STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425105	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millennium Post Acute Rehabilitation	2416 Sunset Boulevard West Columbia, SC 29169

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on facility policy review, observation, and interviews, the facility failed to ensure the confidentiality and security of resident Protected Health Information (PHI) for two of two residents (R)3 and R4) observed for resident rights. Specifically, a resident's code status document containing PHI was observed uncovered and unsecured in a clear wall-mounted mailbox, located in a hallway accessible to staff, residents, and visitors. Additionally, a staff member left a computer unattended in a common area with the screen displaying a resident face sheet, which included personally identifiable information such as the resident's name, photograph, and medical details.Findings include:Review of the undated facility document titled, HIPAA Privacy and Security Operational Guide, revealed: The everyday definition of breach is an infarction or violation of a law, obligation, or standard. HIPAA defines breach as the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of the PHI. PHI is defined by this document as Protected Health Information. Examples of PHI as determined by the facility document includes but is not limited to: Information doctors, nurses, therapists, consultants, and other health care providers document in the medical record; both on paper and electronically. Document also reveals that an example of a breach in PHI includes but is not limited to, Unsecured documents (not shredded, left open/unlocked). Observation of Hall 100 Computer on Wheels (COW) on 9/9/25 at approximately 12:37 PM revealed the computer on wheels was unattended by a staff member. The computer was observed to be on, displaying a resident face sheet and picture displayed on the unattended screen. The Assistant Director of Nursing (ADON) was then observed taking away the COW and closing down the resident's chart.An observation of the Social Services clear mailbox on the 100 hallway, on 9/9/25 at 1:05 PM revealed, Protected Health Information (PHI) was inappropriately exposed and left unsecured. Documentation left exposed included Millennium Post Acute Advance Directives for Resident (R)3, and R4, and R4's signed document for Emergency Medical Services Do Not Resuscitate Order.An interview with the Social Services Assistant (SSA) on 9/9/25 at 1:29 PM revealed that the PHI stored uncovered and exposed should not have been left out in the open, the way it was. SSA revealed, PHI that need to be stored in her mailbox need to be placed in a folder and should be secured and covered. If there is no folder available, then the expectation is for staff to slide PHI underneath her door.During a group interview conducted on 9/10/25, at 3:30 PM with the Administrator (LNHA), Director of Nursing (DON), and ADON confirmed that it is their clear expectation for all staff to protect residents' PHI and comply with the Health Insurance Portability and Accountability Act (HIPAA). The leadership emphasized that PHI must not be left visible or unattended, should not be discussed in open or public areas, and must not be shared with individuals who are not directly involved in the resident's care. Additionally, they stated that when computers on wheels (COWs) are left unattended, screens displaying resident information must be properly secured to prevent unauthorized access. The leadership team acknowledged that staff failed to follow facility policy and expectations regarding the safeguarding of PHI. They confirmed that a resident's electronic health record was left open and unattended, exposing PHI in violation of HIPAA regulations and facility policy. Furthermore, leadership acknowledged that documents containing PHI were inappropriately left unsecured in the SSA's clear mailbox, which does not align with the facility's standards for protecting confidential information.

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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. Based on review of the facility policy, observations, and interviews, the facility failed to ensure proper tracheostomy care, in relation to documentation and changing the tracheostomy neck tie, according to professional standards of practice for 1 of 1 resident reviewed.Findings include:Review of a facility policy titled Trach Tie Change dated 01/2025, revealed Policy: The respiratory care provider should use accepted practices to change trach ties.Frequency: Every seven days, after showers or when visibly soiled.A review of the admission record revealed that the facility admitted Resident (R)4 on 09/05/2025, with diagnoses that included, but were not limited to, chronic respiratory failure with hypoxia, dependence on respiratory [ventilator] status, functional quadriplegia, and persistent vegetative state.A review of R4's Respiratory Administration Record (RAR) dated 07/01-31/2025 revealed an order to change the trach ties weekly on Thursday (Thurs) and as needed every day shift every Thurs.During a review of R4's August Medication Administration Record (MAR), the review did not reveal an order to change the tracheostomy ties.A review of R4's Care Plan, initiated 03/13/2025, revealed that R4 has a tracheostomy related to (r/t) chronic respiratory failure. The resident also has Chronic Obstructive Pulmonary Disease (COPD). The interventions further revealed tracheostomy care per facility protocol.A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/2025, revealed R4 had a Brief Interview for Mental Status (BIMS) that was not scored.During an observation on 09/09/2025 at 01:00 PM, the RAR did not reveal the changing of tracheostomy ties, weekly.During an interview on 09/09/2025 at 01:06 PM, Licensed Practical Nurse (LPN)4 stated, My new nursing orientation training was for 30 days. They are responsible for changing the tracheostomy neck ties. Respiratory does everything associated with the R4's tracheostomy.During an interview on 09/09/20025 at 01:15 PM, Respiratory Therapist (RT)1 stated, I've worked here for 3 years. We change his tracheostomy ties every Thursday and as needed. He lays on his side and drools a lot, so we may have to change it a little more than once a week.During an interview on 09/09/2025 at 01:36 PM, the Director of Respiratory stated, If they have skin breakdown proximity to the stoma site, the wound nurse changes the dressing. When R4 was in and out of the hospital, the order fell off for changing the tracheostomy ties. I realized his tracheostomy ties were not being changed once I observed there was no documentation for it.During an interview on 09/09/2025 at 02:29 PM, the Director of Respiratory stated, We do not have any documentation on trach changes for August.During an interview on 09/10/2025 at 05:22 PM, the Director of Nursing (DON) stated, They get checked off on changing the neck ties. It is one of the things we do during our annual skills fair.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 facility policy review, record review, observations and interviews, the facility failed to ensure medications were properly stored and secured for one of one resident (R)1, observed for pharmacy services. Specifically, a cup containing Guaifenesin (Robitussin) was observed left unattended on R1's bedside table without documentation of a self-administration assessment or physician authorization.Findings include:Review of the facility policy titled, Medication Administration: General Guidelines, with a last review date of 7/28/25 revealed: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Policy further reveals, Medications are administered at the time they are prepared. Medications are not pre-paired/pre-set/pre-crushed. Only one patient/resident's medications are prepared and administered at a time.An observation of R1's bedside table on 9/9/25 at 11:50 AM revealed R1 had a medication cup in her bed side table with a red liquid. During a subsequent interview, R1 revealed it was a cough medicine that a night shift nurse gave her 2 nights ago.An observation and interview with Licensed Practical Nurse (LPN)2 on 9/9/25 at 1:38 PM revealed a loose white pill tablet that had H-49 engraved on the back of the pill. H-49 Imprint is identified as Sulfamethoxazole and Trimethoprim 800 mg [milligrams] / 160 mg, commonly used to treat various bacterial infections. LPN2 revealed she does not know what the pill is, where it came from, or who it is for. LPN2 denies pulling it for R1. LPN2 was observed wasting medication.Record review of R1's orders revealed no PRN [as needed] and or one time order for cough medication, or Sulfamethoxazole and Trimethoprim in the past 3 days.Record review of R1's electronic health record reveals no self-medication administration assessment completed on file nor was there a provider order for R1 to self-administer medication.During an interview with LPN1, completed on 9/10/25 at 3:37 PM, revealed the facility has standing orders for all residents from the Provider for common symptom relief, among these medications is Guaifenesin/Robitussin: 10ml/po every 8 hours as needed which is a medication used to treat a common cough/cold like symptoms. Subsequent record review was completed with LPN1 of R1's orders revealed no standing orders for cough medication. Further review of R1's electronic health record indicated no one time order or note indicating that the resident was ordered for and received cough medication. Observation was then made with LPN1 of unknown red substance in the medication cup. LPN1 was able to identify the substance as Guaifenesin/Robitussin. LPN1 acknowledged that the resident should have had an order or at least a progress note indicating the use and need for the cough medication.During an interview with the Administrator (LNHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON) on 9/10/25 at 3:30 PM, revealed the leadership team has emphasized that, in accordance with safe medication administration practices, nursing staff must first verify that a resident has a valid provider order for any medication. The medication must be active on the Medication Administration Record (MAR), and provider instructions must be carefully followed prior to administration. Following this, staff are expected to document whether the resident took the medication and record the outcome in the resident's Electronic Health Record (EHR). The leadership team further clarified that residents should never have medications at their bedside, particularly medications that have not been prescribed. In this case, the leadership acknowledged, the nurse who administered the cough medication failed to obtain a provider order and did not adhere to the established protocols, thereby not meeting leadership's expectations for safe and compliant medication practices.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policies, Resident [NAME] of Rights, record review, observations and interviews, the facility failed to ensure the nutritional well-being of Resident (R)5,while respecting an individual's right to make choices about their diet. Findings include: Review of the Resident's [NAME] of Rights (South Carolina Code of Laws, Section 44-81-20 et. Seq., revealed under personal treatment, to be treated with respect and dignity. Review of the facility's Heart Healthy Precautions, copyright 2022, revealed indications for use are for the individual desiring to reduce their risk of developing heart disease or minimize further complications from heart disease .A less restrictive diet is shown to increase intake, enjoyment, and palatability of the meal. Nutritional Adequacy revealed with the proper selection of foods, the Heart Healthy Precautions meets the current Dietary Reference Intakes/Recommended Dietary Allowances/Adequate Intakes, Food and Nutrition Board, Institute of Medicine, National Academy of Science, 2011 for individuals ages 31 years and older. Review of the facility's Heart Precautions Educational Handoutcopyrighted 2022, revealed well balanced, nourishing meals include the following component daily: · 6 ounces of protein – one ounce is equivalent to one ounce cooked meat or fish, one ounce cheese, ¼ cup cottage cheese, one egg or ½ cup of cooked beans. Review of R5's Face Sheet revealed that R5 was admitted to the facility on [DATE] with diagnoses including but not limited to: chronic respiratory failure, tracheostomy status, chronic obstructive pulmonary disease, and hypertensive heart disease without heart failure. Review of R5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/08/25, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 14, indicating an intact cognitive response. Review of R5's Care Plan with a start date of 01/02/2025 documented, “R5 has a nutritional problem or potential nutritional problem, PEG use related to (r/t) dysphagia, type 2 diabetes mellitus, heart failure, gastroesophageal reflux disease (GERD), congestive heart failure (CHF) with weight fluctuations expected resident and family are non-compliant with the ordered diet. Further review of the Care Plan revealed the following approach, “Diet as ordered by the physician, RD to evaluate and make diet change recommendations as needed (PRN), risk versus benefit to resident and family for appropriate diet for resident.” Review of R5's Treatment Administration Record (TAR), revised 08/29/2025 revealed Consistent Carbohydrate Diet (CCHO), regular texture, thin liquids consistency, no concentrated sweets/no fried foods/large protein portions. During an interview on 09/10/2025 at 09:12 AM, R5 stated, “They have me on a strict diet. I am tired of chicken. I eat chicken every day. They gave me two tortillas with salsa with no meat. It is days they don't give me meat. I really don't know much about the Heart Healthy diet. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/10/2025 at 10:30 AM, the Long-Term Care (LTC) ombudsman stated, “When I went out to speak with R5. I was informed that R5 is on a diet. The plan was for R5 to lose weight. But then R5 started complaining that they were not giving R5 enough to eat, and the food is not good. ” During an interview on 09/10/2025 at 04:17 PM, Dietary Assistant Supervisor stated, “We get a diet form from the nursing station that tell us what the diet is so they write it on a preference slip. We then try to find out what they like. We go through the meats, milks, drinks, vegetable that we have at Millennium. On the dietary slip, it also let us know what their food allergies are. She never request more food. I know she has to have skinless meat for her heart healthy meal. Our diet slip breaks it down to what our meals are and what they can have and what they can't have. We follow up their preferences as much as possible. R5 can also reach out to the CNA or the Nurse if they want to request a change of diet selections. If the tray is already out, we will make the changes in the system or reprint the ticket or scratch it off. If it's something they can't have I have to have permission to change their diet. We offer salads and hamburger patties. She has an alternate menu posted in her room. I posted it myself. It is under her meal plan she has. They can call on their phone to us directly to change their menu selection. It is in front of her bed. She verified she can see the Menu. We have a cook after hours. I stay till six.” During an observation on 09/10/2025 at 04:39 PM, the surveyor had difficulty reading the weekly menu on the resident's wall. During an interview on 09/10/2025 at 04:39 PM, R5 stated, “I am unable to read the menu on the wall. ” During an interview on 09/10/2025 at 05:03 PM, the Dietary Assistant Supervisor stated, “My boss had a conversation with her recently. If we ask if she is ok, R5 says she is ok. I cannot speak on extra portions for her meals because I was not here. We do try our best to see if R5 enjoys their meal.” During an observation on 09/10/2025 at 05:00 PM, the Dietary Assistant Supervisor stated, “She could not see the menu on the wall.” During an observation on 09/10/2025 at 05:00 PM, the Dietary Assistant Supervisor provided the surveyor with a menu for week 2. On Wednesday (Day 11), for dinner, the menu revealed cheese enchiladas, refried beans, pico salad, fresh grapes, sugar cookies, and milk/beverage. During an interview on 09/10/2025 at 05:05 PM, the Dietary Assistant Supervisor provided the surveyor with a menu that was changed out for Wednesday (Day 11). The menu revealed cheese quesadilla- 1 cup, carrots-4 ounce (oz), pico salad #8 scp, fresh grapes-4oz, sugar cookie-1, skim milk/beverage-1 cup. She could not confirm the portion sizes. During an interview on 09/10/2025 at 07:15 PM, the Administrator stated, “R5's Resident Representative (RR) will send food that is not on her heart-healthy diet. We have educated the RR to adhere to her diet, fluid-restricted, low-sodium. The problem is getting her to follow her diet. We are fighting that battle with what she is eating. She DoorDash. A Registered Dietitian (RD) is here weekly. The RD may say she has had her allotted protein for the day. The RD tracks the daily and weekly menu.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on record review and interviews, the facility failed to employ a full-time qualified Licensed Medical Social Worker (LMSW), as required for facilities with more than 120 certified beds. 130/130 certified beds, all of which are potentially affected by the lack of a full-time LMSW to provide necessary psychosocial support and services.Findings include:Review of facility staff list revealed there is no Licensed Medical Social Worker employed in the facility. Review of the facility census dated 9/9/25 revealed the facility was certified for 132 beds. During an interview with the Social Services Assistant (SSA) on 09/09/25 at 1:29 PM revealed the facility's Social Services Director, who was a Social Worker (SW) left the facility around Mid-August of 2025. SSA revealed the facility has been without a SW since that time and that she has done her best to fill in the role since her departure. SSA revealed that there is a Corporate liaison that she can call if she needs help, but she is unaware of her official title or role. SSA revealed her background is that of a Certified Nursing Assistant (CNA).During an interview with the Administrator (LNHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON) on 9/10/25 at 3:30 PM revealed, Social workers at the facility are responsible for scheduling care plans, handling grievances, assisting with discharge planning, and coordinating discharge and home health services. The full-time LMSW left the facility in mid-August, and the facility has been without an LMSW since that time. The LNHA stated that the facility is currently posting and interviewing for the position, with a candidate scheduled to complete a facility walk-through on Friday, 9/12/25. The DON reported that the facility currently has a resource supporting the SSA. A subsequent interview revealed that this resource is an RN, not an LMSW, and confirmed that the facility is currently without a licensed medical social worker.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on review of the facility policy, record review, observations, and interviews, the facility failed to ensure the call bell was within reach for one of one resident (R)2) reviewed for physical environment, which resulted in a delay in care. Specifically, R2 was observed in bed with the call bell positioned out of reach, on the opposite side of the bed. During the observation, R2 stated they were unable to call for assistance and had waited over 30 minutes to request pain medications. Findings include:Review of the facility policy titled, CALL LIGHTS - ACCESSIBILITY AND TIMELY RESPONSE-POLICY, with a last update date of 10/31/24 revealed: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.Review of R2's face sheet revealed a diagnosis of muscle weakness and history of cerebral infarction.Review of R2's Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/31/25 revealed resident is dependent on staff for self-care and mobility. R2's MDS also reveals resident has impairment on both lower extremities (hip, knee, ankle, foot).During an observation of R2 on 9/9/25 between 1 PM and 1:20 PM revealed R2 was lying in bed, on her right side, supported by positional wedges on her left. The call light was located approximately 6 inches from the ground on the left side of the bed, out of the resident's reach. The resident attempted to access the call light, but was unsuccessful due to her current position. Subsequent interview with R2 revealed she cannot reach her call light and needs to talk to the nurse because she is in pain. R2 rated the pain 8/10 and stated the pain is all over her body. R2 revealed she has been attempting to get a hold of staff for the past 15 minutes.During an observation with Licensed Practical Nurse (LPN)1 completed on 9/9/25 between 1:20 PM and 1:35 PM, the surveyor called LPN1 to R2's room. LPN1 acknowledged the placement of the call bell and confirmed that it was out of the resident's reach. While speaking with R2, the resident requested her pain medication. LPN1 promptly notified the nurse responsible for R2's care, regarding the resident's request for pain management. In a subsequent interview, LPN1 confirmed that the facility's expectation is for call bells to always be within residents' reach. Staff are trained to conduct regular rounding as needed and at least every two hours to ensure that residents have access to their call bells at all times. Additionally, staff are instructed to verify that call bells are within reach before leaving a resident's room. LPN1 acknowledged that failure to ensure call bell accessibility can lead to negative patient outcomes and admitted that R2's call bell should have been positioned within the resident's reach.Review of R2's Electronic Medication Administration Record (EMAR) for 9/9/25 at 1:39 PM, documentation revealed that the resident was administered Hydrocodone-Acetaminophen 5-325 mg in response to a reported pain level of 9 out of 10.During an interview with the Administrator (LNHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON) on 9/10/25 at 3:30 PM, revealed the leadership team expects staff to respond to call bells as promptly as possible when available. However, response times may vary during high demand periods such as meal service or when staff are assisting other residents. Regardless, residents must always have an assistive call device within reach. For residents with mobility limitations or other specific needs, the Interdisciplinary Team (IDT) addresses these concerns through individualized care planning, ensuring appropriate devices such as blow calls, pressure pads, or standard call bells are provided based on the resident's capabilities. Leadership staff conduct routine Angel Rounds to ensure expectations are being met and to support resident care directly on the floor. All staff are expected to round on residents at least every 2 to 3 hours and as needed to maintain safety and accessibility. In the incident observed, the call bell was noted to be on the wrong side of the bed, leadership team reveals the call bell should have been positioned on the side accessible to the resident to ensure timely assistance and compliance with facility standards. Leadership team reveals in this instance, the facility staff did not follow their expectations.