STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425310	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUE RIDGE OF SUMTER	**1761 PINEWOOD ROAD SUMTER, SC 29154**

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 0565 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to organize and participate in resident/family groups in the facility.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review, the facility failed to establish a process to ensure that resident/family concerns that were raised in the Resident Council Meeting were consistently addressed. Resident #80 stated during a group interview on 3/2/2020 at 3:30 PM that resident grievances were voiced during Resident Council meetings but there was no follow-up addressing their concerns. Multiple residents in attendance, including Resident #71, agreed with Resident #80's comments. Resident #80 stated during the group interview that the grievances were written on paper during Resident Council meetings. Resident #39, the Resident Council President, who always signed the Resident Council Minutes with a mark that was witnessed by the Activities Director (AD), said that s/he didn't read the minutes and that sometimes they would read the minutes to him/her. The findings included: Review of facility's policy titled Filing Grievances/Complaints (revised 8/2008) reflected that the facility policy stated that any resident (including representatives) may file a grievance or complaint orally or in writing, that the Administrator (ADM) has delegated the responsibility for grievance and/or complaint to the Social Services Director (SSD), the SSD or involved department manager will investigate the allegations and submit a written report to the ADM, and the ADM will review the findings with the person investigating the complaint for corrective actions as necessary. The policy states that the resident or person filing the grievance will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The ADM or his/her designee will make such reports orally within five working days of the filing of the grievance. Resident #80 was admitted to the facility on [DATE]. Review of Resident #80's Annual Minimum Data Set ((MDS) dated [DATE] revealed the resident had a Brief Interview Mental (BIMS) score of 15 indicating no cognitive impairment. The resident was assessed to have no mood or behavioral problems and required limited assistance with his/her mobility. Resident #71 was admitted to the facility on [DATE]. Resident #71's Quarterly MDS dated [DATE] revealed the resident had a Brief Interview Mental Status score of 14 indicating no cognitive impairment. The resident was assessed to have no mood or behaviors and required one-person assistance with activities of daily living (ADLs). Resident #39 was admitted to the facility on [DATE]. Resident #39's Quarterly MDS dated [DATE] revealed a Brief Interview Mental Status a score of 15 indicating no cognitive impairment. The resident was assessed to have no mood or behaviors and required one-two person assistance with Activities of Daily Living (ADLs). During group interview on 3/2/20 at 3:30 p.m. Resident #80 stated that during the Resident Council meetings, minutes were taken (written down on paper), and that the residents were not informed of any follow-up investigations or actions. Multiple residents at the meeting indicated their agreement with Resident #80's statement. When asked about specific complaints Resident #80 said to look at what was written on the paper. During the group interview Resident #80 and Resident #71, among other residents, verbalized ongoing issues with staff service, food, availability of activities, and availability of social work support and they stated that this had been reported multiple times during Resident Council meetings. During an interview with the ADM on 3/2/20 at 10:50 a.m. s/he stated that minutes of the resident council meetings are taken by the ADM or the Social Services Manager (SSM) and that any concerns verbalized at the meetings will be recorded and followed-up related to the concerns shall be addressed per facility policy. The ADM confirmed that all meeting minutes were correct and complete. During an interview with the SSM on 3/2/20 at 11:00 AM, the SSM stated that the minutes of the resident council meetings are taken by the SSM or the ADM and that any concerns would be recorded on the minutes and follow-up to the concerns would be made per facility policy. The SSM confirmed that all meeting minutes were correct and complete. The SSM stated that s/he is the facility grievance official and is responsible for ensuring that resident grievances are addressed according to facility policy. During an interview on 3/4/20 at 10:10 AM with Resident #39, President of the Resident Council, stated that s/he does not read the minutes of the meetings that s/he signs. Resident #39 stated that sometimes they would read the minutes to him/her and he/she understood what they said. S/he verbalized satisfaction that the resident council/resident concerns addressed at the group interview would be addressed and stated that s/he looked forward to speaking to the ombudsman. During an interview with the Director of Nursing (DON) on 3/4/20 at 12:00 PM, the DON stated that it was his/her expectation that resident grievances reported in Resident Council meetings be accurately recorded and addressed promptly according to facility policy. The DON stated that s/he could easily say who the residents were that complained, as they complained frequently. The DON stated that many of the residents had psychiatric issues. During an interview with the Administrator (ADM) on 3/4/20 at 12:45 PM the ADM stated that s/he always follows-up with filed grievances. The ADM stated that it was his/her expectation that all grievances from Resident Council be recorded accurately per facility policy and includes the expectation that all grievances will be followed up. S/he stated that if there was no grievance that there would be no grievance follow-up. During an interview with ADM on 3/4/20 at 5:00 PM the ADM stated that many of the residents with grievances were frequent complainers and that many of the residents had psychiatric issues. Review of the Resident Council Minutes from March 2019-February 2020 reflected that every report stated Old Business reflected Minutes from previous resident council meeting was read and approved. Old business was followed up from previous month; every report stated Facility Policies and Procedures Developed/Revised/Updated in Past 30 Days reflected Facility policies and procedures have been updated in the past 30 days; every report stated New Business and the minutes of 2/19/19, 3/19/19, 4/23/19, 5/28/19, 6/18/19, 7/23/19, 8/20/19, 9/24/19, 10/22/19, and 12/17/19 each reflected the statement Residents were satisfied with meals, activities, volunteer groups and care being provided in the facility. The minutes of 11/26/19 Resident Council Minutes reflected no record of any resident concerns. The minutes of 1/21/20 and 2/18/20 reflected various grievances by the residents (the only recorded grievances received for the entire year of Resident Council meetings minutes reviewed). Review on 3/4/2020 of the meeting minutes and facility grievance logs reflected erratic documentation of resident council concerns. Although no concerns were recorded on the 8/20/19 minutes, a concern form reflected that a concern was reported for Resident #39 by the SSM for a report made during Resident Council. Although no concerns were recorded on the 9/24/19 Resident Council Minutes, two concern forms reflected that they were reported for Resident #80 by the SSM for reports made during the Resident Council. Multiple concerns were reported on the January-February 2020 Resident Council Minutes but not every concern recorded in the Resident Council minutes was recorded on the facility grievance log or follow-up documented with concern forms. Review of the Resident Council Minutes from May 2019-February 2019 reflected that all minutes were signed by Resident #39 with a mark and the signature witnessed by the AD.
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**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on observation, interview, record review, and facility's policies review it was determined the facility failed to develop the care plan to indicate the size of the indwelling catheter and follow the comprehensive plan of care for securing the urinary catheter to prevent trauma or injury for one (1) resident identified for Foley catheters. (Resident #36) The facility also failed to develop a care plan for one (1) resident from a sampled 19 residents identified for upper extremity contractures. (Resident #26) The findings included: Record review revealed Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's Annual Minimum Data Set (MDS) assessment dated [DATE] assessed the resident, with severely impaired cognition, was totally dependent of staff with two (2) person assistance for all activities of daily living (ADLs). The resident was assessed to have functional limitation of range of motion (ROM) on one (side) of his/her upper extremities and bilateral limited ROM of the lower extremities. Review of the resident's most recent Quarterly MDS assessment dated [DATE] documented the resident had limited ROM in one (1) upper extremity and in bilateral lower extremities. Observation during the initial tour on 3/1/2020 at 11:30 AM revealed Resident #26 in bed sleeping with the bed elevated at 45 degrees. Resident's right arm covered bed sheets and left arm flexed resting on his/her chest with finger contractures. Resident was not wearing a splint on this arm. No splints visible on the nightstand or chair at resident's bedside. Observation on 3/1/2020 at 2:00 PM revealed Resident #26 in bed with head of bed (HOB) elevated 45 degrees. Resident's hands were balled into fist position resting on his/her chest area and contractures of lower extremities, no splints or orthotic devices were observed in place at this time. Observation on 3/2/2020 at 8:20 AM revealed resident #26 in bed with HOB elevated. Resident #26 with bilateral upper and lower extremities contractures. Resident #26 noted with wedge between his/her knees; however, no orthotic devices in place on resident's upper extremities. No orthotic devices observed anywhere in the resident's room. Interview with the Unit Manager (UM) #1 on 3/1/2020 at 1:34 PM revealed the resident had contractures of the upper and lower extremities; was receiving therapy for the contractures; and should be wearing splints. A review of the Occupational Therapy (OT) Discharge Summary dated 7/26/19 documented the resident was to wear a carrot orthotic in the right and a palm protector in the left daily for four (4) to six (6) hours as tolerated. Review of the resident's care plan with a start date of 7/26/18 and a revision date of 1/2/2020 failed to identify the resident had bilateral contractures of upper and lower extremities. Nor did the care plan identify that the resident was to wear the orthotic devices as indicated in the OT discharge summary. During an interview on 3/4/2020 at 2:10 PM the MDS Coordinator stated the resident did not have bilateral contractures of the upper extremities. After reviewing the resident's OT discharge summary, the MDS Coordinator acknowledged the resident had bilateral upper extremity contractures and a care plan was not developed to address the contractures or the use of orthotic devices. 2. Review of the facility's policy titled Catheter Care, Urinary, revised September 2014, revealed the purpose of this procedure is to prevent catheter-associated urinary tract infections. Continued policy review revealed step 19 in the procedure is to secure the catheter to the resident utilizing a leg band. Review of Resident #36's medical record revealed the facility admitted the resident on 7/23/19 with [DIAGNOSES REDACTED]. Review of Resident #36's Quarterly Minimum Data Set (MDS) Assessment, dated 1/15/20, revealed the facility assessed the resident to have an indwelling urinary catheter and to have a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15), indicating severe cognitive impairment. Review of Resident #36's physician's orders [REDACTED]. Review of Resident #36's Comprehensive Care Plan, dated 08/05/19, revealed the resident had an Indwelling Urinary Catheter. Continued review revealed the goal stated the resident would not develop any complications related to catheter usage through the next review date of 04/28/20. Further review of the Comprehensive Care Plan revealed the interventions included to assess for and record any changes in bladder status, change catheter per facility policy/physician order, change drainage bag per policy, keep catheter tubing free of kinks, keep drainage bag below the level of bladder, and prevent tension on urinary meatus from catheter, monitor for signs and symptoms of Urinary Tract Infection and report abnormalities to the physician, monitor labs as ordered and report abnormalities to the physician, and provide catheter care every shift per policy. Additional review revealed there was no documented evidence that Resident #36 did not want to have the indwelling urinary catheter secured to his/her leg. Further review revealed the French (FR) size of the indwelling catheter was not indicated on the care plan. Observation on 03/03/20 at 10:56 AM of Resident #36 during catheter care, performed by Certified Nursing Assistant (CNA) #4, revealed the resident did not have a securing device to his/her leg to secure the indwelling urinary catheter. Interview on 03/04/20 at 11:00 AM with CNA #4 revealed the residents with indwelling urinary catheters should have leg straps to secure the catheter tubing to the resident. He/she further stated that Resident #36 didn't have the catheter secured to his/her leg because it was his/her preference not to have the catheter tubing attached to his/her leg. Further interview revealed care plans had care that needs to be provided for the residents. CNA #4 stated he/she followed the care plans but wasn't sure if Resident #36's care plan stated to not secure the catheter to his leg. CNA #4 stated the resident had told him/her in the past that he/she didn't want the catheter attached to his/her leg. Interview with Unit Manager (UM) #2 on 03/03/20 at 3:56 PM, revealed that it was standard nursing practice to secure the indwelling urinary catheter tubing to the resident's leg to prevent pulling on the catheter causing pain and to prevent the catheter from being pulled out. Continued interview revealed, should an indwelling urinary catheter be pulled out, the nursing staff would not know what size catheter for Resident #36 because there wasn't a physician's orders [REDACTED]. Additional interview revealed he/she expected staff to follow the care plan to secure the catheter to the resident's leg to prevent excessive trauma. Further interview revealed she believed Resident #36 had refused to wear a device on his/her leg that secured the indwelling urinary catheter; however, was unable to provide documentation of Resident #36's refusal. Interview with the Regional Nurse Consultant (RNC) on 03/04/20 at 1:48 PM, revealed he/she was responsible for oversight of the clinical processes in the facility as of January 1, 2020. Further interview revealed he/she performs chart audits monthly that included, but not limited to, review of physician's orders [REDACTED]. Continued interview revealed the purpose of the care plan was to make sure nursing staff are providing the care the resident needs. The RNC stated he/she had not identified any issues with the physician's orders [REDACTED]. Interview on 03/04/20 at 2:03 PM with the MDS Coordinator revealed he/she was responsible for completing all MDS assessments on the residents, reviewing the baseline care plan developed by the admission nurse, and initiating and/or updating the comprehensive care plan. The MDS Coordinator stated the care plan is updated based on the resident's physician orders [REDACTED]. The MDS Coordinator further stated that the purpose of the care plan was for the care of the resident, so the nurses know what care to provide the residents. However, he/she had not thought to add the size of the indwelling catheter as an intervention on the care plan for it should have been on the physician's orders [REDACTED]. and specific needs for the purpose of promoting an optimal outcome. Further interview revealed that the admission nurse established the baseline care plan within 48 hours, the MDS Coordinator completed the comprehensive care plan after the care plan conference within 72 hours, then the care plan was reviewed and updated with every MDS assessment thereafter. The DON stated that the care plan should indicate the indwelling catheter size so that nursing staff will know what size to reinsert if the catheter dislodged and the catheter should be secured to the resident's leg to prevent trauma unless there is a resident refusal. Interview with the Administrator on 03/04/20 at 12:56 PM, revealed he/she was responsible for all the residents in the facility and expected the staff to follow all orders and policies as written.
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure that one (1) resident identified with bilateral upper extremity contractures received the orthotic devices issued by therapy from a sampled 19 residents. The findings included: Record review revealed Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's Annual Minimum Data Set (MDS) assessment dated [DATE] assessed the resident, with severely impaired cognition, was totally dependent on staff with two (2) persons assistance for all activities of daily living (ADLs). The resident was assessed to have functional limitation of range of motion (ROM) one (side) of his/her upper extremities and bilateral limited ROM of the lower extremities. Review of the resident's most recent Quarterly MDS assessment dated [DATE] also assessed the resident to have limited ROM in one (1) upper extremity and in bilateral lower extremities. A review of the Occupational Therapy (OT) Discharge Summary dated 7/26/19 documented the resident had contractures of the elbow, contracture of the muscle of the right upper arm and left upper arm muscle. The short term goal as follows The patient will tolerate wearing B (bilateral) orthotics for up to 4 hours -6 hours as tolerated (attempt for small carrot/hand roll for R (right) hand and palm and elbow skin protector to LUE) improving to in order to promote good

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) skin integrity and contracture management. Review of the resident's care plan with a start date of 7/26/18 and a revision date of 1/2/2020 revealed the resident's bilateral contractures of upper and lower extremities were not addressed. Nor did the care plan identify that the resident was to wear the orthotic devices as indicated in the OT discharge summary. Observation during the initial tour on 3/1/2020 at 11:30 AM revealed Resident #26 in bed sleeping with bed elevated at 45 degree. Resident's right arm covered bed sheets and has left arm flexed resting on his/her chest with finger contractures. Resident was not wearing a splint on this arm. No splints visible on the nightstand or chair at resident's bedside. Interview with the Unit Manager (UM) #1 on 3/1/2020 at 1:34 PM revealed the resident had contractures of the upper and lower extremities; was receiving therapy for the contractures; and should be wearing splints. Observation on 3/1/2020 at 2:00 PM revealed Resident #26 in bed with head of bed (HOB) elevated 45 degrees. Resident's hands were balled into fist position resident on his/her chest area and contractures of lower extremities, no splints or orthotic devices were observed in place at this time. Observation on 3/2/2020 at 8:20 AM revealed resident in bed with HOB elevated. Resident with bilateral upper and lower extremities contractures. Resident with wedge between his/her knees; however, no orthotic devices in place on resident's upper extremities. No orthotic devices observed anywhere in the resident's room. Observations on 3/2/2020 at 3:30 PM revealed the resident remained in bed no splints in place on upper extremities. Observation 3/3/20 at 10:30 AM revealed the resident remained without orthotic devices on upper extremities Observation on 3/4/20 at 11:01 AM revealed the resident did not have the orthotic devices in place. The Certified Nursing Assistants (CNAs) were in the process of preparing the resident care. CNA #2 was asked if the resident was supposed to wear splints. CNA#2 responded the resident has a carrot for one hand and splint to place in palm of other hand. CNA looked around the room and found splints in the resident's nightstand drawer. The CNA also stated PT usually applies the splints in the afternoon and they are removed by the evening shift staff. Interview on 3/4/2020 11:45 AM with Physical Therapist (PT) #1 states resident is no longer seen by PT. The Therapist acknowledged the resident had orthotic devices to wear and the floor staff had been trained to apply the splints. It was the nursing staffs' responsibility to ensure the splints were in place. If the staff had a problem applying the splint, they should have notified PT for further evaluation but no one had said anything. An additional observation on 3/4/2020 at 2:02 PM revealed CNA #2 placing the orthotic devices on the resident's hands. The CNA was asked to inspect the resident's hands for skin breakdown, none was noted.
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, interview, record review, and facility policy review it was determined the facility failed to have an effective system in place for administering oxygen therapy in accordance with professional standards of practice for three (3) of 19 sampled residents. (Resident #50, #64, and #75). Resident #50 had a physician's order to administer oxygen at two (2) to five (5) liters per minute (LPM) to maintain oxygen saturation levels greater than 92% via nasal cannula as needed (PRN) and check oxygen (O2) saturation every shift and as needed. Resident #64 had a physician's order to administer oxygen at two (2) to five (5) liters per minute (LPM) to maintain oxygen saturation levels greater than 92% via nasal cannula as needed (PRN). Resident #75 had a physician's order to administer oxygen at two (2) to five (5) liters per minute (LPM) to maintain oxygen saturation levels greater than 92% via nasal cannula and to monitor lung sounds and oxygen saturation levels twice a day. However, there was neither a physician's order for oxygen therapy titration nor an oxygen therapy titration policy by pulse oximetry policy and procedure. The findings included: Review of the facility's policy titled Oxygen Administration, dated October 2010, revealed the procedure included to verify that there is a physician's order for the procedure, review the physician's orders or facility protocol for oxygen administration, review the resident's care plan to assess for any special needs for the resident, and place the resident on the prescribed oxygen. 1. Review of Resident #50's clinical record revealed the facility admitted the resident on 5/15/19 with [DIAGNOSES REDACTED]. Review of Resident #50's Quarterly Minimum Data Set (MDS) Assessment, dated 1/30/2020, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 10 indicating moderately impaired cognition but was still interviewable. Further review of the MDS revealed Resident #50 received oxygen therapy. Review of Resident #50's Physician's Order, dated 02/25/2020, revealed staff was to administer the resident oxygen at two (2) to five (5) liters per minute (LPM) to maintain oxygen saturation levels greater than 92% via nasal cannula as needed (PRN) and check oxygen (O2) saturation every shift and as needed. Observation of Resident #50 on 3/1/2020 at 1:17 PM and on 3/2/2020 at 8:21 AM, revealed the resident was receiving oxygen at two (2) LPM via nasal cannula. 2. Review of Resident #64's clinical record revealed the facility admitted the resident on 2/3/2020 with [DIAGNOSES REDACTED]. Review of Resident #64's Admission Minimum Data Set (MDS) Assessment, dated 2/10/2020, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 10 indicating moderately impaired cognition, but was still interviewable. Further review of the MDS revealed Resident #64 received oxygen therapy. Review of Resident #64's Physician's Order, dated 2/4/2020, revealed staff was to administer the resident oxygen at two (2) to five (5) liters per minute (LPM) to maintain oxygen saturation levels greater than 92% via nasal cannula as needed (PRN). Review of the Nurse's Progress Note, dated 3/3/2020, revealed Resident #64's oxygen saturation was 96% on room air and was receiving oxygen at three (3) LPM via nasal cannula. During initial tour on 3/1/2020 at 11:00 AM Resident #64 was observed in bed wearing oxygen nasal cannula with a setting at three (3) liters per minute. During the observation the resident stated the oxygen setting should be at five (5) liters per minute. An observation on 3/2/2020 at 11:16 AM revealed Resident #64 wearing oxygen nasal cannula with a setting at two (2) liters per minutes. The resident was not experiencing any respiratory distress. 3. Review of Resident #75's clinical record revealed the facility admitted the resident on 12/02/19 with [DIAGNOSES REDACTED]. Review of Resident #75's Significant Change in Status Minimum Data Set (MDS) Assessment, dated 02/17/20, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of three (3), determined the resident was severely cognitively impaired, and determined not interviewable. Further review of the MDS revealed Resident #75 received oxygen therapy. Review of Resident #75's Physician's Order, dated 12/02/19, revealed staff was to administer the resident oxygen at two (2) to five (5) liters per minute (LPM) to maintain oxygen saturation levels greater than 92% via nasal cannula as needed (PRN) and a Physician's order dated 12/05/19 to monitor lung sounds and oxygen saturation twice a day. Observation of Resident #75 on 3/1/2020 at 1:32 PM and 3/3/2020 at 2:42 PM, revealed the resident was receiving oxygen at five (5) LPM via nasal cannula. Interview on 3/3/20 at 3:06 PM with Licensed Practical Nurse (LPN) #1, revealed that all resident's physician's orders for oxygen administration were two (2) to five (5) LPM to maintain oxygen saturation greater than 92%. He/she stated that the resident would be started on the oxygen flow rate that they were on when admitted to the facility. LPN #1 stated that the resident's oxygen flow would be increased by one (1) LPM when the resident's oxygen saturation was below 92%. Further interview revealed he/she was not aware that a physician's order was needed for oxygen titration but was trained on how to titrate oxygen during new employee orientation. Interview with the Director of Nursing (DON) on 3/3/2020 at 3:22 PM, revealed that he/she is responsible for reviewing all physician's orders and clinical training for nursing staff. Continued interview revealed that the facility did not have a physician's order for oxygen therapy titration or an oxygen therapy titration policy by pulse oximetry. The DON stated that nurses have been trained to start oxygen administration with the lowest oxygen flow rate on the physician's order, then after checking the oxygen saturation levels, can change the oxygen flow rate up to five (5) LPM if needed to maintain the oxygen level above 92%. The DON further stated he/she had not identified any issues with the physician's orders and wasn't aware that an order was needed for oxygen titration. Interview with the Administrator on 3/4/2020 at 12:37 PM revealed that he/she supervised the Director of Nursing and expected oxygen administration to be performed in accordance with the facility policy.
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** Based on observation, interview and review of the facility's policies it was determined the facility failed to prepare, store, distribute and serve food in accordance with professional standards for food safety. Observations of the kitchen during the brief tour on [DATE] revealed food in the dry food storage area, the refrigerator, and the freezer was not stored properly and a female staff walked through the kitchen during lunch meal preparation with uncovered hair. The findings included: 1. Review of the facility's policy titled Code of Dress and Personal Appearance, dated [DATE], revealed all dining services employees would comply with: printed and posted personal hygiene guidelines, sanitation practices, and the facility's dress code. Further policy review revealed employees would wear hair restraints, such as hairnets, hair

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) bonnets and beard guards to prevent contamination of food or food contact surfaces. Observation of the kitchen on [DATE] at 10:18 AM, revealed a sign posted on the entrance door stating, Hairnets apply to everyone. Further observation on [DATE] at 11:10 AM, revealed the Dietary Manager walked from the entrance door to the dry food storage room during preparation of the lunch meal without a hair restraint. Interview with the Dietary Manager (DM) on [DATE] at 11:15 AM, revealed that dress code policy indicated all employees must wear a hair restraint when in the kitchen. Continued interview revealed he/she posted a sign on the door informing staff to wear a hairnet and indicating hairnets were available for use upon entrance to the kitchen. The DM stated he/she forgot to put the hairnet on this morning before entering the kitchen, but always wore it in the kitchen. The DM further stated all staff should wear hairnets so hair would not fall in the residents' food. Interview with the Administrator on [DATE] at 12:24 PM, revealed he/she supervised the Dietary Manager and expected staff to wear hairnets in the kitchen while food was being prepared. The Administrator stated there was a sign on the outside of the kitchen door directing staff to wear hairnets. The sign indicated hairnets were available outside the kitchen door. Continued interview revealed that hairnets should be worn in the kitchen because it was an infection control issue. 2. Review of the facility's policy titled Labeling and Dating Foods (Date Marking), dated [DATE], revealed once a package was opened, it would be dated with the date the item was opened and would be used by the safe food storage guidelines or by the manufacturer's expiration date. Further review revealed frozen food packages removed from the case would be dated with the date the item was received into the facility and stored using the first in first out method of rotation. Further review revealed once a refrigerated food item was opened, ready to eat, potentially hazardous food would be dated with a use by date according to current safe food storage guidelines or the manufacturers expiration date. Observation of the dry food storage area in the kitchen, on [DATE] at 10:25 AM, revealed (10) 16 ounce Fritos Corn Chips packages in ziplocked bags unlabeled and undated in a clear storage container, two (2) 5 pound (lbs.) of opened Sysco Classic Creamy Peanut Butter jars undated, one (1) 2 lbs. 10 ounces of opened Sysco House Recipe Quick Hot Oat Cereal bag undated, and one (1) 5 lbs. of opened Quaker Quick 5-minute Grits bag in a ziplocked bag undated. Observation of the walk-in kitchen freezer, on [DATE] at 10:45 AM, revealed two (2) 4 X (by) 6 size Crispy Whole Grain Thin Crust Pizzas topped with tomato sauce and blended mozzarella cheese in an unlabeled ziplocked bag with open date of [DATE] and no use by date, eleven (11) opened, unsealed Portico Classic Breaded Pollock Fish Squares in a plastic bag with open date of [DATE] and no use by date, and one (1) 3 pound bag of opened, unsealed and undated Sysco Classic Okra package. Interview with Dietary Aide (DA) #1, on [DATE] at 9:17 AM, revealed he/she was the supervisor on [DATE] which included the responsibilities of preparing the food for the day, checking the temperatures in the refrigerator and freezer, checking food for open and use by dates and discarding expired foods. Further interview revealed he/she had been trained upon hire to check the food items for open and use by dates in dry food storage, the freezer, and refrigerator. He/she stated he/she had not completed the task on [DATE]. Interview with the DM on [DATE] at 11:20 AM, revealed the policy indicated food items should be sealed if opened, food should be labeled to identify the items, and the open and use by dates should be written on the outside of the package with a marker. He/she stated that it's the responsibility of all staff to ensure proper storage of food. Further interview revealed the unlabeled, unsealed and undated food items should be discarded to prevent residents from getting sick. Interview with the Administrator on [DATE] at 12:24 PM, revealed that he/she routinely walked through the kitchen to ensure food was served in a sanitary manner but had not identified any issues. Further interview revealed staff was expected to date food items per the food protocol. The Administrator expected the DM to train staff and fix problems in the kitchen. 3. Review of the facility's undated policy titled Leftovers, revealed food handling rules for leftovers should be followed by dietary employees. Further review revealed leftover food and/or beverage should be stored in seamless containers with tight-fitting lids. All containers should be labeled and dated. Further review revealed prepared food or opened foods should be discarded after 72 hours. Observation on [DATE] at 10:57 AM, during initial kitchen tour, revealed there was leftover chicken noodle soup in a clear container covered with aluminum foil dated [DATE]. Interview with DA #1 on [DATE] at 9:17 AM revealed he/she was the supervisor on [DATE] which included the responsibilities of preparing the food for the day, checking the temperatures in the refrigerator and freezer, checking food for open and use by dates and discarding expired foods. Further interview revealed he/she had not checked the date on the chicken noodle soup. He/she stated leftovers should be discarded within three (3) days per the leftover policy. Interview with the DM on [DATE] at 11:20 AM, revealed the leftover policy directed staff to discard leftovers after three (3) days. The DM stated he/she expected the cook to check the dates of food items in the refrigerator when they arrived in the kitchen. The DM stated the chicken noodle soup should have been discarded within 72 hours and he/she was not sure how this was missed. Interview with the Administrator on [DATE] at 12:24 PM revealed he/she expected all leftover food to be discarded within the three (3) days per the policy.
F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a policy regarding use and storage of foods brought to residents by family and other visitors.** Based on observation, interview and review of the facility policy it was determined the facility failed to follow its policy to allow residents the ability to store food brought by families and visitors. Observations of the residents' rooms during the initial tour conducted on 3/1/2020 revealed no personal refrigerators and observation on 3/3/2020 of the refrigerator in the business office contained no food items. Interviews with staff on 3/3/2020 revealed food brought in by family members and visitors was discarded because there wasn't a refrigerator available to store the food. The findings included: Review of the facility policy titled Foods Brought by Family/Visitors, revised February 2014, revealed staff must be aware of and approve food(s) brought to a resident by family/visitors. Further review revealed perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator; containers would be labeled with the resident's name, the item and the use by date. Home-prepared and home-preserved foods were permitted if brought by family or visitors for individual residents. Observations during the initial tour conducted on 3/1/2020 at 1:17 PM, revealed no refrigerators were available for residents to store personal food in the resident's rooms or at the nurse's stations on Units 100, 200, 300 and 400. Interview during resident council meeting on 3/2/2020 at 3:32 PM, revealed a total of eleven (11) residents confirmed the facility did not provide storage for food brought in by family members. Resident #84 stated that a staff member took food brought in by his/her family on Thanksgiving Day last year. During an interview with the Dietary Manager (DM) on 3/1/2020 at 11:30 AM, he/she verified there were no refrigerators for residents or residents' families to store food in the facility. Interview on 3/3/2020 at 10:48 AM with the Infection Preventionist revealed there wasn't a refrigerator to store food for residents or foods brought in by family and visitors. Continued interview revealed staff educated family and visitors that food could not be left in the facility because they did not have a place to store it. Interview with the Administrator on 3/4/2020 at 12:24 PM, revealed staff were not following the policy regarding allowing food to be stored when brought in by family and visitors due to the lack of an available refrigerator to store the food safely.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to ensure sanitary practices were maintained after providing incontinent care and removal of a wound dressing for one (1) resident from a sampled 19 residents. The findings included: Record review revealed Resident #73 was admitted with [DIAGNOSES REDACTED]. Review of the resident's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition but at times would resist care and/or treatment. The resident required extensive to total assistance of one (1) to (2) staff members. The resident was assessed as having an indwelling catheter and Stage IV sacral ulcer. Observation on 3/2/2020 at 10:45 AM revealed Certified Nursing Assistant (CNA) #1 with assistance of another CNA providing incontinent care to Resident #73. As CNA #1 removed the resident's brief it was noticed the resident did not wear a catheter strap. CNA #1 performed incontinent care. The resident was repositioned on his/her side so that the CNA could clean the resident's buttocks. After cleaning the resident's buttocks CNA #1 proceeded to remove the resident's sacral ulcer dressing without changing gloves. The CNA left the wound uncovered while the resident was transported to the shower. During an interview with CNA #1 on 3/2/2020 he/she stated that he/she had changed his/her gloves after providing incontinent care to and before removing the resident's sacral dressing. The CNA also stated that he/she had been trained on Infection Control techniques when providing incontinent care and assisting with dressing, but he/she was nervous with observation and just forgot. During the interview on 3/4/2020 at 1:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425310	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUE RIDGE OF SUMTER	**1761 PINEWOOD ROAD SUMTER, SC 29154**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) PM with Unit Manager the surveyor described the observation of CNA #1 providing incontinent care of the resident and removal of the sacral dressing. He/She also stated the CNA should have changed gloves and washed hands after providing incontinent care and then don new gloves to remove the dressing.