

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Lancaster Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2044 Pageland Hwy Lancaster, SC 29720	

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 0726  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.  (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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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the facility policy, observation, interview, and record review, the facility failed to ensure that staff demonstrated the required competencies to provide safe tube-feeding management for 1 of 1 resident (Resident (R)5). Specifically, the facility failed to ensure that nursing staff possessed and demonstrated the necessary competencies to manage tube feedings safely. The lack of competency resulted in the tube feeding being administered while the resident was laying flat in a supine position. This failure resulted in the resident receiving tube feeding in a supine/flat position at zero (0) degrees, thereby placing the resident at risk for aspiration, abdominal distention, nausea, and avoidable discomfort. Findings include: Review of the facility policy titled Sample Guidelines for Writing Enteral Orders, Standard Gravity Bolus Tube Feeding Order with a complete revision date of May 5, 2023, states to elevate HOB (head of bed) 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding is stopped. Review of R5's Face Sheet revealed the resident was admitted to the facility on [DATE] with an extensive medical history, including but not limited to diagnoses of: hemiplegia and hemiparesis, acute cough, chronic obstructive pulmonary disease (COPD), pain, anxiety disorder, dysphagia, long-term opiate analgesic, vascular dementia, seizures, and gastro-oesophageal reflux disease (GERD), warranting absolute total care as noted on the resident's face sheet notes. Review of R5's physician's orders indicated a tube feed order to keep R5's head of his bed elevated every shift. Days 07:00 AM - 07:00 PM and Nights 07:00 PM - 07:00 AM. Review of R5's Care Plan and Medication Administration Record (MAR) revealed an order dated 11/19/2025 for Glucerna 1.5 at 60 cc/hour x 22 hours/day along with a monitoring approach noted to observe for and report signs and symptoms of aspiration, congestion, coughing, elevated temperature, and abdominal distention. Review of R5's MAR indicated to keep head of bed elevated every Shift 10/27/2025 - open-ended. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 10/15/2025 revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating R5's cognition to be severely impaired. During an interview with Resident (R)6, who is R5's roommate, on 11/19/25 at approximately 3:45 PM, R6 stated he had been waiting approximately one hour for staff to assist his roommate with elevating the head of his bed. R6 further explained that R5 was unable to speak up for himself and that he wanted to advocate not only for himself but also on behalf of his roommate. During an observation on 11/19/25 at approximately 3:45 PM, R5 was witnessed laying flat in a supine position while actively receiving his tube feeding, which initiated an immediate nurse notification. The nurse and Administrator promptly repositioned R5 and verified tube feeding, as appropriate. R5 appeared to be in no apparent distress, as indicated by his flat affect and lack of behaviours. During an interview on 11/19/25 at approximately 4:39 PM, R5's floor nurse, Licensed Practical Nurse (LPN)1 revealed R5 was last seen sitting with the head of his bed elevated at an appropriate position for feeding (30 to 45 degrees). LPN1 further stated that she believed the agency Certified Nursing Assistant (CNA), last seen with the resident, may have repositioned the resident while providing care and left without elevating his head. Although she was unable to definitively state when R5 was laid supine, LPN1 further explained that it is expected that all CNAs round every two (2) hours. During an interview on 11/19/25 at approximately 4:45 PM, CNA1 revealed when changing or adjusting residents with tube feedings, the feeding pump is placed on hold, head of the bed lowered, the bed is adjusted and/or the resident is changed as needed, and then the head of the bed and feeding pump are turned back on. CNA1 reports 1st shift CNA changed R5 at the end of the 1st shift. CNA1 stated she had not made her rounds yet to R5's room; however, she was made aware of the head of bed not being elevated during tube feed by other staff after being discovered by two surveyors. During an interview on 11/19/25 at approximately 4:55 PM, the Director of Nursing (DON) revealed nurses are responsible for tube feeding management. Administration enters orders, and nursing staff are expected to check rates and flush tube feeding, as appropriate. Additionally, CNAs are expected to round every two (2) hours, and nonverbal residents are under constant supervision. The DON further stated that CNAs hold tube feeding while residents are being repositioned.</p>		