STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425332	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Charleston	2600 Elms Plantation Blvd N Charleston, SC 29406

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, observations, interviews, and record review, the facility failed to send quarterly statements to the resident and the resident's representative for Residents (R)42, R78, R118, R101, and R120.Findings include:Review of the facility's policy titled, Personal Needs Account, revised 12/15/16, revealed, All residents are eligible, but not required, to participate in the personal needs account. This allows the resident to place money in an interest-bearing checking account, which they can access for personal needs.Procedure:5. The resident will receive an account summary on a quarterly basis or at more frequent intervals at his/her request.Review of R42's electronic medical record (EMR) revealed R42 was admitted to the facility on [DATE]. Review of an undefined Minimum Data Set (MDS) revealed R42's Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating normal cognitive function.During an interview on 01/06/2026 at 01:15 PM, R42 stated, I do not have or receive any statements of funds. I know I get $30, but it goes to my bill.During an interview on 01/07/2026 at 12:37 PM, the Business Office Manager (BOM) stated, The Resident Representative (RR) gets the quarterly statement. If they are alert and oriented, the residents get their statements, and sometimes the RP. Some of the alert and oriented (A&O) residents don't get their statement, but the RR always gets the statement by mail.Review of R78's EMR revealed R78 was admitted on [DATE]. Review of an undefined MDS revealed R78's BIMS score of 03 of 15, indicating severe cognitive impairment.During an interview on 01/08/2026 at 2:22 PM, R78's RR called and stated, They are not receiving quarterly statements of personal funds. They stated they receive a lot of EOBs [explanation of benefits].A review of R120's facesheet revealed R120 was admitted to the facility on [DATE]. Review of an undefined MDS revealed R120 has a BIMS score of 14 of 15, indicating intact cognitive function.During an interview on 01/08/2026 at 02:35 PM, R120 stated, I don't think I have any money here.Review of R96's EMR revealed R96 was admitted on [DATE]. Review of an undefined MDS revealed R96's BIMS score of 11 of 15, indicating moderate cognitive function.During an interview on 01/08/2026 at 02:35 PM, R96 stated, No, I do not receive any statements.A review of R101's facesheet revealed R101 was admitted to the facility on [DATE]. Review of an undefined MDS revealed R101's Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating intact cognitive function.During an interview on 01/08/2026 at 03:04 PM, R101 stated, I do not receive any quarterly statements for my account.During an interview on 01/08/2026 at 04:40 PM, the BOM stated, I do not have proof of the quarterly statements I sent. I do not keep a log of the quarterly statements that I send to the RR. I can start doing that.During an interview on 01/08/2026 at 04:55 PM, the Administrator stated, I anticipate going forward to keep a log of the quarterly statements, the date and time, and who they were sent to. I will have the field controller educate on the proper way to keep records. We will be educated by corporate.

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and interview, the facility failed to initiate a Significant Change of Status Minimum Data Set (MDS) to reflect Resident (R)88's election for Hospice Services, for 1 of 2 residents reviewed for Hospice.Findings include:Review of the facility policy titled Resident Assessment Instrument and Care Plan Development with a reviewed date of 08/29/25, documented, Procedure The Resident Assessment Instrument is composed of the MDS, Care Area Assessments, and Utilization Guidelines . 2. MDS assessments are completed at a minimum upon admission, quarterly, annually, and with a significant change in patient status . 4. The Care Area Process begins with the Care Area Triggers are completed with the admission MDS, annual MDS, and with a significant change in patient status assessment. 5. The Care Area Triggers are derived from the information coded on the MDS that identify patients who have or at risk for developing specific functional problems that require further assessment . 8. The information identified using the MDS and Care Area Assessment process is used to develop an individualize person-centered Care Plan .Review of the facility policy titled Area of Focus: Hospice with a reviewed date of 12/02/25, documented, What Hospice Care: means a comprehensive set of services . identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill resident . How . Accurate and thorough assessment of the resident is fundamental in determining the resident's need for hospice services. The resident must receive a comprehensive assessment to provide direction for the development of the resident's care plan to address the choices and preferences of the resident who is nearing the end of life.Review of CMS's RAI Version 3.0 Manual dated [DATE], documented, . An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or change hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election .Review of R88's Face Sheet revealed R88 was admitted to the facility on [DATE], with diagnoses including, but not limited to, Alzheimer's Disease, anxiety disorder, major depressive disorder, single episode, purulent endophthalmitis, bilateral, pseudobulbar affect, and gross hematuria.Review of R88's Annual MDS with an Assessment Reference Date (ARD) of 12/02/25 revealed R88 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating R88 had severe cognitive impairment. Further review of the MDS did not indicate that R88 was receiving Hospice Services.Review of R88's 06/15/24 Quarterly MDS, 09/12/24 Quarterly MDS, 12/09/24 Annual MDS, 03/05/25 Quarterly MDS, 06/04/25 Quarterly MDS, and 09/03/25 Quarterly MDS, did not indicate R88 was receiving Hospice Services.Review of R88's Physician Order revealed, Interim Hospice admit date : [DATE] DX: Alzheimer's disease Review of R88's Care Plan with a review start date of 12/04/25 and a completed date of 12/09/25, documented, The resident has a terminal prognosis and receives hospice services through Interim.Review of R88's Referral Order dated 07/29/24, revealed, .HOSPICE & PALLATIVE MEDICINE REFERRAL. Will refer to hospice to admit to case load if appropriate w/ Interim hospice.Review of R88's Hospice admission Consent & Election of Hospice Services dated 07/30/24, documented, the effective date of election was 07/30/24.During an interview on 01/08/26 at 9:31 AM, the MDS Director stated, When we are notified, we open a significant change MDS for the resident. If someone goes on Hospice today, we start significant change of status with a 14-day ARD. We streamline the process, we talk about it in a meeting with the IDT team, once the eval is completed social services lets me know by email or text, and we look for the order, and I get started on the MDS. That's probably one that got missed. I don't see it.During an interview on 01/08/26 at 9:42 AM, the Administrator and Director of Nursing (DON) stated there was a lack of communication during that time frame. But now we have a process in place that ensures that is done. Now it's a whole discussion whenever a resident goes on hospice.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, observations, and staff interviews, the facility failed to identify, assess, and implement appropriate care-planned interventions to address 1 of 1 resident's known behavior of manipulating prescribed oxygen flow rates. This failure placed the resident at risk for receiving oxygen inconsistent with physician orders, and increased the risk for potential respiratory complications, including but not limited to oxygen toxicity or masking of changes in the resident's condition. Findings include:Record review of the Facility Policy titled, Oxygen Administration (Infection Control, Safety, & Storage last revised on 09/30/2025 and reviewed on 09/24/2024 revealed The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals and preferences, and 483.65 of this subpart.Record review of Resident (R)18's Face Sheet revealed that R18 was admitted to the facility on [DATE] with diagnoses including but not limited to congestive heart failure and chronic obstructive pulmonary disorder. Review of R18's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 14 out of 15, which indicates that she is cognitively intact. Further review of the admission MDS revealed that R18 receives Respiratory Therapy, as a special treatment. During a resident interview on 01/06/2026 at 10:41 AM, R18 stated that her Oxygen (O2) concentrator in her room is malfunctioning and the facility had to provide her with a portable tank. A portable tank was observed on the back of R18's wheelchair. Additionally, the control knob on the oxygen regulator of the portable tank was observed to be set at 3L (liters)/minute. R18 further complained that her tank ran out of O2 and no one realized it. She went on to explain that staff had to increase her O2 level to more than what she needed to get her back to a comfortable state.During a second interview with R18 on 01/07/2026 at 03:35 PM, R18 stated that her O2 level is at 3L and she prefers it that way. R18 further explained that her O2 Concentrator is working, but just does not feel as good as her portable tank. When R18 was advised that her O2 order was for 2L, R18 offered no further comment. Again, R18's oxygen rate was observed 3L/PM via a portable tank placed on the back of her wheelchair. Additionally, her O2 concentrator with a humidifier bottle (labeled 01/04/2026) was sitting by her bedside. During an interview on 01/07/2026 at 03:55 PM, Licensed Practical Nurse (LPN)4 stated the R18's oxygen level on her portable tank was set at 2L earlier in the day. When LPN4 was advised that the Liters Per Minute (LPM) was currently at 3LPM, LPN4 explained that she has attempted to explain to the resident that the prescribed O2 level is to be maintained per physician's order, but R18 has not cooperated and has remained non-compliant. Record review on 01/07/2026 at 04:23 PM of R18's Care Plan revealed two (2) respiratory-related care plans:1. The resident has an altered respiratory status/difficulty breathing related to CHRONIC RESPIRATORY FAILURE WITH HYPOXIA. The resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date. Administer medication/puffers as ordered. Maintain a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as ordered/required to clear secretions. Observe for changes in orientation, increased restlessness, anxiety, and air hunger.2. The resident has Emphysema/COPD. The resident will display optimal breathing patterns daily through review date. Avoid extremes of hot and cold. Give aerosol or bronchodilators as ordered. Observe for any side effects and effectiveness. Observe for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance. OXYGEN SETTINGS: O2 via n/c as ordered.Record review on 01/07/2026 at 04:36 PM revealed R18 had a Physician's Order dated 12/23/2025 for oxygen continuously at two liters per minute via nasal cannula. Record review on 01/08/2026 at 09:53 AM revealed R18 also had an order for Oxygen on an (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Order Summary Report-(Active Orders As of: 01/06/2026): Oxygen at 2 liters/minute continuously per nasal cannula. Document every shift. Order Date: 12/23/2025, Start Date: 12/23/2025, End Date: NONE.Record review on 01/08/2026 at approximately 09:54 AM revealed an updated order for Oxygen on an Order Summary Report-(Active Orders As of: 01/08/2026): Oxygen at 3 liters/minute continuously per nasal cannula. Document every shift. Order Date: 01/07/2026, Start Date: 01/07/2026, End Date: NONEDuring an interview with the Director of Nursing on 01/08/2026 at 01:37 PM, it was stated that her expectation is for Oxygen therapy to be provided according to physician's orders.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's policy, observations, interviews, and record review, the facility failed to ensure ostomy care was provided in accordance with professional standards, as no physician order for ostomy care was in place for 1 of 1 resident.Findings Include: Review of the policy titled, Colostomy and Ileostomy Care last revised on 09/20/2021 and reviewed on 09/04/2025 revealed on page 1 of 12 that, A physician's order will be obtained for ostomy care to include specific physician preference regarding appliance, skin barrier, and skin care. Record review of R129's Face Sheet revealed he was admitted on [DATE] with the diagnoses including but not limited to congestive heart failure, atrial fibrillation, dementia, insomnia, hyperlipidemia, colostomy, and need for assistance with personal care. Record review of R129's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/2026 revealed that R129 has the Brief Interview of Mental Status (BIMS) score of 12 out of 15, which indicates moderate cognitive impairment. Further review of the admission MDS revealed that R129 was admitted with an Ostomy Appliance under Section H of the Bladder and Bowel section. During an observation and interview on 01/07/2026 at 10:07 AM, R129 was observed lying in bed with no apparent distress. During a brief interview on 01/07/2026 at 10:08 AM, R129 stated that his ostomy was not understood and the staff member that attempted to change it did not know exactly how to manage it. During an interview on 01/07/2026 at approximately 01:30 PM with both Licensed Practical Nurse (LPN)4 and LPN3, R129's ostomy care was discussed. LPN4 stated that R129 is receiving ostomy care but was unable to locate an order. LPN3 further explained that R129's stool is very loose and that the ostomy appliance was leaking at the bottom.he will eat and then go fill it right up. Upon further discussion and an observation of LPN4 reviewing the chart, LPN4 stated, I don't see anything from Wound Care Nursing (WOCN) or an order for ostomy care.where is it? No, I don't see anything from wound care? When asked what type of supplies were used for R129's ostomy care, LPN4 stated that the facility uses their own supplies usually, but that most recently, she used his supplies that are in his drawer and the supplies he came with. During an interview on 01/08/2026 at 01:37 PM, the Director of Nursing (DON) was unable to verify a physician's order for ostomy care. The DON went on to explain, I'll make sure that order gets in. We have our own wound nurse here that I can have speak with you right away. During an interview on 01/08/2026 at approximately 01:39 PM with LPN5, the Wound Care Nurse (WOCN) stated that ostomy care is usually addressed when they do their rounds. The WOCN further stated, I don't see orders. Ostomy appliances are usually checked and changed every shift and/or changed on an as needed basis. When asked to walk through the admission and ostomy appliance care process, LPN4 (WOCN) stated that usually report is called into the receiving LPN, but the facility does not know definitively until the resident arrives at the facility. After arrival, orders are usually placed, as appropriate. Then ostomy care is provided based on the order that usually entails a good cleaning, skin prep, and then a wafer and bag. LPN4 (WOCN) went on to explain how it is changed once weekly depending on the type of bag system and checked every shift. LPN4 (WOCN) also stated, I am always open to teaching them. R129's Medication Administration Record/Treatment Administration Record (MAR/TAR) was initially reviewed and printed on [DATE] at 12:25:44 EST. It was dated from 1/1/26 to 1/31/26. It revealed only two (2) references to Ostomy care-No Ostomy Care indicated (OLD):Medical Condition: COLOSTOMY STATUS (Z93.3)Enhanced Barrier Precautions Diagnosis: Colostomy every shift -Order Date [1]01/07/2026 1603