STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425337	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Columbia	2514 Faraway Drive 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)
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 the Resident Assessment Instrument (RAI) Manual, record review, interview and facility policy, the facility failed to complete and submit a significant change Minimum Data Set (MDS) within 14 days after the facility determined that there had been a significant change in Resident (R55)'s physical or mental condition for 1 of 17 residents reviewed for completion of comprehensive assessment after a significant change. Findings include: Review of the facility policy titled Resident Assessment Instrument and Care Plan Development, with a revision date of 09/05/24, documents, Policy: The facility will follow the procedures set forth in the Resident Assessment Instrument (RAI) Users Manual 3.0 when completing the MDS, Care Area Assessment, and Comprehensive Care Plan. 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. 3a. The instructions for completing the RAI are found in the Centers for Medicare & Medicaid Services Long - Term Care Facility Resident Assessment Instrument User's Manual 3.0. 8. The information identified using the MDS and Care Area Assessment process's is used to develop an individualized person - centered Care Plan that includes the patient's voice, the patient's goals while residing in the facility and for discharge that assist the patient to attain and/or maintain their highest practicable level of well - being. 9. The RAI is not all inclusive therefore other sources of information are to be included when developing an individualized person - centered care plan for each patient that is reviewed by the interdisciplinary team with each assessment including the patient and other participants as the patient desires. Review of R55's Face Sheet revealed that R55 was admitted to the facility on [DATE], with diagnoses including but not limited to: metabolic encephalopathy, Alzheimer's disease, depression, anxiety disorder and type 2 diabetes mellitus. Review of R55's Significant Change MDS with an Assessment Reference Date (ARD) of 04/01/25, revealed the assessment was still in progress and was not submitted. Review of R55's Quarterly MDS with an ARD of 05/13/25, revealed the assessment was still in progress and was not submitted. (continued on next page)

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	During an interview with MDS Coordinator 1 on 06/18/25 at 6:20 PM revealed that the time frame for submission of a MDS assessment according to the RAI is 14 days, the facility's expectation is 5 days for a Medicare assessment and 14 days for all other assessments. MDS Coordinator 1 stated there is no documentation of this expectation, I received that information from the previous regional. The MDS schedule is reviewed every morning in stand up meeting at 9 AM. The clinical dashboard in PCC (electronic medical record) indicates when an assessment is due. Everyone has access, it is expected to be reviewed each morning. This facility has a chronic or historic issue of submitting assessments late, the number is not an accurate representation of what is truly late, being that information was behind when I first took the position. I am currently not up to date. During an interview with the Director of Nursing (DON) and the Administrator on 06/19/25 at 9:16 AM, revealed, the Administrator was notified yesterday regarding MDS assessments that are late. The DON revealed that she was notified regarding the late MDS assessments this morning. The DON revealed that her expectations are for the late assessments to be completed. The MDS nurses should communicate with her the departments that are behind completing the MDS so that she can make sure those departments complete the assessments in a timely manner. The Administrator revealed his expectations are that we go over the MDS calendar in morning meeting and review each MDS that is due. Each MDS should be completed timely and verified with me daily. During an interview with MDS Registered Nurse (RN)2 on 06/19/25 at 2:54 PM revealed, the significant change MDS on 04/01/25 was due to a wound greater than a stage 2. We give the wound 14 days to heal if facility acquired. We were waiting on section F which is the activities section. MDS RN2 stated I don't know how floor staff would know how to take care of a resident if the MDS is not submitted and the care plan is not updated. MDS assessments that are due are also gone over during morning meeting. The MDS team will also give department heads a list of patients with MDS assessments which needs to be completed by department heads and the dates that assessments are due and required dates that the assessments need to be submitted. The CNAs on the floor would not know any new care plan interventions for a resident if the MDS is not completed and submitted because the care plan would not be updated and the kardex would then not be updated.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument (RAI) Manual, record review, interviews and review of facility policy, the facility failed to ensure comprehensive assessments were initiated, completed, submitted, or exported for 17 out of 17 residents reviewed for resident assessments, Resident (R)65, R28, R96, R46, R106, R91, R30, R31, R15, R88, R62, R75, R37, R9, R105, R50 and R55. Findings include: Review of the facility policy titled Resident Assessment Instrument and Care Plan Development, with a revision date of 09/05/24, documented, Policy: The facility will follow the procedures set forth in the Resident Assessment Instrument (RAI) Users Manual 3.0 when completing the MDS, Care Area Assessment, and Comprehensive Care Plan. 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. 3a. The instructions for completing the RAI are found in the Centers for Medicare & Medicaid Services Long - Term Care Facility Resident Assessment Instrument User's Manual 3.0. 8. The information identified using the MDS and Care Area Assessment process is used to develop an individualized person - centered Care Plan that includes the patient's voice, the patient's goals while residing in the facility and for discharge that assist the patient to attain and/or maintain their highest practicable level of well - being. 9. The RAI is not all inclusive therefore other sources of information are to be included when developing an individualized person - centered care plan for each patient that is reviewed by the interdisciplinary team with each assessment including the patient and other participants as the patient desires. Review of the RAI Version 2.0 Manual, Chapter 5: Submission and Correction of the MDS Assessments documented, MDS assessments are edited to verify that clinical responses are within valid ranges, dates are reasonable, and assessments are consistent with the previous assessments completed for the same resident. The facility is notified of the results of this evaluation on the Initial Feedback Report or the Final Validation Report. Timeliness Criteria: Assessment Transmission: Comprehensive assessments must be transmitted electronically within 31 days of the Care Plan Completion Date (VB4). All other MDS or MPAF assessments must be submitted within 31 days of the MDS Completion Date (R2b). Review of R65's Face Sheet revealed that R65 was admitted to the facility on [DATE], with diagnoses including but not limited to: traumatic hemorrage of cerebrum, occipital condyle fracture, dementia and type 2 diabetes mellitus. Review of R65's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/10/25, revealed the assessment was not initiated and was 25 days overdue. Review of R28's Face Sheet revealed that R28 was admitted to the facility on [DATE], with diagnoses including but not limited to: other complications of gastrostomy, type 2 diabetes mellitus with diabetic neuropathy, dementia and chronic lymphocytic leukemia of B-cell type. Review of R28's Quarterly MDS with an ARD of 05/08/25, revealed the assessment was still in progress, not submitted and 27 days overdue. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R96's Face Sheet revealed that R96 was admitted to the facility on [DATE], with diagnoses including but not limited to: Parkinson's Disease without dyskenesia without mentions of fluctuations, dementia, type 2 diabetes mellitus and bipolar disorder. Review of R96's Quarterly MDS with an ARD of 05/03/25, revealed the assessment was still in progress and not submitted. The assessment was 32 days overdue. Review of R46's Face Sheet revealed that R46 was admitted to the facility on [DATE], with diagnoses including but not limited to: nondisplaced fracture of seventh cervical vertebra, type 2 diabetes mellitus, late onset dementia and adjustment disorder with mixed disturbance of emotions and conduct. Review of R46's Quarterly MDS with an ARD of 05/14/25, revealed the assessment was still in progress and not submitted. The assessment was 21 days overdue. Review of R106's Face Sheet revealed that R106 was admitted to the facility on [DATE], with diagnoses including but not limited to: type 2 diabetes mellitus, schizophrenia, anxiety disorder and depression. Review of R106's Quarterly MDS with an ARD of 04/19/25, revealed the assessment was still in progress and was not submitted. The assessment was 46 days overdue. Review of R91's Face Sheet revealed that R91 was admitted to the facility on [DATE], with diagnoses including but not limited to: fracture of head and neck of right femur, nontramatic subarachnoid hemmorage, cerebral infarction due to embolism of left cerebral middle artery and type 2 diabetes mellitus. Review of R91's Quarterly MDS with an ARD of 05/04/25, revealed the assessment was still in progress and was not submitted. The assessment 31 days overdue. Review of R30's Face Sheet revealed that R30 was admitted to the facility on [DATE], with diagnoses including but not limited to: cerebral infarction, flaccid hemiplegia affecting right dominant side, aphasia and type 2 diabetes mellitus. Review of R30's Quarterly MDS with an ARD of 04/19/25, revealed the assessment was still in progress and was not submitted. The assessment 46 days overdue. Review of R31's Face Sheet revealed that R31 was admitted to the facility on [DATE], with diagnoses including but not limited to: sequelae of cerebral infarction, type 2 diabetes mellitus, hypovolemic shock and peripheral vascular disease. Review of R31's Quarterly MDS with an ARD of 05/05/25, revealed the assessment was still in progress and was not submitted. The assessment was 30 days overdue. Review of R15's Face Sheet revealed that R15 was admitted to the facility on [DATE], with diagnoses including but not limited to: lobar pneumonia, schizoaffective disorder, chronic viral hepatitis C and hypertension. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R15's admission MDS with an ARD of 12/11/23, revealed the assessment was not initiated and was 557 days overdue. Review of R88's Face Sheet revealed that R88 was admitted to the facility on [DATE], with diagnoses including but not limited to: severe protein-calorie malnutrition, dementia, major depressive disorder and latent tuberculosis. Review of R88's Quarterly MDS with an ARD of 04/06/25, revealed the assessment was still in progress and was not submitted. The assessment was 59 days overdue. Review of R62's Face Sheet revealed that R62 was admitted to the facility on [DATE], with diagnoses including but not limited to: acute embolism and throbosis of left femoral vein, Alzheimer's disease, sick sinus syndrome and long QT syndrome. Review of R62's Annual MDS with an ARD of 03/31/25, revealed the assessment was completed but not exported. The assessment remained in the que and was ready for export on 03/31/25, however was not exported. Review of R75's Face Sheet revealed that R75 was admitted to the facility on [DATE], with diagnoses including but not limited to: non-ST, elevation myocardial infarction, type 2 diabetes mellitus, asthma and anxiety disorder. Review of R75's Quarterly MDS with an ARD of 04/14/25, revealed the assessment was still in progress and was not submitted. The assessment was 15 days overdue. Review of R37's Face Sheet revealed that R37 was admitted to the facility on [DATE], with diagnoses including but not limited to: atherosclerotic heart disease of native coronary artery without angina pectoris, hypertensive heart disease without heart failure, dysphagia and depression. Review of R37's Quarterly MDS with an Assessment Reference Date (ARD) of 04/17/25, was still in progress and was not submitted. The assessment was 48 days overdue. Review of R9's Face Sheet revealed that R9 was admitted to the facility on [DATE], with diagnoses including but not limited to: spinal stenosis, acute respiratory failure, paranoid schizophrenia and Alzheimer's disease early onset. Review of R9's Quarterly MDS with an ARD of 05/14/25, revealed the assessment was still in progress and was not submitted. The assessment was 14 days overdue. Review of R105's Face Sheet revealed that R105 was admitted to the facility on [DATE], with diagnoses including but not limited to: displaced intertrochanteric fracture of left femur, pulmonary fibrosis, emphysema, and type 2 diabetes. Review of R105's Quarterly MDS with an ARD of 05/14/25, revealed the assessment was still in progress and was not submitted. The assessment was 114 days overdue. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R50's Face Sheet revealed that R50 was admitted to the facility on [DATE], with diagnoses including but not limited to: cerebral infarction, vascular dementia, chronic kidney disease stage 3 and type 2 diabetes mellitus. Review of R50's Quarterly MDS with an ARD of 05/06/25, revealed the assessment was not started. The assessment was 43 days overdue. Review of R55's Face Sheet revealed that R55 was admitted to the facility on [DATE], with diagnoses including but not limited to: metabolic encephalopathy, Alzheimer's disease, depression, anxiety disorder and type 2 diabetes mellitus. Review of R55's Significant Change MDS with an ARD of 04/01/25, was still in progress and was not submitted. Further review of R55's Quarterly MDS with an ARD of 05/13/25, revealed the assessment was still in progress and was not submitted. The assessment was 44 days overdue. During an interview with the MDS Coordinator on 06/18/25 at 6:20 PM, revealed that the time frame for submission of a MDS assessment according to the RAI is 14 days, the facility's expectation is 5 days for a Medicare assessment and 14 days for all other assessments. There is no documentation of this expectation, I received that information from the previous regional. The MDS Coordinator stated the MDS schedule is reviewed every morning in stand up meeting at 9 AM. The clinical dashboard in PCC (electronic medical record) indicates when an assessment is due. Everyone has access, it is expected to be reviewed each morning. The Executive Director (ED) and DON are notified if a part of the MDS is not completed in a timely manner. This facility has a chronic or historic issue of submitting assessments late, the number is not an accurate representation of what is truly late, being that information was behind when I first took the position. I am currently not up to date. The MDS Coordinator further stated, there is someone that is overseeing the area until someone is hired. We are not able to complete and submit the MDS because we are restricted by other areas. If the MDS is ready for export and not exported, it means its just sitting in the que, but nothing should be sitting in the que since March. During an interview with the Director of Nursing (DON) and the Administrator on 06/19/25 at 9:16 AM, revealed, the Administrator was notified yesterday regarding MDS assessments that are late. The DON revealed that she was notified regarding the late MDS assessments this morning. The MDS department reports to the DON. The DON revealed that her expectations are for the late assessments to be completed. The MDS nurses should communicate with her the departments that are behind completing the MDS so that she can make sure those departments complete the assessments in a timely manner. The MDS nurses should be showing us the calendar so that we are aware of what assessments are due. The Administrator revealed his expectations are that we go over the MDS calendar in morning meeting and review each MDS that is due. Each MDS should be completed timely and verified with me daily. During an interview on 06/19/25 at 9:57 AM, the Activities Director revealed, I do complete the Activities portion of the MDS. The MDS woman [name] will tell me when an assessment is due. I have not received a calendar. I am behind on assessments. I got behind on the last couple of days since you all have been here. The MDS is for Medicaid clearance. My section is important to make sure we are doing what we should do for the residents. The admission MDS is due three days after the resident's admission. I don't know when the assessments are due after that. I'm just given a date that I need to complete it. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/19/25 at 10:59 AM, the Director of Social Work revealed, Yes, I complete part of the MDS. One way I know when an MDS is due is by the MDS print off. Another way is a calendar but that has not been distributed in 2 or 3 weeks. The calendar comes from MDS. I saw it in the morning meeting and I liked it and asked for a copy. I received it twice and then have not seen it again. I have gotten behind but we do try to catch up. I know when an MDS is due by the MDS nurse telling me, Point Click Care (electronic medical record) and by printing off the MDS list. I am sure that there are some sections that need to be caught up and we will catch them up. The MDS is submitted to whomever and that is how we get paid. The MDS is also how we look at the overall functioning of the residents and how to care for the residents. Assessments are important for the overall functioning of the resident as well as communicating the status of a resident. In the future, my assistant and I will complete the MDS by the end of the day. During an interview with MDS Registered Nurse (RN) on 06/19/25 at 2:54 PM, revealed we were waiting on section F which is the activities section. The MDS RN stated, I don't know how floor staff would know how to take care of resident if the MDS is not submitted and the care plan is not updated. The MDS RN revealed that the MDS team emails department heads about outstanding MDS assessments that need be completed. MDS assessments that are due are also gone over during morning meeting. The MDS team will also give department heads a list of patients with MDS assessments which needs to be completed by department heads and the dates that assessments are due and required dates that the assessments need to be submitted. The Certified Nursing Assistants on the floor would not know any new care plan interventions for a resident if the MDS is not completed and submitted because the care plan would not be updated and the kardex would then not be updated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to accurately code the quarterly Minimum Data Set (MDS) assessment for Resident (R)105, specifically coding a glucagon-like peptide receptor agonist (GLP-1) as insulin for 1 out of 17 residents reviewed for resident assessments. Findings include: Review of the facility policy titled Certification of Accuracy of the MDS revised on 04/22/25, states, The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The Observation Period (also known as the Look-back period) is the time frame over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Review of R105's Face Sheet revealed R105 was admitted to the facility on [DATE], with diagnoses including, but not limited to, type 2 diabetes mellitus. Review of R105's Quarterly MDS with an ARD of 02/24/25 and a completion date of 02/25/25, revealed a 1 coded for the number of days that insulin injections were received during the last seven days of the look back period. Review of R105's Quarterly MDS with an ARD of 05/27/25 and a completion date of 06/10/25, revealed a 1 coded for the number of days that insulin injections were received during the last seven days of the look back period. Review of R105's Orders with a start date of 12/25/24, revealed an order for, Trulicity Subcutaneous Solution Auto-injector 1.5 MG/0.5ML (Dulaglutide) Inject 1.5 mg subcutaneously one time a day every Wed for DM. Further review of the Orders did not reveal an order for insulin. Review of R105's Medication Administration Record (MAR) for 02/25 and 05/25, revealed no order for insulin and no administration of insulin. During an interview with MDS Coordinator 1 and MDS Coordinator 2 on 06/18/25 at 6:45 PM, MDS Coordinator 1 confirmed Trulicity is a GLP-1 medication and not insulin. MDS Coordinator 2 questioned whether Trulicity was insulin. MDS Coordinator 1 stated they were trained by the prior regional MDS Director, who is no longer with the company, to code Trulicity as insulin in the MDS. Both were unable to provide documentation to support this. During an interview with the Administrator on 06/19/25 at 5:33 PM, revealed he has begun to put a plan in place to correct the MDS errors. The Administrator stated the new Director of Nursing, who takes over Monday, has also begun putting controls in place regarding the MDS process.

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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 foods that were are stored in the freezer, coolers, and dry food storage were appropriately sealed, labeled, dated, and/or discarded after the manufacturer's expiration date in 1 of 1 walk in freezer, 1 of 1 walk in cooler, and 1 of 1 dry storage room. This had the potential to affect all residents who received meals from the kitchen. Findings include: Review of the facility policy, revised on 04/26/23, titled, Food Safety, revealed, food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. Food Safety Policy Food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. 2. Pre-packaged food is placed in a leak-proof, pest-proof, non-absorbent, sanitary (NSF) container with a tight-fitting lid. The container is labeled with the name of the contents and date (when the item is transferred to the new container). 'Use by Date' is noted on the label or product when applicable. 3. The 'use by date' guide is easily accessible to all associates involved with resident for storage. 6. Dented, leaky, rusted and swelling cans that could affect food safety are returned to the vendor but stored in a designated area away from other food. These items will not be used. Dry Storage 2. Opened packages of food are resealed tightly to prevent contamination of the food item and 'use by date' will be used when applicable. Review of the facility policy, revised on 04/30/23, tiled Safe Food Handling revealed, all food purchased, stored and distributed is handled with accepted food-handling practice and per federal, state and local requirements. 5. Food that is not stored, prepared, handled and/or consumed in any area which food may be contaminated . Review of the facility undated policy, titled, Use by Date revealed, The following guide can be used to determine a use by date for labeling food (opened or unopened) that should be used within a certain time frame. All opened containers of food in the dry storage area should be placed in an enclosed container, labeled, and dated with the open date and the use by date. Any unopened cans/packages should be marked with the date received. After opening, the above guideline is followed regarding opened containers of food. During an initial observation on 06/17/25 at 9:30 AM, the Dry Storage Room revealed the following: 1 - 62 ounce (oz) can mushroom pieces and stems- dented on rack for use. 1 - gallon jug Worcestershire sauce was open with no open date or use by date. 1 - 10 pound (lb) bag rainbow sprinkles with no open date. 1 - 7.5 lb jug Old Bay seasoning with the top covered with white debris, labeled in 04/08/25 out 05/08/25, no clear expiration or best by date. At 9:56 AM the walk in cooler revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1 - box of bacon strips open on top shelf, labeled shelf life 6/17 use by 6/24 and not properly sealed. 1 - gallon dill pickle chips with an open date of 05/03/25 and a use by date of 05/03/25. 1 - gallon jug sliced jalapeno peppers with no open or use by date. 1 - gallon jug container mayonnaise, marked R (received) 6/5 no open or used by date. 1 - gallon barbeque sauce, marked R date 6/5 no open or use by date. 1 - 8.44 lb container mild chunky salsa dates 4/24 use by 5/24. 1 - 5 lb container sour cream with a best by date of 06/04/2, no open or use by date. 1 - 5 lb container low fat cottage cheese with a best by date of 05/10/25, no open date. 1 - 48 oz block cream cheese with a best by date of 05/27/25. 1 - 5 lb container ricotta cheese with a best by date of 03/20/25. 2 - 5 lb container ricotta cheese with a best by date of 05/01/25; 1 - bag fresh cut vegetables/cabbage with no open or use by date. 1 - bag iceburg lettuce with a use by date of 06/14/25 with no open date. At 10:20 AM the freezer revealed the following: 1 - bag French fries was opened with no open date and not sealed properly. During an interview on 06/18/25 at 4:45 PM, the Dietitian revealed that she does a monthly walk through of the kitchen and once it's complete she provides a report to the Executive Director, the Dietary Manager and the Director of Nursing. The Dietitian stated that during her walk through she is looking for anything that may be expired, that the walk-in refrigerator and freezer temperature are at the right temperature, that the logs are properly completed, that items are properly dated with an open and use by date, check for the cleanliness of the floors, ceilings and that the staff are performing proper sink sanitation. The Dietitian further stated that she has provided a printout of a use by guide for staff to refer to for properly dating food items, and she advises them to memorize it because it is a daily task. The Dietitian further explains that for any food items in the area past its use by date it should be discarded, and if items are opened and dated and past the use by date, items should be discarded. The Dietitian concluded that her expectation is that any items open should be labeled with an open date and a use by date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425337	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Columbia	2514 Faraway Drive Columbia, SC 29223

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/18/25 at 5:06 PM, the Dietary Manager (DM) revealed that items are labeled with received date, when they are delivered to the facility, and then when an item is opened staff will put a tag on it marking it with a prep/open date and an expiration/use by date. That date will vary depending on the item. The DM stated that the use by date and expiration date are determined by a national data base, use by recommendation and the facility policy. The DM further stated that all items should be discarded if opened and not labeled with an open/use by label for dry storage, coolers and freezers, and any items beyond the use by date needs to be discarded immediately. The DM concluded that he does a daily walk through of the kitchen and if he is not here, the walk through should be done by his assistant or chef on duty. During an interview on 06/18/25 at 5:41 PM, the Administrator revealed that the DM oversees the kitchen, however he does walk through the kitchen once a week and sometimes more. The Administrator stated that during the walk through he checks the vents, the sprinklers to make sure there is no build up on them, checks the rinse area, temperature logs, makes sure there are no fall hazards, check the three compartment sink, the freezer and cooler to make sure everything is labeled properly, checks to ensure that there is nothing too close to the ceiling. The Administrator stated he walked through the kitchen about a week ago and did not notice anything in the walk-in cooler. The Administrator further revealed that his expectation is that if items are beyond the use by date they should be discarded and he expects that the kitchen is clean.