STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on the facility policy, observations, record reviews and interviews, the facility failed to maintain dignity for Resident (R)39 during the administration of an insulin injection for 1 of 3 residents observed receiving an insulin injection. Findings include: Review of the facility policy titled, Dignity, issued 05/06/2019 and reviewed 09/26/2024 states: Policy, Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the resident's individuality as well as, honor and value their input. Respect and Dignity. The resident has a right to be treated with respect and dignity. The facility admitted R39 on 10/08/2024 with diagnoses including, but not limited to diabetes mellitus type 2 without complications, morbid obesity, and long term use of insulin. During an observation on 12/18/2024 at 08:00 AM of insulin administration for R39, Licensed Practical Nurse (LPN)1 assisted R39 onto the bed. R39 was wearing a dress, socks, and a brief. She kept asking for a blanket to cover herself with. The room door was open and her roommate was sitting at the doorway, facing the resident on the bed. LPN1 did not provide a blanket or privacy. LPN1 pulled up R39's dress, unfastened her brief, and injected the insulin into her abdomen. The nurse then refastened R39's brief, and pulled her dress down, still not providing a blanket for R39 or a top cover for R39. During an interview on 12/18/2024 at 08:07 AM with LPN1, she confirmed that she had not provided privacy and maintained dignity for R39 during the insulin injection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide proper supervision for Resident (R)97, resulting in R97 eloping from the facility. Specifically, a resident pulled a fire alarm, resulting in R97 evacuating the facility alone, without staff knowledge. This resulted in R97 falling, while in the facility's unsecured courtyard, and suffering a fractured clavical. On 12/19/24 at 12:45 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 10/05/24. The IJ was related to 42 CFR 483. 25 - Quality of Care. On 12/19/24 at 5:00 PM, the facility provided an acceptable IJ Removal Plan. On 12/20/24, the survey team, validated the facility's corrective actions and removed the IJ, as of 12/20/24. The facility remained out of compliance at F689 at a lower scope and severity of D. An extended survey was conducted in conjunction with the Recertification Survey for non-compliance at F689, constituting substandard quality of care. Findings include: Review of the facility policy titled Fire Procedures reviewed on April 2024, documented, Departmental Fire Procedures III. If Alarm Sounds from Elsewhere in Building: -close all doors in area. -remain in your area and await further instructions. If not in area, report back. -If with residents, remain with them and provide reassurance. -Account for all residents and staff in your area and be prepared to report results to Control Station. Review of R97's Face Sheet revealed R97 was admitted to the facility on [DATE], with diagnoses including but not limited to: metabolic encephalopathy, vascular dementia, unspecified severity, with mood disturbance, type 2 diabetes mellitus, unsteadiness on feet, history of falling, cognitive communication deficit. Review of R97's Physician Progress Notes dated 10/07/24, documented, Follow-up: Fall . Family at beside reports they were called by the facility where she is currently getting rehab to report she had an unwitnessed fall and they think she might have hit her head so they were sending her to the ED for evaluation . Pt had fall with significant bruising with pooling to L clavicle/ shoulder area. abnormality noted at time of exam. Will order stat xray to r/o fx . 1. Fall - Per nursing staff, s/p fall on 10/5 now with c/o Left shoulder/clavicle pain. Will order Xray 2 views Left Clavicle and Left shoulder to r/o fx post fall. Review of R97's Incidents Follow-up and Recommendation Form with an incident date of 10/05/24, documented, Summary of Investigative Facts: Resident became anxious during fire alarm and went into courtyard (locked) and layed [sic] on ground. Recommendations/Actions Taken: Resident offered non skid socks - xray obtained 10/7/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R97's Un-witnessed Fall document dated 10/05/24, documented, During a fire alarm this nurse noticed the resident lying on the ground on her left side with a blanket under her head as a pillow. Resident was dressed in pants, shirt, had on a clean dry brief with no socks or shoes. Review of R97's Trident Health Patient Visit Information dated 10/07/24, revealed, You were seen today for: Fracture of left clavicle. Collarbone Fracture received 10/07/24. Review of Accuweather.com revealed that on 10/05/24, the high was 80 degrees Fahrenheit and the low was 74 degrees Fahrenheit. During an interview on 12/17/24 at 11:17 AM, R97's Husband stated that R97 fell and fractured her shoulder the second night she was here, when she made it outside after the fire alarm went off. During an interview on 12/18/24 at 2:55 PM, Licensed Practical Nurse (LPN)3 revealed that a resident on another hall pulled the fire alarm which caused all the doors to be opened and the Certified Nursing Assistant (CNA) left the unit to go assist manning the doors on the Dayspring unit. LPN3 stated they left the unit to go to Dayspring to reset the fire alarm and once they returned to the unit, they were notified that R97 was not in their bed. LPN3 further stated that R97 was the only resident that went out during the alarm and that R97 was found outside in the courtyard, right off the unit, lying on the ground with her blanket under their head and the resident stated that they were trying to get away from the fire. During an interview on 12/19/24 at 9:16 AM, CNA1 stated that a resident on the Dayspring Unit pulled the fire alarm, and they had to leave the Pebble Creek unit to help man the doors on Daysprings. CNA1 stated that after they did their rounds on Daysprings they went back to Pebble Creek and the nurse left the unit to go turn off the alarm. CNA1 stated that it was possibly about 5 minutes before the nurse found the resident outside in the courtyard. CNA1 further revealed that they did not complete a head count on the Pebble Creek unit during the fire alarm. During an observation and interview on 12/19/24 at 9:52 AM, the Maintenance Director (MD), revealed the path used by R97 to evacuate the facility. R97 exited the facility through a secured door on the Pebble Creek Unit. The MD stated, when the fire alarm is activated, the doors are no longer secured. The door leads to a gated courtyard. Further observation revealed, two gates located to the left and right of the courtyard. Both gates were not secured. The MD stated the gates are never secured. During an interview on 12/19/24 at 8:53 AM, the MD revealed there are fire alarm pull stations next to the exit doors. The resident room doors as well as the hallway doors are three-hour fire doors. There is an employee stationed on every door. There is enough staff to man each door even at night. The MD stated all staff report to the location of the fire. All staff are assigned a job at this point. No staff member is preassigned a particular door to be stationed at. The MD further stated no one is going to fuss at the staff if they choose to evacuate the hall. They may choose to take the residents behind the fire doors, or they may choose to evacuate the residents outside the facility. The MD further stated, the only incident that I am aware of in October occurred on October 12, 2024 at 9:30 AM, when a resident pulled the pull station outside of room [ROOM NUMBER]. There have been no other Incidences in October. The MD concluded, I was not informed that a resident was found outside during this incident on 10/05/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/19/24 at 5:00 PM, the facility provided an acceptable IJ Removal Plan, which included the following: 1. How correction action will be accomplished for those residents found to have been affected by the deficient practice. On 10/5/2024 resident MR#209959 exited the facility unsupervised sustaining a fracture. The resident ambulated with the Charge Nurse back inside the facility denying any pain. On 10/5/2024, the Charge Nurse completed a skin assessment with no injuries or bruising. On 10/5/2024, an Incident Report and notifications were made to the family and MD. On 10/5/2024, a Fall risk evaluation was completed and the patient identified as a risk with a score of 16. The Executive Director, Director of Nursing and Interdisciplinary Team completed a Root Cause Analysis (RCA) on 12/19/2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 10/5/2024, the Charge Nurses completed a head count for all patients inside the facility. All patients were accounted for. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? During the monthly PI committee meetings, the following will be reviewed: -The Executive Director and Maintenance Director will be responsible for ensuring compliance with supervision when drills/fire alarm sounds. -The Director of Nursing will be responsible for reviewing the Event Management System for trends and patterns. -The Staff Development Director will be responsible for reviewing the education completion of associations on: Departmental Fire Procedures policy, Incident and Reportable Event Management Policy, and Fall Management Policy. On 12/19/2024, the Regional Director of Clinical Services provided education to the Executive Director (ED) and the Director of Nursing (DON) on the following: Departmental Fire Procedures policy, Incident and Reportable Event Management Policy, and Fall Management Policy. The ED, DON, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and/or licensed nurse will provide education to all facility staff on the following: Departmental Fire Procedures policy, Incident and Reportable Event Management Policy, Fall Management Policy. Any associate who has not completed training by 12/19/2024 will not be allowed to provide direct resident care until training is completed. The Executive Director (ED), Director of Nursing (DON), Staff Development Coordinator (SDC), and/or licensed nurse will provide education to all new associates upon hire during orientation. Medical Director reviewed and agreed with this plan of removal on 12/19/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	AD Hoc QAPI meeting was held 12/19/2024 regarding this plan of removal. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The ED and/or Maintenance Director will complete fire drills weekly x8 weeks. The DON will review Event Management System for trends and patterns daily x8 weeks. Associate Education will be continued until all associates have been educated on Departmental Fire Procedures policy, Incident and Reportable Event Management Policy, and Fall Management Policy. 5. Date when corrective action will be completed. 12/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on the facility policy, observations and interviews, the facility failed to ensure a medication administration error rate of less than 5 percent to include 4 of out 26 opportunities for error. The facility additionally failed to ensure an ordered medication for Resident (R)39 was administered timely. The medication administration error rate is 15.38 percent. Findings include: Review of the facility policy titled, Insulin Pen Administration, revised 08/30/2023 and reviewed 09/17/2024, states: Policy: The facility will ensure residents with orders for insulin administration through the use of a pen delivery device is performed in accordance with current standards or practice with manufacturer's guidance. Procedure: 4. The insulin pen should be primed prior to each use (in accordance with manufacturer's guidelines) to prevent the collection of air in the insulin reservoir. a. General guidance for priming an insulin pen in the absence of manufacturer's guidance; i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat the procedure until at least one drop appears. 6. To verify that all insulin is injected, keep the pen needle in the subcutaneous fat layer for 6 to 10 seconds after the injection with the thumb remaining on the push button plunger. An observation during med pass on 12/18/2024 at 08:20 AM for R39 revealed Licensed Practical Nurse (LPN)1 administering 10 units of Glargine Insulin without first priming the insulin pen. LPN1 also failed to administer Sertraline 100 milligrams (mg) at 9:00 AM medication by mouth. During an interview on 12/18/2024 at 08:30 AM, LPN1 confirmed that she did not prime the insulin pen and stated that she was not aware that she needed to prime the insulin pen. LPN1 also stated that the Sertraline 100 milligrams was not in the med cart with R39's other AM medications, so she would have to order the medication from the pharmacy. She stated that if she ordered the medication before 5:00 PM, the medication would be delivered from the pharmacy later today. Review of the Medication Administration Record (MAR) revealed, the Sertraline was not given for 12/18/2024 at 09:00 AM. During an interview on 12/19/2024 at 11:45 AM, the Director of Nursing (DON) confirmed that the ordered Sertraline 100 milligrams was in the facility pyxis and should have been given on 12/18/2024 and on time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 12/18/2024 at 09:25 AM of the administration of Glargine Insulin revealed LPN2 priming the pen holding it horizontal with the needle cap on the the pen. LPN2 then administered the ordered 23 units of insulin for R8. LPN2 confirmed that she had primed the insulin pen horizontally with the needle cap still on the pen. An observation on 12/19/2024 at revealed at 08:06 AM, LPN3 was preparing to give R1, Glargine Insulin via a flex pen. LPN3 held the pen horizontally and with the needle cap still applied attempted to prime the pen. LPN3 then proceeded to administer the insulin. LPN3 prepared the resident's site for the injection then stuck the needle in and pushed the plunger and immediately removed the needle. During an interview with LPN3, she confirmed that she had primed the pen horizontally with the cap on the pen and then after administering the insulin removed the needle quickly, and stated she should have held it in place for at least 10 seconds. She could not confirm that R1 had received the correct dose of insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on the facility policy, observations, and interviews, the facility failed to ensure the proper priming of insulin pens, and correct administration on insulin via an insulin pen, therefore could not ensure 3 of 3 residents (R) received the correct dosage of insulin. Findings include: Review of the facility policy titled Insulin Pen Administration, revised 08/30/2023 and reviewed 09/17/2024, states: Policy: The facility will ensure residents with orders for insulin administration through the use of a pen delivery device is performed in accordance with current standards or practice with manufacturer's guidance. Procedure: 4. The insulin pen should be primed prior to each use (in accordance with manufacturer's guidelines) to prevent the collection of air in the insulin reservoir. a. General guidance for priming an insulin pen in the absence of manufacturer's guidance; i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat the procedure until at least one drop appears. 6. To verify that all insulin is injected, keep the pen needle in the subcutaneous fat layer for 6 to 10 seconds after the injection with the thumb remaining on the push button plunger. An observation during med pass on 12/18/2024 at 08:20 AM for R39 revealed Licensed Practical Nurse (LPN)1 administering 10 units of Glargine Insulin without first priming the insulin pen. During an interview on 12/18/2024 at 08:30 AM, LPN1 confirmed that she did not prime the insulin pen and stated that she was not aware that she needed to prime the insulin pen. LPN1 could not confirm that R39 received the correct dosage of insulin. An observation on 12/18/2024 at 09:25 AM of the administration of Glargine Insulin revealed LPN2 priming the pen holding it horizontal with the needle cap on the the pen. LPN2 then administered the ordered 23 units of insulin for R8. During an interview, LPN2 confirmed that she had primed the insulin pen horizontally with the needle cap still on the pen and could not confirm that R8 received the correct dosage of insulin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 12/19/2024 at 08:06 AM revealed LPN3 preparing to give R1 Glargine Insulin via a flex pen. LPN3 held the pen horizontally and with the needle cap still applied and attempted to prime the pen. LPN3 then proceeded to administer the insulin after preparing the site for the injection LPN3 stuck the needle in and pushed the plunger and immediately removed the needle. During an interview with LPN3, she confirmed the observations and could not ensure that R1 had received the correct dosage of insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on the facility policy, observations and interviews, the facility failed to ensure expired, outdated or discontinued medications were removed and not stored with resident medications in use in 3 of 5 medication carts and 1 of 1 treatment carts. The facility additionally failed to ensure a medication cart was locked, and medications were not left on top of the med cart unattended on Morning Star Unit, medication cart #2. Findings include: Review of the facility policy titled, Drug Storage Guide, states under, Medication Cart Check, The MAR/EMR are covered when unattended. The medication care is locked when unattended. Expired controlled substances are not present. The drug storage guide did not include expired medications and biologicals, or medications unsecured and on the top of the med cart. The facility's drug storage guide did not mention the storing of discontinued medications in the medication cart. An observation on 12/17/2024 at 10:32 AM of the medication cart 2 on the Dayspring Unit revealed: Risperidone 1 milligam (mg), 20 tabs with Lot #8198-4007 were discontinued and stored on the medication cart. Acetaminophen 325 mg with Lot#J074J, Manufactured by Timely, 6 tablets were expired on 07/30/2024. The stored and expired medications were verified by Licensed Practical Nurse (LPN)1 and removed from storage. An observation on 12/19/2024 at 10:40 AM of the Meadow Ridge medication cart 2 revealed: Elder Tonic Lot# 20709 16 fluid ounces was expired on 07/2024. The expired medication was verified by LPN5 and removed from storage. An observation on 12/19/2024 at 10:50 AM of the Meadow Ridge treatment cart revealed: One tube, 20 ounces of Hemorrhoidal Ointment, manufactured by SunMark had expired on 11/20/2024. The expiration date was confirmed by LPN1 and the medication was removed from storage. An observation on 12/19/2024 at 11:10 AM of the Rosewood medication cart 1 revealed: Vitamin E 180 mgs with Lot #752W01 was expired on 11/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The expired medication was confirmed and removed from storage by Registered Nurse (RN)1. Oxycodone 5 mgs with Lot#18202A, 26 tablets were discontinued and stored on the medication cart. These stored narcotics were confirmed by RN1 and removed from storage on the medication cart. An observation on 12/19/2024 at 11:24 AM of the Morning Star Unit revealed a medication cart 2 in the hallway unlocked and unattended with a stack of a resident's medication blister packs, which contained pills lying on the top of the cart. The computer screen was open to a resident's private information. The nurse was in a resident's room, doors down from the cart. During an interview on 12/19/2024 at 11:26 AM, LPN6 confirmed the findings and stated that she had just walked away from the cart leaving the cart unlocked, medications on top and the computer screen open to a resident's private information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings include: Review of the facility's policy Hand Hygiene, revised 06/13/2023 showed Procedure: 2. Associates perform hand hygiene (even if gloves are used) in the following situations. a. Before and after contact with a resident; c. After contact with objects and surfaces in the resident's environment; During a dining observation on the Pebble Creek unit on 12/17/24 at 12:09 PM, Licensed Practical Nurse (LPN)7 came from behind the desk and pulled a tray from the food cart without performing proper hand hygiene. LPN7 placed the tray on top of the food cart. While speaking with a resident representative, LPN7 touched her face, the hand rail, and her hair before removing the tray from the top of the food cart and putting the tray back inside the cart. During further observation on 12/17/24 at 12:12 PM, LPN3 was observed pulling the food cart down hall to room [ROOM NUMBER] while touching her hair. She then opened the food cart and pulled another tray from the cart and took the tray to a resident room and placed the tray on the resident's overbed table, all without using proper hand hygiene before or after entering room [ROOM NUMBER]. She then came back out and pulled the cart to room [ROOM NUMBER]. LPN7 continued to pull trays from the food cart and enter and exit rooms 50 at 12:14 PM, then room [ROOM NUMBER], then room [ROOM NUMBER] at 12:15 PM and room [ROOM NUMBER], setting up resident trays without performing proper hand hygiene. During an interview on 12/17/24 at 12:18 PM with LPN7 revealed that while serving dining trays she should wash hands before serving residents and not touch the resident's food. LPN7 further revealed that she should sanitize her hands between serving each resident. During an interview on 12/19/24 at 3:05 PM with the Infection Preventionist (IP), LPN3 revealed that the facility has a policy regarding hand hygiene and training is done annually at the skills fair. LPN3 explains that performance improvement -hand hygiene has been part of facility in-services are done as well. Hand hygiene is done annually and as part of our performance improvements. CNA hand hygiene when passing trays are as follows: wash hands before taking tray off cart, sanitizing between patients CNA should sanitize before she gets each tray out and between each resident. Based on observation, staff interviews, and a review of facility dietary policies, the facility failed to ensure proper sanitization of kitchen equipment, failed to discard expired foods past use by date in 1 of 1 main cooler, and failed to label and date open items in 1 of 1 freezer. These deficiencies could potentially affect 119 residents who reside in the facility and who consume food from the kitchen. Additionally, the facility failed to ensure Certified Nursing Assistants (CNA) properly sanitized their hands during meal service. The findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility policy titled Use by Date Guide states:Life Care may require s shorter time frame on a food item to reduce the number of items under refrigeration. For Example, the food code indicates that leftovers may be kept up to 7 days, however, Life Care guidelines are for 3 days (72 hours). A review of facility policy titled Food Safety with a revision date of 05/1/2024 states: Page 5, Leftovers are dated properly and discarded after 74 hours unless otherwise indicated. A review of the facility policy titled Cleaning Schedule with a revision date of 04/30/2024 states: The Director of Food and Nutrition Services develops a cleaning schedule to include all equipment and areas to be cleaned. Designated Cleaning tasks are assigned to each position. The Director of Food and Nutrition Services monitors the cleaning schedule to ensure the tasks are completed timely and appropriate. Initial walk-through of the facility kitchen on 12/17/2024 at 10:45 AM alongside the Dietary Manager (DM) confirmed the findings below: Cooler: Two (2), 4-inch-deep stainless steel quarter pans, 1 containing Puree eggs with no preparation date, handwritten use by date 12/12/2024. The second pan contained Puree bread with no preparation date, a handwritten use by date of 12/11/2024. Freezer: Two (2) 18x24 pans of frozen dough, 95 frozen rolls, not in original packaging, with no open date, or use-by date. An observation of the facility's industrial stove revealed a heavy accumulation of old food/grease debris was observed on the side and backsplash of the stove. There was an accumulation of grime observed around the knobs and along the front side of the stove. An observation of a full-height 2-door heated hotbox being opened by the Dietary [NAME] revealed dry yellow and brown grease drippings on both interior doors. There was also an accumulation of liquid stains and build-up surrounding the knobs on the tray line. The deep fryer's side panel had a heavy accumulation of old grease mixed with crumbs observed on the side and backsplash of the stove. 7 out of 14 fans, located in the kitchen ceiling had dust buildup surrounding it. A follow up walk-through of the facility kitchen on 12/18/2024 at 11:33 AM and 12/19/2024 at 12:50 PM revealed the equipment was in the same condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with the Dietary Manager (DM) on 12/17/2024 at 11:04 AM stated Her expectation is for all staff to look at the items in coolers and ensure all items that are expired or close to expiration are thrown out. DM stated Her expectation is for all staff who are responsible for dating leftovers to accurately fill out the stickers. DM states it is everybody's responsibility to look. DM states main cooking methods are deep fryers, stoves, and ovens. Cleanings are daily, after each meal. She states deep cleans are done weekly, which includes breaking down equipment. DM states she utilizes a cleaning sheet that breaks down by item, who is to clean it, and the staff member is to initial when done. DM states she goes behind every staff member to ensure cleanliness. DM confirmed the findings and stated the floor tech is responsible for wiping ceiling fans down once a month. DM also stated she can't remember the last time he cleaned the ceiling fans. DM stated she was unable to provide documentation related to cleaning logs. An interview with the Director of Nursing (DON) on 12/19/2024 at 1:00 PM revealed she expects to have no expired food in the kitchen and for dietary staff to be deep cleaning and wiping down kitchen equipment. DON stated The kitchen staff should be auditing that stuff like we have to do medicines. The Registered Dietician completes mock surveys, so it's surprising to me.