STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425333	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - Lexington	2993 Sunset Blvd 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of facility policy, observation, and interview, the facility failed to ensure medications were not pre-poured prior to administration for 3 of 3 residents observed during medication administration. Findings include:Review of the facility policy titled, Medication Administration Policy dated 01/01/26 revealed, Policy Statement: Medication shall be prepared and administered safely, accurately, and in accordance with physician orders, professional standards of nursing practice, and all applicable federal and state regulation. Medication Preparation. Pre-pouring is permitted ONLY for a single resident.During observation on 04/01/26 at 7:45 AM, of medication administration revealed, in the medication cart drawer were 3 medication cups labeled with residents' last names which contained tablets and capsules. The first medication cup was for Resident (R)137. The second medication cup was for R132 and the third medication cup was for R165. Prior to administering the medications, Registered Nurse (RN)1 provided this surveyor with the empty pill pouches next to each resident's medication cup. This surveyor took the empty pill pouches for each resident to determine the contents in the medication cups. During an interview on 04/01/26 at approximately 7:45 AM, RN1 was asked about pre-pouring medications for multiple residents, RN1 replied, I always prepare my medications this way. It helps me stay on time. RN1 was than asked, how she ensures the medication cups contain the medications she originally put in, RN1 stated, I am the only one with the keys to this cart, so I am the only one who can get into it.During the medication administration observation on 04/01/26 at 7:45 AM, the Director of Nursing (DON) was present, after the DON left, RN1 stated, I think she was telling me I shouldn't have prefilled the medication cups.During an interview on 04/01/26 at 8:15 AM, the DON asked this surveyor how RN1 performed during the medication administration. This surveyor reported there did not appear to be any errors, however, this surveyor expressed concerns about the pre-pouring of the medications. The DON stated, I agree. During a follow-up interview on 04/02/26 at approximately 2:45 PM, the DON stated she had talked with RN1, who denied pre-pouring the medication cups. The DON denied having observed multiple pre-poured medication cups in the medication cart drawer. The DON denied agreeing with the surveyor about pre-pouring medication cups immediately after the medication administration on 04/01/26. The DON verified their policy is to allow pre-pouring of medication for only one resident and again stated RN1 told her that she did not pre-pour multiple resident's medications.

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