

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2024
NAME OF PROVIDER OR SUPPLIER  Midlands Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 N King St Columbia, SC 29223	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>31846</p> <p>Based on the facility policy, records reviews and interviews, the facility failed to ensure Resident (R)41 and her responsible party received notice of transfer, for a hospital stay, in writing and in a language they could understand of the reason for transfer for 1 of 2 residents reviewed for hospitalization .</p> <p>Review on 08/26/24 at 03:10 PM of the facility policy titled, Admission, Discharge and Transfer, states:</p> <p>4. Facility staff provides, upon admission, at the time of transfer to a hospital, and before therapeutic leave begins, written information to the patient/resident and a family member or representative concerning the duration of the bed-hold policy under the state plan and under alternative payor plans. Facility staff documents in the medical record that written notice was provided.</p> <p>21. The patient/resident/family member receives notice of transfer or discharge, as soon as practical depending on the reason for the discharge, in a language they can understand.</p> <p>A. Safety or health of the patient/resident or others is at stake.</p> <p>C. An immediate transfer or discharge is required by the patient/resident's urgent medical needs.</p> <p>22. The written notice of transfer or discharge includes.</p> <p>A. The reason for discharge.</p> <p>B. The effective date of the transfer or discharge.</p> <p>C. The location to which the patient/resident will be transferred or discharged .</p> <p>23. The reasons's for transfer or discharge are recorded in the patient/resident's clinical record.</p> <p>The findings include:</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility admitted R41 on 04/18/24 with diagnoses including, but not limited to, severe sepsis with septic shock, Alzheimer's, dementia, schizophrenia, atrial fibrillation, diabetes mellitus and hypertension.</p> <p>Review of the medical record on 08/27/24 at 09:03 AM for R41 revealed a discharge to the hospital on 07/22/24 for respiratory distress. There was no documentation to ensure the resident nor the resident received notification of transfer to the hospital to include the reason for transfer.</p> <p>The Administrator provided a form titled, SNF/NF to Hospital Transfer Form, the form included the resident's name, the date of birth and the date of transfer to the hospital. No other documentation was on the form.</p> <p>A second form was provided which states, Pursuant to Federal and State regulations, this Notice is being provided as a formal notification that this resident is transferred and or discharged from this facility on 07/22/24 for the following reason, no reason was documented. The facility social worker signed the document, but no documentation to ensure the resident nor the personal representative received a copy.</p> <p>During an interview on 08/28/24 at 08:40 AM with the Administrator, this surveyor brought to her attention that the transfer form contained the resident's name, date of birth, and the date transferred to the hospital and that no other documentation was on the form. The Administrator circled an area on the form, Additional Relevant Information, an acute care transfer list of relevant documentation sent to the resident/patient. The checklist was not provided for R41 nor her responsible party.</p> <p>During an interview on 08/28/24 at 09:20 AM with Registered Nurse (RN)1, she stated, when asked about the process for resident transfer to the hospital and she stated, First we assess the resident, get vitals, and notify the attending physician and the resident's personal representative. If we receive orders to send out to the hospital then we call 911. When asked about the notice of transfer to the hospital, she stated, it is filled out and a copy is presented to the resident and the personal representative along with the Bed Hold Policy. She also mentioned the check list that is completed and in the medical record. No completed checklist was provided for R41's discharge to the hospital.</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>31846</p> <p>Based on the facility policy, record reviews and interviews, the facility failed to ensure Resident (R)41 or her responsible party received a copy of the Bed Hold Policy, in a timely manner, for a discharge to the hospital from 07/22/24 through 07/31/24.</p> <p>Review of the facility policy titled, Facility's Policy and State Requirements for Temporary Leave Bed-Hold, states,</p> <p>If a resident leaves the facility for temporary hospitalization or therapeutic leave, the resident or his/her representative may ask the facility to hold the resident's bed until the resident is ready to return. The resident and/or his/her representative will be given an copy of the facility's bed-hold policy before the resident actually leaves for his/her temporary leave or hospitalization . In the case of an emergency, hospitalization , the bed hold policy may accompany the resident to the hospital or will be given to the resident or his/her legal representative within twenty-four (24) hours of the resident's hospitalization .</p> <p>The findings include:</p> <p>The facility admitted R41 on 04/18/24 with diagnoses including, but not limited to, severe sepsis with septic shock, Alzheimer's, dementia, acute respiratory failure and pneumonia.</p> <p>Review of the medical record on 08/27/24 at 09:03 AM for R41 revealed a discharge to the hospital on 07/22/24 through 07/31/24 for respiratory distress. There was no documentation to ensure the resident nor the resident received a copy of the facility bed hold policy in a timely manner.</p> <p>During an interview on 08/28/24 at 08:40 AM with the Administrator she provided a copy of the bed hold policy dated 07/22/24 which included the resident representative's name, and the date that R41 was transferred to the hospital but no documentation to ensure the resident or the representative received a copy of the bed hold policy within a timely manner of the discharge to the hospital.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31846</p> <p>Based on the facility policy, observations, record reviews and interviews, the facility failed to ensure Resident (R)20 was afforded and/or provided an ongoing program of activities designed to meet her interest and preferences for 1 of 2 residents reviewed for activities.</p> <p>Review of the facility policy titled, Activity/Recreation Programming, states as the policy, Based on a comprehensive assessment, individualized care plan and the preferences of each resident, the Activity/Recreation Director and staff shall provide an ongoing Activity/Recreation program to support resident's personal choice of activities, facility-sponsored group and individual activities, and independent activities designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident, encouraging both independence and community interaction.</p> <p>Purpose: To implement an ongoing resident centered activities program that incorporated the resident's needs, interests, hobbies and cultural preferences which is integral to maintaining and/or improving physical, mental, psychosocial well-being and independence. To create opportunities for each resident to have a meaningful life by supporting the domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning).</p> <p>The findings include:</p> <p>The facility admitted R20 on 06/14/24 with diagnoses including, but not limited to, muscle wasting and atrophy, need for assistance with personal care, muscle weakness, end stage renal disease with need for Dialysis.</p> <p>Review of the Minimum Data Set Assessment (MDS) revealed a five day assessment dated [DATE] and the Brief Interview for Mental States (BIMS) is scored as a (0) indicated R20 is severely impaired cognition.</p> <p>Multiple observations on 08/25/24, 08/26/24, 08/27/24 and 08/28/24 at various times revealed R20 in bed, daily with no activities provided.</p> <p>During an interview on 08/25/24 at 06:30 PM with the personal representative for R20, she stated that R20 is always in the bed, never gotten up and activities are not provided for this resident.</p> <p>Review of the Comprehensive Care Plan for R20 states, Resident needs one to one visits such as listening to music, reading of the daily chronicles in an effort to meet her emotional, intellectual, physical and social needs. The goal states, she will benefit from one to one as evidenced to improve quality and effectiveness.</p> <p>The interventions listed are:</p> <p>Staff will read to resident during one to one visits.</p> <p>Activity staff will observe and document resident's response to the one to one visit.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff will provide music of interest during one to one visits.</p> <p>Activity staff will provide one to one visits such as reading of the daily chronicles ad gospel music.</p> <p>Review of the documented activity sheets for 3 months which included June '24, July '24 and August '24 revealed, R20 was visited one time weekly in June '24 which included, 06/14/24, 06/21/24, 06/24/24 and 06/28/24 and the resident received reading of the current events and the radio was on during the visits. Nail care was provided only one time in the 3 months reviewed, which is documented on June 18th.</p> <p>Review of the activity attendance sheets for July '24 revealed, R20 received reading of cultural events on 7/01/24, 07/02/24 and 07/12/24. Current events news was provided on 07/31/24. During the one to one visits music was provided on 07/04/24 and 07/12/24. Reading was provided on 07/16/24 and 07/19/24 and 07/31/24. No documentation was for the time spent with the resident or if there was any type response from R20 during the activity.</p> <p>Review of the activity attendance sheet for August '24 revealed that 2 times weekly music and reading are provided at the same time. No current events are offered for August '24 and only 3 times for July '24. No documentation of the resident response if any or the amount of time spent with the resident was provided.</p> <p>During an interview on 08/27/24 at 11:14 AM with the Activity Director she stated, this resident needs in room activities. She stated, when asked, if R20 is able to get up or be gotten up into a geri chair and she stated she is able to get up into a geri chair and could possibly attend social activities with other resident's. This surveyor asked about the documented day of nail care on 06/18/24 since it was only documented as receiving one time, and she stated, if the aide has already provided nail care then she does not do it, but the resident likes to have manicures.</p> <p>R20, likes gospel music and religious services, but none were provided. No social interaction or group activities were offered to R20 for the 3 months of activity attendance reviewed.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>31846</p> <p>Based on the facility policy, observations and interviews, the facility failed to ensure expired medications were removed and not stored with other medications in use for residents in 3 of 4 med carts and 2 of 2 medication rooms. The facility further failed to ensure medications that were discontinued, or the medications for discharged residents were not stored in a med room on the North Hall. The facility additionally failed to ensure personal snacks were not stored on the North Hall front med cart.</p> <p>Review of the facility policy titled, Section 5 - Medication Disposal and Returns, states under procedures:</p> <ol style="list-style-type: none"> <li>1. When medication is discontinued or a resident is discharged , facility staff should refer to the LTC Provider Pharmacy policies regarding medication return eligibility and the process to be followed for returns.</li> <li>2. Nursing staff shall dispose of any medication that has been discontinued, expired or that is not returnable to the pharmacy according to Facility Policy.</li> <li>3. Facility should segregate and securely store the medications to be returned to pharmacy until they are picked up by pharmacy.</li> </ol> <p>Review of the facility policy titled, Section 8 - Medication Storage, states under policy:</p> <ol style="list-style-type: none"> <li>1. Medications and biological's are stored safely, securely and properly following a manufacturer's recommendations or those of the supplier.</li> <li>2. The medication and biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff member.</li> </ol> <p>Procedures:</p> <ol style="list-style-type: none"> <li>6. Once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates of opened medications.</li> <li>7. Once any multi-dose packaged medication or biological is opened, nursing will mark the multi-dose products (e.g. inhalers, insulin, ophthalmic, otics and the like) with the date opened and follow manufacturer's/supplier guidelines with respect to expiration dates.</li> </ol> <p>The findings include:</p> <p>An observation on 08/25/24 at 11:42 AM of the North Hall A medication cart revealed:</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A bottle of Levetiracetam 100 milligram/milliliter, Manufactured by APL Healthcare Limited was expired.</p> <p>A Basaglar Kwik Pen, Manufactured by Lilly with Lot #D667654C has no open date and no expiration date.</p> <p>A Lispro Kwik Pen, Manufactured by Lilly with Lot #D672155A opened on 07/23/24 with no expiration date had expired after being in use for over 28 days.</p> <p>During an interview with Licensed Practical Nurse (LPN)1 at 08/25/24 at 11:45 AM, she confirmed the findings and removed the expired medications from the medication cart.</p> <p>An observation on 08/25/24 at 12:28 PM of North Hall B medication cart revealed:</p> <p>One bottle of Geri Care Saline Nasal Spray 1.5 ounces, Lot #97051 was expired on 06/24.</p> <p>Also stored in the medication cart North B was an opened cherry coke and a pack of cheese Ritz crackers.</p> <p>During an interview at this time with LPN2 confirmed the expired nasal spray, the cherry coke and the cheese Ritz crackers and removed them from the medication cart.</p> <p>An observation on 08/27/24 at 10:32 AM of the North Medication Room revealed:</p> <p>The medication Lorazepam 1 milligram/milliliter, individual wrapped 25 packages with Lot #254510 was expired on 07/28/24.</p> <p>Lorazepam 1 milligram/milliliter, individual wrapped 2 packages with Lot #252609 was expired on 06/17/24.</p> <p>One bag of Vancomycin 250 milliliters for intravenous use with ID 32571 and RO #27805 contained a use by date of 08/19/24.</p> <p>The medications were confirmed as expired and removed from storage by the Assistant Director of Nursing (ADON).</p> <p>During the North Hall Medication Room observation, the cabinets contained 3 shelves high of medications that were either discontinued or the residents were no longer residing in the facility. The cabinet contained 3 shelves full of blister packs of medications. The cabinet was locked on one side and the other side was easily opened.</p> <p>During an interview with the ADON, she stated the medications are awaiting to be discontinued for 60 days before they can be returned to the pharmacy. She stated the pharmacy will not take them back until they have been in the facility storage for 60 days. This surveyor asked the ADON who was monitoring the meds for the 60 days and she stated she did not know if anyone was monitoring the medications.</p> <p>Review on 08/27/24 at 10:50 AM of the South Hall Medication Storage Room revealed:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Expired medications in the Emergency Medication Box.</p> <p>The medication Fluconazole 50 milligrams, 5 pills with Lot #FL0823001A, Manufactured by NorthStar were expired on 07/31/24. Also in the emergency medication box were 6 tablets of Baclofen with Lot #07352 expired on 04/30/24.</p> <p>The South Medication Room expired medications were verified as expired by the ADON on 08/27/24 at 11:10 AM and removed from storage.</p> <p>During observations of med pass on 08/27/24 at 08:00 AM revealed LPN5 administering medications. LPN5 was in the process of pulling an inhaler from North Med Cart A, she removed the inhaler and handed it to this surveyor. The inhaler was for Symbicort and was opened on 05/25/24 and was only to be used for 3 months and then discarded. The inhaler was expired and LPN5 confirmed that it was expired and pulled a second inhaler for the resident from the med cart and administered it.</p> <p>During an interview on 08/28/24 at 10:05 AM with the Administrator, she stated that the pharmacy comes on Tuesdays, and will pick up the discontinued meds at that time. This surveyor informed her that the cabinet was overly full and the medications should not be stored in the med room for long periods of time. The medications were not controlled drugs but could easily be taken from the medication room.</p>		