STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425291	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Health & Rehab Center	831 McDow Drive Rock Hill, SC 29732

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 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. Based on observation, interview, and facility policy review, the facility failed to ensure raw meat was stored properly in the walk-in refrigerator. This deficient practice had the potential to affect all 6 residents who currently resided in the facility.Findings included:Review of the facility policy titled, Food and Supply Storage, revised 01/2026, indicated, Separate cooked and raw foods. Store ready-to-eat (including pasteurized eggs) and cooked food above raw food. If raw animal foods are stored on the same rack, store them in the following order from top of the rack to the bottom of the rack: raw shell eggs, fish, whole cuts of beef, pork, ground meat and poultry.During a concurrent interview and observation of the walk-in refrigerator in the kitchen on 02/23/26 at 10:28 AM with the Administrator and Clinical Dietician, there were three boneless pork tenderloins located on the second shelf above a covered bowl of coleslaw and a covered bowl of fruit cocktail. Also, there was 15 pounds of raw bacon above some tomatoes. The Clinical Dietician stated the raw pork tenderloin should not have been stored above the coleslaw and fruit cocktail and the raw bacon should not have been stored above the tomatoes because it could cause contamination to the residents if the raw meat dripped.During an interview on 02/25/26 at 2:23 PM, the Director of Nursing stated she expected raw meat to be stored properly.During an interview on 02/25/26 at 2:56 PM, the Administrator stated he expected food to be stored consistent with regulatory practices that governed the kitchen.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure transfer and discharge notifications were sent to a representative of the State Long Term Care (LTC) Ombudsman for 2 (Resident (R)6 and R8) of 2 sampled closed records reviewed. Findings included: A facility policy titled, Transfer or Discharge Notices, revised 03/2025, indicated, 3. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. 4. Notice of the State LTC Ombudsman will occur at the same time as the notice of discharge is provided to the resident and resident representative. 1. A Resident Face Sheet revealed the facility admitted R8 on 11/06/25. According to the Resident Face Sheet, the resident discharged home on [DATE]. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/15/25, revealed R8 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated there was an active discharge plan in place for the resident to return to the community. R8's Care Plan included a problem statement edited 12/16/25, that indicated the resident was to receive a comfortable transition home after the completion of the respite/LTC stay. Interventions directed staff to confer with all disciplines to ensure the discharge was safe and secure (initiated 11/12/25). R8's Transfer/Discharge Notice dated 01/06/26, indicated the resident discharged home. 2. A Resident Face Sheet indicated the facility admitted R6 on 12/24/25. According to the Resident Face Sheet, the resident discharged to a local hospital on [DATE]. R6's Transfer/Discharge Notice dated 12/30/25 indicated the resident had a change in medical condition and was transferred/discharged to the hospital. During an interview on 02/24/26 at 2:55 PM, the Director of Social Services (DSS) stated she was not providing a representative of the Office of the State LTC Ombudsman with resident discharge notices, but she was responsible for providing the Ombudsman with the notification. The DSS stated she had not sent R6's or R8's discharge notice to a representative of the Office of the State LTC Ombudsman. During a telephone interview on 02/25/26 at 12:56 PM, the Ombudsman stated she had not received a resident discharge notice from the facility since 05/25. During an interview on 02/25/26 at 2:20 PM, the Director of Nursing (DON) stated if the requirement was to send discharge notifications to the Ombudsman, then that was what they should do. The DON stated she was not aware the facility was not sending the notices to the Ombudsman. During an interview on 02/25/26 at 3:03 PM, the Administrator stated the facility would comply with the requirement.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and facility policy review, the facility failed to ensure their medication error rate was not greater than 5 percent (%). There were 2 errors out of 29 opportunities, which resulted in a medication error rate of 6.9% for 2 (Resident (R)9 and R11) of 3 residents observed for medication administration. Findings included:A facility policy titled, Administering Medications, revised 04/2019, indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame.1. A Resident Face Sheet indicated the facility admitted R9 on 12/01/25. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of allergic rhinitis.R9's Physician Order Report, for the timeframe 01/25/26 - 02/25/26, revealed an order dated 11/18/25, for Flonase allergy relief 50 micrograms (mcg) per actuation (spray), administer two sprays to each nostril once a day.During medication administration observation on 02/23/2026 at 3:34 PM, Registered Nurse (RN)1 prepared and administered R9's medications. RN1 administered Flonase allergy relief 50 mcg/spray to R9; however, she administered only one spray to each of the resident's nostril. Prior to exiting R9's room on 02/23/2026 at 4:00 PM, RN1 confirmed she administered one spray to each nostril for the Flonase nasal spray.During an interview on 02/24/26 at 3:56 PM, RN1 stated R9 was administered one spray of Flonase to each nostril. RN1 reviewed R9's physician orders and stated the physician order was for two sprays to each nostril. RN1 stated she should have administered two sprays of Flonase to each of the resident's nostrils.2. A Resident Face Sheet indicated the facility admitted R11 on 02/20/26. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of osteoporosis.R11's Physician Order Report, for the timeframe 01/25/26 - 02/25/26, revealed an order dated 02/21/26, for cholecalciferol 125 micrograms (mcg), give one capsule by mouth daily for supplement.During medication administration observation on 02/24/26 at 8:38 AM, Licensed Practical Nurse (LPN)2 administered one 25 mcg one tablet of cholecalciferol to R11 instead of the ordered dose of 125 mcg.During an interview on 02/24/26 at 11:56 AM, LPN2 provided and observed the bottle of cholecalciferol that was used for R11's medication administration. LPN2 confirmed the cholecalciferol bottle was 25 mcg and was what he administered. LPN2 reviewed R11's physician orders and stated the order was for 125 mcg, and he only gave one tablet.During an interview on 02/25/26 at 2:28 PM, the Director of Nursing (DON) stated she expected for the nurse to follow the physician orders and check the five rights of medication administration. The DON stated she expected the medication error rate to be less than 5%. The DON stated both residents should have received the correct dose of medication.During an interview on 02/25/26 at 2:55 PM, the Administrator stated his expectation was that all medications would be administered according to physician orders.