

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2025
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare - Charleston		STREET ADDRESS, CITY, STATE, ZIP CODE 2230 Ashley Crossing Drive Charleston, SC 29414	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, interview, and policy review, the facility failed to utilize personal protective equipment (PPE) for enhanced barrier precautions (EBP) for one of two residents (Resident (R) 61) reviewed for EBP out of a sample of 18 residents. This created the potential for transmission of infection to staff and other residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Enhanced Barrier Precautions dated February 2025, revealed, Providers and partners must wear gloves and a gown for the following high-contact patient care activities: . device care or use: central line, urinary catheter, feeding tube .</p> <p>Review of R61's Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed admitted on [DATE] with diagnoses gastrostomy (an opening in the stomach for a feeding tube), and dysphagia (difficulty swallowing) following cerebral infarction (stroke).</p> <p>Review of R61's Care Plan under the RAI (Resident Assessment Instrument) tab of the EMR revealed a problem area of requires tube feeding related to dysphagia/protein calorie malnutrition created 10/04/24.</p> <p>Review of R61's Orders tab of the EMR dated 10/04/24 indicated, give all medication via peg [feeding] tube . Klonopin (anti-anxiety medication) 1mg [milligram] every six hours dated 03/31/25, and Seroquel (anti-psychotic medication) 25mg three times daily, dated 01/08/25.</p> <p>During an observation on 05/14/25 at 1:24 PM, Registered Nurse (RN)1 brought crushed Klonopin and Seroquel into R61's room. R61's door had an EBP sign on it which indicated to wear gown and gloves RN1 washed her hands and donned gloves. RN1 checked the feeding tube for placement, flushed the tube with water, administered each medication separately, ending by flushing the tube with water, and securing the abdominal binder. RN1 did not wear a gown during the administration of R61's medications per the gastrostomy tube.</p> <p>During an interview on 05/15/25 at 2:22 PM, Certified Nurse Aide (CNA)1 stated staff were to wear a gown and gloves when doing any contact activity with a resident who has a feeding tube.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/15/25 at 3:07 PM, RN1 stated that EBP were followed when providing wound care, any line care (for intravenous medications) and maybe feeding tubes. When asked if a gown was to be worn when doing a dressing change for a feeding tube site or administering medications via a feeding tube, RN1 stated she was unsure in a nursing facility setting, that a gown was not used for those activities.</p> <p>During an interview on 05/15/25 at 3:09 PM, Unit Manager (UM)2 stated EBP was utilized whenever anything was administered through a feeding tube, when providing wound cares, or with any contact activities of daily living (ADLs) with someone with wounds, lines, feeding tubes, etc.</p> <p>During an interview on 05/15/25 at 3:12 PM, the Assistant Director of Nursing (ADON) stated that residents on EBP had signs on their doors and caddies with PPE on their side of the room. It was expected that nurses wore gowns and gloves when they administered medications via a feeding tube, flushed a feeding tube, or changed a feeding tube dressing.</p> <p>During an interview on 05/15/25 at 3:21 PM, the Director of Nursing (DON) reported the expectation that staff follow EBP with any prolonged contact with residents with catheters, drains, feeding tubes, or colonization with a MDRO (multi-drug-resistant bacteria). This included wearing a gown and gloves with a feeding tube dressing change or administering medications via a feeding tube.</p>		