, investigate and report allegations of abuse/neglect, misappropriation of funds related to Resident #178. Cross refer to F226-Developing Policies and Procedures for Abuse/Neglect and Misappropriation of funds/personal property related to Resident #178. Cross refer to F-323 Supervision to prevent accidents/incidents related to Resident #178. During the Recertification and Complaint Survey, on 4/21/16 the Department of Health and Environmental Control (DHEC) Certification State Agency office received an additional eight (8) allegations of abuse/neglect. Review of the allegations revealed the facility had identified a concern related to the allegation that involved resident # 178. The administrator went to the resident (#178) and was told by the resident that someone had come in his/her room at 3:00 AM, wearing a hoodie and had him/her sign a paper. The resident did not know who the person was or what was on the paper that s/he signed. The resident stated s/he did not write the note and did not want to talk to the patient advocate. The DON stated the same person seen in Resident #178's room was seen on the same night by staff members copying resident charts. The DON stated when s/he came in, the person had already left the facility. During the interview the Administrator and DON and DON in training stated the person that had entered the facility during the night was an employee, a Licensed Practical Nurse (LPN), who worked the 7A-7P shift. The employee was out on medical leave at the time of the survey. The Administrator was asked by the surveyor, what had been done to protect the residents from unknown persons entering the building in the middle of the night, coercing the residents. The Director of Nursing stated the County Sheriff's Department had been asked by the facility to be placed on their security patrol route. The DON did not know how often the police would patrol the facility at night. S/he did not know what medical records had been allegedly copied by the person. The DON and DON-in-training were unable to provide an investigation into the incident with resident #178, regarding the night visitor nor any information regarding the copied medical records. The DON in training repeatedly stated the employee was just doing what s/he thought was right. Additional information from documentation provided in a timeline from the Administrator included the following: 3/17/16- The LPN called myself (administrator) at 6:00 AM to tell me s/he was sick and wasn't coming into work for his/her shift at 7:00 AM; ADON worked his/her shift. The LPN called and texted multiple staff, all day to the point where one staff member called---- for being harassed by him/her. That night the LPN was seen and reported in the building after Midnight- s/he told staff that s/he was here to work on his/her charting. The staff said they found it weird but let him/her continue. 1 staff member said s/he saw the LPN copy papers from a chart, not on his/her normal hallway and take the papers with him/her. 2 staff members said that while the LPN was there she made threats of physical violence toward a CNA, who had just left the building a few hours prior .The LPN was also seen going down the 200 hall, and coming back to the 100 Hall later. CFR 483.75(l)(3), 483.20(f)(5) F-516 Release Resident Information, Safeguard Clinical Records was identified at a scope and severity level of (L). The facility failed to ensure confidentiality and unauthorized use of resident clinical record information for Resident #178. The facility Administrator, Director of Nursing, and Director of Nursing in Training were informed of the Immediate Jeopardy on 4/21/16 at approximately 5:20 PM. The facility provided an Allegation of Compliance (AOC) that was acceptable on 4/28/16 at 2:05 PM. Observation, record review and interview provided evidence to the survey team prior to exit the AOC had been implemented by the facility and the Immediate Jeopardy at F-516 was removed, but the citation remained at a lower scope and severity of F. The AOC included the following: AOC: It has been alleged in the context of the pending survey process that the Facility's response to events allegedly occurring on or around March 17th-20th, was insufficient. In an effort to demonstrate and achieve substantial compliance with applicable and involved regulations, the Facility proposes and has initiated implementation of the following plan of correction: * Resident Security- 1. In an effort to put immediate corrective action in place, Resident #1 was asked by the Administrator to inform Facility Administration in the event there is a recurrence of uninvited or unwanted visitors entering (his/her) room (employees or otherwise). Further, the Resident was reminded of (his/her) right to speak with the Department of Health or the Ombudsman should (he/she) ever have questions or concerns, or should (he/her) require additional information on any topic affecting (his/her) Facility admission. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has conducted an investigation into the subject events which included interviews of all residents. Specifically, each resident has been asked if they have ever been visited by people they did not recognize, and where applicable, the time, dates are being investigated to determine the nature of the visit. Further, on 4/22/16, the Facility has provided each current resident with a flyer containing the phone numbers of the South Carolina Department of Health and Environmental Control, and the local Ombudsman. Going forward, this same flyer will be distributed to incoming residents on admission. Additionally, the codes have been changed at each pedestrian entrance door. (4/23/16) 3. The following measures have been put in place to ensure the deficient practice will not reoccur: * A sign-in log was placed at the front desk. All visitors (which includes employees who are in the Facility for reasons other than working a scheduled shift) will be required to sign in at the front desk, and indicate their purpose in visiting the Facility. If a visitor is there to see a resident, the name and room number of the Resident must be indicated on the sign-in log. * All employees have been informed via in-service that they should not be present on Facility premises unless they are assigned to work, or have other work-related business at that time Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * The following information has been inserviced: Abuse, Neglect, Misappropriation, and timely reporting of an allegation Resident Rights, and timely reporting of any violations Door code change for security, an sensitivity of code. * All employees have been trained (4/23/16) that in the event any employee is seen entering the Facility at hours not typically worked by that employee, they are obligated to report such unusual activity to Facility management. Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * Signs have been posted at or near each door leading in to the Facility, instructing all visitors to sign in at the front desk (4/25/16). * The code to all exit doors was changed on 4/21/16. All active employees, and resident responsible parties were notified of the code change. * Protection of Private Health Information 1. In an effort to put immediate corrective action in place, Resident #1 was informed by the Administrator that an employee of Compass Post-Acute Care is alleged to have collected private information about (him/her) outside the scope of (his/her) employment. Our guidance to (him/her) reflected the information we have to date and the possibility that (his/her) protected health information may have ben accessed for reasons unrelated to (his/her) treatment, payment or other healthcare purpose. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has invited members of our Compliance Department to come and evaluate our existing practices. All employees have been re-educated (4/27/16) regarding their obligations under HIPAA, and all new employees (and agency if necessary) will receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425391	A. BUILDING _____ B. WING _____	**04/28/2016**

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F 0516 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 12) the more comprehensive training upon hire via a web-based module [MEDICATION NAME] approximately 45 minutes. 3. In addition to the physical security items listed above, the following measures have been put in place to ensure the deficient practice will not reoccur: * Any time a chart is removed temporarily from the nursing station, the employee doing so must note the removal in the log created to capture this information. The employee will need to log the date, time of removal, time of return, and purpose associated with the temporary removal. * Employees who remove medical records from the Facility or who access the chart for reasons inconsistent with Federal and State Privacy Laws will be disciplined up to and including the possibility of termination. * A video surveillance system is to be installed and contractors have been contacted. The system will provide remote visualization of each door leading in to the Facility, and will also show activity in public or shared areas including but not limited to hallways, nursing stations, dining rooms, etc.). * Resident rooms will not be included in the areas capable of being viewed by the cameras. The Department should also be aware that the employee whose conduct is at issue has been suspended pending the results of our investigation. (He/she) has not worked in the Facility or had contact with any Facility resident since. We allege compliance as of this day (4/27/16).
F 0519 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care.** Based on record review and interview during the Extended Survey, the facility failed to have a written transfer agreement with one or more hospitals. The findings included: Record review on the Extended Survey on 4/28/16 revealed no transfer agreement with one or more hospitals. During an interview on 4/28/16 at 4:43 PM, the Administrator confirmed the facility did not have a written transfer agreement with a hospital.
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on full and/or limited record reviews, interviews, and review of facility policies, it was determined on 4/21/16 at approximately 4:20 PM Immediate Jeopardy and/or Substandard Quality of Care existed for CFR483.75 F-520 which was identified at a scope and severity level of (L). The facility failed to identify quality deficiencies related to prevention of abuse/neglect, proper implementation of abuse/neglect policies, provision of supervision to ensure resident safety, and provision of medical record security. Failure of the Quality Assurance (QA) Committee to identify and implement action plans related to these quality deficiencies resulted in Immediate Jeopardy for Resident #69 and Resident #178. The findings included: Based on record reviews and interviews, the facility failed to identify concerns related to prevention of abuse/neglect, provision of supervision to ensure resident safety, and provision of medical record security. During an interview on 4/28/16, the Administrator and Director of Nursing stated and confirmed that the QA Committee had not identified and had not implemented action plans related to the concerns identified for Resident #69 and Resident #178. Based on full and/or limited record reviews, interviews, and review of facility policies, it was determined on 4/21/16 at approximately 4:20 PM Immediate Jeopardy and/or Substandard Quality of Care existed in the facility as of 3/17/2016. The facility Administrator, Director of Nursing, and Director of Nursing in Training were informed of the Immediate Jeopardy on 4/21/16 at approximately 5:20 PM. The facility provided an Allegation of Compliance (AOC) that was acceptable on 4/28/16 at 2:05 PM, and the Immediate Jeopardy at F-224, F-226, F-323, F490, F516 and F-520 was removed but the citations remained at a lower scope and severity. The AOC included the following: AOC: It has been alleged in the context of the pending survey process that the Facility's response to events allegedly occurring on or around March 17th-20th, was insufficient. In an effort to demonstrate and achieve substantial compliance with applicable and involved regulations, the Facility proposes and has initiated implementation of the following plan of correction: * Resident Security- 1. In an effort to put immediate corrective action in place, Resident #1 was asked by the Administrator to inform Facility Administration in the event there is a recurrence of uninvited or unwanted visitors entering (his/her) room (employees or otherwise). Further, the Resident was reminded of (his/her) right to speak with the Department of Health or the Ombudsman should (he/she) ever have questions or concerns, or should (he/her) require additional information on any topic affecting (his/her) Facility admission. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has conducted an investigation into the subject events which included interviews of all residents. Specifically, each resident has been asked if they have ever been visited by people they did not recognize, and where applicable, the time, dates are being investigated to determine the nature of the visit. Further, on 4/22/16, the Facility has provided each current resident with a flyer containing the phone numbers of the South Carolina Department of Health and Environmental Control, and the local Ombudsman. Going forward, this same flyer will be distributed to incoming residents on admission. Additionally, the codes have been changed at each pedestrian entrance door. (4/23/16) 3. The following measures have been put in place to ensure the deficient practice will not reoccur: * A sign-in log was placed at the front desk. All visitors (which includes employees who are in the Facility for reasons other than working a scheduled shift) will be required to sign in at the front desk, and indicate their purpose in visiting the Facility. If a visitor is there to see a resident, the name and room number of the Resident must be indicated on the sign-in log. * All employees have been informed via in-service that they should not be present on Facility premises unless they are assigned to work, or have other work-related business at that time Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * The following information has been inserviced: Abuse, Neglect, Misappropriation, and timely reporting of an allegation Resident Rights, and timely reporting of any violations Door code change for security, an sensitivity of code. * All employees have been trained (4/23/16) that in the event any employee is seen entering the Facility at hours not typically worked by that employee, they are obligated to report such unusual activity to Facility management. Our two assistant ADONs, (names), have conducted the training, which was completed today (4/27/16). * Signs have been posted at or near each door leading in to the Facility, instructing all visitors to sign in at the front desk (4/25/16). * The code to all exit doors was changed on 4/21/16. All active employees, and resident responsible parties were notified of the code change. * Protection of Private Health Information 1. In an effort to put immediate corrective action in place, Resident #1 was informed by the Administrator that an employee of Compass Post-Acute Care is alleged to have collected private information about (him/her) outside the scope of (his/her) employment. Our guidance to (him/her) reflected the information we have to date and the possibility that (his/her)

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 13) protected health information may have ben accessed for reasons unrelated to (his/her) treatment, payment or other healthcare purpose. 2. In an effort to identify other residents who have the potential to be affected by the same practice, the Facility has invited members of our Compliance Department to come and evaluate our existing practices. All employees have been re-educated (4/27/16) regarding their obligations under HIPAA, and all new employees (and agency if necessary) will receive the more comprehensive training upon hire via a web-based module [MEDICATION NAME] approximately 45 minutes. 3. In addition to the physical security items listed above, the following measures have been put in place to ensure the deficient practice will not reoccur: * Any time a chart is removed temporarily from the nursing station, the employee doing so must note the removal in the log created to capture this information. The employee will need to log the date, time of removal, time of return, and purpose associated with the temporary removal. * Employees who remove medical records from the Facility or who access the chart for reasons inconsistent with Federal and State Privacy Laws will be disciplined up to and including the possibility of termination. * A video surveillance system is to be installed and contractors have been contacted. The system will provide remote visualization of each door leading in to the Facility, and will also show activity in public or shared areas including but not limited to hallways, nursing stations, dining rooms, etc.). * Resident rooms will not be included in the areas capable of being viewed by the cameras. The Department should also be aware that the employee whose conduct is at issue has been suspended pending the results of our investigation. (He/she) has not worked in the Facility or had contact with any Facility resident since. We appreciate your consideration of this AOC, and welcome any questions or comments you might have. Furthermore, we allege compliance as of this day (4/27/16).