STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425411	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Gadsden Episcopal Health Care Center	1 Bishop Gadsden Way Charleston, SC 29412

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to individualize comprehensive plans for urinary catheter bulb size for two (2) of two (2) residents reviewed for catheter care (Resident (R)11 and R123). This failure could place the residents at risk for discomfort and/or pain. Findings include: A review of the facility policy titled Physician Orders, with a revision date of October 2024, documented: 1. Policy It is the policy of [NAME] to obtain, document, and implement physician (or other licensed practitioner) orders in accordance with federal and state regulations, facility protocols, and standards of clinical practice. It is the policy of [NAME]'s SNF [skilled nursing facility] to review charts for any changes in Physician Orders. This will be done by the charge nurse every shift using the 24-hour alerts or 'Display New Orders' feature. 2. Procedure Order Documentation All orders must be documented in the resident's medical record, either electronically or in written form. Orders must include: *Medication *Dosage *Frequency *Route (continued on next page)

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Reason for administration *Date and time of the order *Resident identification *Specific Instructions *Provider name & Electronic signature *Indication for any PRN [as needed] medications *Oxygen orders should include rate of flow, route, and rationale . A review of the facility policy titled Comprehensive Care Plans, with a review date of September 2024, documented: 1. Policy: The facility develops a comprehensive care plan for each resident that includes measurable goals and timetables to meet the resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. 2. Procedure: -2. The comprehensive care plan is prepared by an interdisciplinary team (IDT), including the attending physician, a registered nurse, and other appropriate staff in disciplines as determined by the resident's needs. 1. A review of the clinical record revealed R11 was admitted to the facility on [DATE], with diagnoses to include Retention of Urine. A review of R11's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a score of four (4) out of fifteen (15) on the Brief Interview for Mental Status Cognition (BIMS), indicating the resident had severe cognitive impairment. A review of R11's current Physician Orders found an order dated 04/09/25, which noted: Insert Urinary Catheter: [18] Fr [French] [5] cc [cubic centimeter] bulb as needed for Occlusion or Leakage As Needed [sic], with the French (Fr) scale referring to the catheter's diameter, and the cc referring to the size of the bulb or balloon used to retain the catheter in the urinary bladder. A review of R11's Care Plan revealed the following focus area, dated 04/09/25: The resident has Indwelling Catheter: Atonal bladder and urinary retention. [sic] Interventions associated with the focus are included: CATHETER: The resident has 18 Fr 10 cc balloon indwelling catheter. The balloon size described in the resident's Care Plan did not match the bulb/balloon size noted in the Physician Order. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of the clinical record revealed R123 was admitted to the facility on [DATE] with diagnoses to include History of Prostate Cancer and History of Bladder Cancer with Chronic Self-Categorization. A review of the admission MDS dated [DATE] revealed a score of 15 out of 15 on the BIMS, indicating the resident's cognition was intact. A review of R123 current Physician Order found an ordered dated 04/14/25, which noted: Urinary Code Catheter: [16] F [10 cc] bulb in place. Patient manages catheter clamping and releasing to void. A review of a Provider Visit Note, dated 04/07/25 at 5:17 p.m., found the following: . Gross hematuria [blood in urine]. History of prostate cancer, bladder cancer. Chronic self-catheterization. Given hx [history], most concerning malignant etiology. Per patient, this has been relatively chronic since starting AC [anticoagulant], and he has self-held his Eliquis [an anticoagulant] at home for hematuria. Self caths 5-6 x/day [self-catheterizes five to six times daily]. Foley [urinary catheter] placed 3/31 given bleeding, diuresis, frequent I/O's [in and out catheterizations]. Hematuria improved w/ foley, likely trauma from frequents I/O's on Eliquis. Urology consulted. Recommended discharge with Foley in place and will f/u [follow-up] as outpatient. Patient wishes to keep foley capped and empty ~4x/day [approximately four times daily]. Urology agreeable to this plan. A review of the R123's Care Plan, dated 04/07/25, revealed the following focus area: The resident has 14fr/10ml [milliliter] Indwelling Catheter. Patient manages catheter clamping and releasing to void. In an interview with the Director of Clinical Excellence on 04/25/25 at 10:29 a.m., he/she confirmed the residents' Care Plan should have the same bulb/balloon size as noted in the residents' Physician Orders for the indwelling catheters, as this was a standard of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of facility policy and clinical records, the facility failed to monitor and/or document the use of a wander guard device according to standards of practice for one (1) of one (1) sampled resident (Resident (R)3), and toprovide care and services consistent with professional standards for the management of pain related to a resident's frequent request for an opioid pain medication prescribed as needed (PRN) and or to ensure the consistent administration of pain medication for one (1) of two (2) residents (R4) sampled for pain. Findings include: 1.) A review of facility policy titled, Wander Management System, reviewed September 2024, revealed 1. Policy- A wander management system will be used for those residents/patients who are assessed to be an elevated risk to wander or elope. 2. Procedure 1. A tag will be assigned to each resident/patient who qualifies for increased monitoring, per wrist band if ambulatory or to wheelchair if unable to ambulate. 2. The system function will be checked to ensure proper working order on a daily basis by the evening shift charge nurse, checking both the wall sensors and the resident/patient tags. A review of R3's clinical record revealed admission to the facility on April 7, 2025, with diagnoses to include Traumatic Subarachnoid Hemorrhage without loss of Consciousness, Fracture of Fifth Metacarpal Bone in Right Hand, Dementia, and Depression. Review of an admission Minimum Data Set assessment (MDS) dated [DATE], revealed that the resident was severely cognitively impaired, and that R3 has wandering behaviors. A review of the resident's Care Plan revealed a focus area forrisk for wandering and therefore has a wander guard (a device that alerts staff when the resident reaches a certain perimeter/exit) in place left ankle, date-initiated April 11, 2025, with interventions to include check skin around wander guard for any irritation and report to Director of Nursing (DON) if noted. Check wander guard daily for placement and function. An observation of R3 on April 22, 2025, at approximately 12:10 p.m., found him/her ambulating in the common area between the East and [NAME] unit looking out the window. At this time, a wander guard was observed on his/her left ankle. During an observation on April 22, 2025, at approximately 1:11 p.m., R3 was seen ambulating on the East unit pleasantly confused. At this time, the wander guard was observed on his/her left ankle. A Social Services note dated April 11, 2025, at 12:32 p.m., revealed a Wanderguard place on patient's left ankle. Patient's daughter is aware. SS [Social Services] will follow up as needed. A Daily Skilled Note dated April 11, 2025, at 2:47 p.m., stated no wander guard was present. An additional Daily Skilled Note dated April 12, 2025, at 3:09 p.m., stated a wander guard was in place. Frequent rounding on patient, attempts to leave unit and ambulate without assistive device. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the resident's Daily Skilled Notes revealed that on April 15, 16, 18 and 20, 2025, staff documented that a wander guard was not in place. And on April 13, 14, 17, 19, 21 and 22, 2025 staff documented that a wander guard was in place. A Physician's Order dated April 22, 2025, at 12:20 p.m., prescribed placement of a wander guard to the left (L) ankle of R3 and to check for placement and function every day and every night shift. A Discharge summary dated [DATE], at 9:50 a.m., indicated the resident was discharged to a memory care assisted living facility. During an interview on April 23, 2025, at approximately 12:20 p.m., the Director of Clinical Excellence (DCE) verified that the current Physician's Order for the wander guard was not obtained timely, and that the facility's documentation of the wander guard's presence was inaccurate. Furthermore, the DCE was unable to provide documentation of the skin checks for any irritation, or daily checks for placement and function as stated in the residents' care plan. and the DCE also confirmed the facility failed to follow facility policy as well as accepted standards of practice for management and monitoring of a wander guard. 2.) A review of facility policy titled, Pain Management, last reviewed by the facility March 2025, indicated that the facility shall provide adequate management of pain to ensure that residents attain or maintain the highest practicable physical, mental, and psychological well-being. The clinical team shall evaluate the resident for pain upon admission, during periodic scheduled assessments, and with changes in condition or status. Assessment and evaluation by the appropriate members of the Inter Disciplinary Team (IDT) may include: asking the resident to rate the intensity of his/her pain using a numerical pain scale or a verbal or visual descriptor that is appropriate for the resident. Current prescribed pain medications, dosage, and frequency. Note all treatments, including non-pharmacological interventions. Non-pharmacological pain management interventions include but are not limited to: exercises, ROM, physical modalities such as warm compress, cold compress. Turning and repositioning, smoothing linens, adjusting room temperature, cognitive/sensory interventions such as diversions, pain education or music, and massage. The IDT is responsible for developing a pain management regimen. The following are general principles for prescribing analgesics in the long-term care setting: Evaluate the resident's medical condition regimen to determine the most appropriate therapy for pain. Opioid treatment for pain shall be appropriately assessed and individualized for each resident. Reassess and adjust the dose to optimize pain relief while monitoring and trying to minimize or manage side effects. A review of the clinical record revealed R4 was most recently admitted to the facility on [DATE], with diagnoses to include Fracture of Left Femur (leg), and Left Humerus (arm), Falls, and Malignant Neoplasm of Bladder. An admission Minimum Data Set assessment (MDS) dated [DATE], revealed that the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. Review of the MDS indicated the resident has had frequent pain rated at an eight (8) on a scale of zero (0) - 10, within the last 5 days. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Care Plan revealed a focus area for potential for pain, date-initiated April 14, 2025, with interventions to administer medication as ordered, if PRN, monitor for effectiveness, assess pain per 0-10 numerical scale or PAINAD, and position for comfort, date-initiated April 14, 2025. A review of current Physician Orders dated April 11, 2025, revealed an order for Tylenol Extra Strength (a non-narcotic analgesic) oral tablet 500 milligrams (mg),one (1) tablet by mouth every six (6) hours as needed (PRN) for left hip pain. A review of Physician Orders dated April 11, 2025, revealed an order for Tramadol HCL (an opioid - narcotic pain medication) oral tablet 50 mg give two (2) tablets by mouth every six (6) hours PRN for pain related to displaced intertrochanteric fracture of the left femur for 14 days. The order was discontinued April 14, 2025. A review of Physician Orders dated April 14, 2025, revealed an order for Tramadol HCL oral tablet 50 mg , give one (1) tablet by mouth every four (4) hours PRN for pain related to displaced intertrochanteric fracture of left femur for 14 days. The order was discontinued April 21, 2025. A review of R4's April 2025, Medication Administration Record (MAR), revealed that nursing administered PRN Tramadol HCL to the resident nine (9) of 11 days, and on five (5) of 11 days, it was administered multiple times a day, for a total of 14 doses, from April 11, 2025, through April 21, 2025. Continued review of the April 2025 MAR revealed the pain scale (0-10 [0 indicating no pain, and 10 the worst pain]) nursing staff had documented the opioid pain medication, Tramadol, was provided to the resident for a pain score range of four (4) to eight (8). The April 2025 MAR further revealed staff administered Tylenol Extra Strength (a non-narcotic analgesic) also for a pain scaled range of four (4) to eight (8). A closer review of the April 2025 MAR revealed the Tramadol HCL, and Tylenol Extra Strength was being administered for pain, without any pain scale parameters. Review of the clinical record, lacked documentation of non-pharmacological interventions (NPI) attempted prior to the administration of the opioid pain medication, Tramadol. During an interview with the DCE on April 23, 2025, at approximately 12:25 p.m., he/she confirmed that nursing administered the PRN opioid pain medication (Tramadol HCL) to the resident 9 of 11 days, and on 5 of 11 days, multiple times a day, for a total of 14 doses, from April 11, 2025, through April 21, 2025. The DCE further stated the physician orders for both the Tramadol and Tylenol failed to include the parameters for the usage. The DCE further confirmed that the pain scale nursing staff had documented for the opioid pain medication, Tramadol, was provided to the resident for the range from a 4 to 8, and Tylenol Extra Strength (a non-narcotic analgesic) ranged of four (4) to eight (8). When questioned how the nursing staff was to determine which medication, Tramadol or Tylenol, to provide the resident, the DCE stated the resident could request the medication desired and/or clinical nursing judgement would be made. The facility failed to clarify the physician's order for the Tramadol and or Tylenol, which as written, was to be used for pain as needed without parameters, which may lead to a possible opioid dependence related to a resident's frequent use, and the resident's Care Plan failed to address the resident's use of the opioid - narcotic pain medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an additional interview with the DCE on April 24, 2025, at approximately 9:13 a.m., he/she was unable to provide documentation of the NPIs used prior to the administration of the opioid - narcotic pain medication (Tramadol) and or the parameters used for opioid administration, which was not consistent with facility policy and/or accepted standards of practice for pain management.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, the facility failed to follow physician orders for oxygen therapy prescribed for one (1) of one (1) sampled resident (Resident (R)14). Findings included: A review of the clinical record revealed that R14 was most recently admitted to the facility on [DATE], with diagnoses to include Acute and Chronic Respiratory Failure with Hypoxia, chronic obstructive pulmonary disease (COPD), Acute Pulmonary Manifestations Due to Radiation, Pneumonia, and Influenza. Review of an admission Minimum Data Set (MDS) dated [DATE], revealed Section O, Special Treatments, Procedures, and Programs, revealed that the resident was receiving oxygen therapy. A review of the R14's Care Plan revealed a focused area for oxygen therapy, date initiated April 8, 2025, with interventions to include give medications as ordered by physician, monitor for signs/symptoms of respiratory distress and report to Medical Doctor (MD) as needed, and oxygen settings via nasal cannula (NC) at 4 liters (L) per minute (/min) during ambulation and 2 L/min at rest. A review of the current physician order dated April 7, 2025, for oxygen to be delivered at four (4)L/min during ambulation, and two (2)L/min at rest via nasal cannula (NC) every shift. An observation on April 22, 2025, at approximately 11:55 a.m., revealed R14 sitting in a wheelchair in his/her room. R14's oxygen concentrator was turned on and ran at one (1)L/min which was not consistent with physician's orders. A second observation on April 23, 2025, at approximately 11:30 a.m., revealed R14 sitting in a wheelchair in his/her room. R14's oxygen concentrator was turned on and running at one (1)L/min. A third observation on April 23, 2025, at approximately 12:30 p.m., in the presence of the Director of Clinical Excellence (DCE), revealed R14 sitting in a wheelchair in his/her room. R14's oxygen concentrator was turned on and running at 1 L/min. Interview with the DCE on April 23, 2025, at approximately 12:35 p.m., confirmed that the physician's order for supplemental oxygen was not followed for R14.