

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Opus Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Agape Drive 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47075</p> <p>Based on observation, interview, and review of facility policy, the facility failed to promote a homelike dining experience. Specifically, the facility failed to ensure staff did not stand to assist residents with the meals for one (1) of one (1) dependent resident (Resident (R)8). Additionally, the facility failed to remove the plated food, eating utensils, and drinks from the serving tray onto the table for three (3) of three (3) residents that dined communally (R1, R2, and R9).</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Resident Rights revised on 10/2015 revealed, . It is the policy of this facility that all residents be treated with kindness, dignity and respect.</p> <p>During a dining observation and interview on 04/15/25 at 12:20 PM, R1, R2, and R9 dined communally in the main dining room, where they all ate directly from the tray the meals were served on. R9 stated, They don't move the tray.</p> <p>During an interview on 04/16/25 at 3:17 PM, the Director of Nursing (DON) confirmed the staff did not remove the serving trays or place the resident's plated meal, eating utensils, or drinks on the table to encourage a homelike experience. The DON stated, It is the expectation that staff should always remove the food from the serving trays, when serving meals to residents.</p> <p>During an observation on 04/15/25 at 1:15 PM, R8 was in bed, with the head of bed elevated approximately 35 degrees, and both of R8's hands drawn to the chest. The Certified Nursing Assistant (CNA)3 stood at the bedside and assisted the resident with the meal, during the 5-minute observation.</p> <p>Review of R8's Face Sheet revealed R8 was admitted to the facility on [DATE], with diagnoses including but not limited to: spinal stenosis, and fusion of spine with quadriplegic (paralyzed from the neck down).</p> <p>Review of R8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/25, revealed R8's Brief Interview for Mental Status (BIMS) score was 13 out of 15, indicating R8's cognition was intact, further review of the MDS revealed R8 was dependent on staff for assistance with meals and activities of daily living (ADL).</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/15/25 at 1:20 PM, CNA3 confirmed she stood to assist the resident with the meal. CNA3 stated, He's a feeder. I know I should sit to feed residents, but I stand with him because it is easier for him.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47075</p> <p>Based on review of facility policy, observation, record review and interview, the facility failed to ensure call lights were within reach for 6 of 13 residents reviewed. Additionally, the facility failed to ensure that a resident wheelchair arms were not in need of repair, for 1 of 1 resident.</p> <p>Findings include:</p> <p>Review of the facility's Call Light/Bell policy, revised on 05/2007, revealed, . It is the policy of this facility to provide the resident a means of communication with nursing staff . Place the call device within resident's reach before leaving room.</p> <p>Review of R1's Electronic Medical Record (EMR) revealed R1 had an admitted [DATE], with diagnoses including but not limited to: unspecified dementia, unspecified severity, with agitation, repeated fall, other sequelae of cerebral infraction, muscle weakness, restlessness and agitation.</p> <p>Review of R1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/02/24, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicates R1 suffered from severe cognitive impairment.</p> <p>Review of R3's EMR revealed R3 had an admitted [DATE], with diagnoses including but not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, type 2 diabetes mellitus with unspecified complications, major depressive disorder, recurrent, mild, and muscle weakness.</p> <p>Review of R3's MDS with ARD of 12/18/24, revealed R3 had a BIMS score of 14 out of 15, which indicates R3 was cognitively intact.</p> <p>Review of R4's EMR revealed R4 had an admitted [DATE], with diagnoses including but not limited to: history of falling, muscle weakness, and need for assistance with personal care.</p> <p>Review of R4's MDS with an ARD of 12/13/24, revealed R4 had a BIMS score of 10 out of 15, which indicates R4 suffered from moderate cognitive impairment.</p> <p>Review of R5's EMR revealed R5 had an admitted [DATE], with diagnoses including but not limited to: hemiplegia and hemiparesis following cerebral infarction and diffuse traumatic brain injury.</p> <p>Review of R5's MDS with an ARD of 03/11/25, revealed R5 had a BIMS that was not completed.</p> <p>Review of R6's EMR revealed R6 had an admitted [DATE], with diagnoses including but not limited to: muscle wasting and atrophy, and muscle weakness.</p> <p>Review of R6's MDS with an ARD of 07/23/24, revealed R6 had a BIMS score of 8 out of 15, which indicates R6 suffered from moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R9's EMR revealed R9 had an admitted [DATE], with diagnoses including but not limited to: limited sequelae of cerebral infarction.</p> <p>Review of R9's MDS with an ARD of 01/29/25, revealed R9 did not complete a BIMS.</p> <p>Review of R12's EMR revealed R12 had an admitted [DATE], with diagnoses including but not limited to: unsteadiness on feet, difficulty in walking, and muscle weakness.</p> <p>Review of R12's MDS with an ARD of 01/29/25, revealed R12 had a BIMS score of 13 out of 15, indicating R12 had intact cognition.</p> <p>During an observation on 04/15/25 at 12:29 PM, R3's call bell was hanging on the wall and not in reach.</p> <p>During an observation on 04/15/25 at 12:34 PM, R6's call bell was hanging on the wall, and not in reach.</p> <p>During an observation on 04/15/25 at 12:44 PM, R4's call bell was on the floor, and not in reach.</p> <p>During an observation on 04/15/25 at 12:56 PM, R1's call bell was hanging on the wall, and not in reach.</p> <p>During an observation on 04/15/25 at 1:01 PM, R12's call bell was on the floor, and not in reach.</p> <p>During an observation on 04/16/25 at 9:37 AM, R5's call bell was hanging off the bed, and not within reach.</p> <p>During an observation on 04/15/25 at 12:20 PM, R9's wheelchair arms were observed tattled, peeling and worn.</p> <p>During an interview on 04/16/25 at approximately 2:44 PM, the Director of Nursing (DON) and Administrator revealed that call bells' should always be within reach of residents.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47075</p> <p>Based on observation, record review and interviews the facility failed to ensure (1) the fall mat was in a position to prevent an accident for 1 of 5 residents reviewed, Resident (R)2. The facility also failed to ensure resident bathroom/shower room floors were not excessively slippery, for 4 of 5 residents reviewed, R3, R7, R10, R11. Additionally, (2) the facility failed to provide appropriate supervision for R1, resulting in R1 falling and suffering injuries, for 1 of 5 residents reviewed.</p> <p>Findings include:</p> <p>Review of the facility's Environment Conditions/Environmental Rounds, policy revised on 11/2019, revealed, . it is the policy of this facility that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public though monthly environmental rounds.</p> <p>(1)</p> <p>Review of R1's Electronic Medical Record (EMR) revealed R1 had an admitted [DATE], with diagnoses including but not limited to: unspecified dementia, unspecified severity, with agitation, repeated fall, other sequelae of cerebral infraction, muscle weakness, restlessness and agitation.</p> <p>Review of R1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/02/24, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicates R1 suffered from severe cognitive impairment.</p> <p>Review of R2's EMR revealed R2 had an admitted [DATE], with diagnoses including but not limited to: unspecified sequelae of cerebral infarction, spinal stenosis, cervical region, and major depressive disorder, single episode.</p> <p>Review of R2's MDS with an ARD of 11/03/24, revealed R2 had a BIMS score of 8 out of 15, which indicates moderate cognitive impairment.</p> <p>Review of R3's EMR revealed R3 had an admitted [DATE], with diagnoses including but not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, type 2 diabetes mellitus with unspecified complications, major depressive disorder, recurrent, mild, and muscle weakness.</p> <p>Review of R3's MDS with an ARD of 12/18/24, revealed R3 had a BIMS score of 14 out of 15, which indicates R3 was cognitively intact.</p> <p>Review of R7's EMR revealed R7 had an admitted [DATE], with diagnoses including but not limited to: idiopathic progressive, arthritis, and cerebrovascular.</p> <p>Review of R7's MDS with an ARD of 07/23/24, had a BIMS score of 15 out of 15, which indicates R7 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R10's EMR revealed R10 had an admitted [DATE], with diagnoses including but not limited to: muscle wasting and atrophy.</p> <p>Review of R10's MDS with an ARD of 01/07/25, revealed R10 had a BIMS score of 4 out of 15, which indicates R10 suffered from severe cognitive impairment.</p> <p>Review of R11's EMR revealed R11 had an admitted [DATE], with diagnoses including but not limited to: muscle weakness and sarcopenia.</p> <p>Review of R11's MDS with an ARD of 01/28/25, revealed R11 had a BIMS score of 11 out of 15, which indicates R11 had moderate cognitive impairment.</p> <p>During an observation on 04/15/25 at 12:15 PM, R2's fall mat was stuck under the wheel of the resident's bed and protruding from under the bed, creating an accident hazard for the resident.</p> <p>During multiple observation on 04/15/25 at approximately 12:30 PM, revealed a bathroom containing a shower in the rooms of R3, R7, R10, and R11. Further observation revealed a buildup of a grey substance on the floors and the floors appeared to be greasy. This surveyor attempted to walk on the floors and the floors were excessively slippery, like walking on oil.</p> <p>During an interview on 04/15/25 at 12:29 PM, R3 stated he has fallen in the bathroom shower, when the floor is wet it's very slippery like oil. R3 further stated that he does not want to take showers anymore.</p> <p>During an interview on 04/15/25 at approximately 12:42 PM, R7 revealed the bathroom floor is always slippery when it is wet, he has had a fall due to it.</p> <p>During an interview on 04/16/25 at 10:39 AM, Licensed Practical Nurse (LPN) stated the bed should not be on top of the fall mats, as it does present an accident hazard for the resident.</p> <p>During an interview on 04/16/25 at 3:17 PM, the Administrator and Director of Nursing (DON) stated that they were not aware of the residents' bathroom floor being slippery.</p> <p>During an interview on 04/16/25 at 5:18 PM, the Maintenance Director (MD) revealed that rooms are checked for cleanliness twice a week. Work order system is utilized to inform housekeeping staff of conditions of each resident rooms. The MD stated he was not aware of the slippery floors. The MD concluded that could be due to either not mopping/rinsing as directed and/or adding to much cleaning solution while mopping.</p> <p>(2)</p> <p>Review of R1's EMR revealed R1 had an admitted [DATE], with diagnoses including but not limited to: unspecified dementia, unspecified severity, with agitation, repeated fall, other sequelae of cerebral infraction, muscle weakness, restlessness and agitation.</p> <p>Review of R1's MDS with an ARD of 12/02/24, revealed R1 had a BIMS score of 5 out of 15, which indicates severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Attempted interviews with R1, were unsuccessful.</p> <p>During an interview on 04/16/25 at approximately 10:52 AM, Registered Nurse (RN) revealed R1 was a two person assist. The RN confirmed that R1 was a fall risk and had multi-falls, due to this, staff are aware and should always keep eyes on R1.</p> <p>During an interview on 04/16/25 at 1:40 PM, Certified Nursing Assistant (CNA)2 revealed he was assigned to R1 and had just brought him back from the dining room back into the resident's room. CNA2 stated R1 was in the geri-chair and CNA2 had locked the wheels on the chair and went to get clothing and an adult diaper so that he could get the resident ready from bed. CNA2 stated he heard R1 fall to the floor, R1 fell off the side of the chair. CNA2 further stated the resident had shown signs of anxiety on the day of the incident and he was shocked to see R1 on the floor. CNA2 continued that he saw blood coming from the resident's head. CNA2 stated he immediately ran to get the nurse, and she came to the room, assessed the resident, applied pressure to his head as she observed a laceration. R1 was sent out to the hospital for further evaluation. CNA2 concluded to prevent the fall, he should have gotten all supplies out of the closet and not turn his back on the resident, he needed to keep eyes on the resident.</p> <p>During an interview on 04/16/25 at 2:48 PM, the DON revealed R1 was care planned for falls. R1 appeared to be comfortable in the geri-chair until the day of the incident. The DON stated to prevent the resident's fall, staff should have made sure that he had all the supplies that was needed for the resident with him, and he should not have turned his back on the resident.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47075</p> <p>Based on observation, record review and interview, the facility failed to assist or offer residents hand hygiene before and/or after meals for 4 of 4 residents. Additionally, the facility failed to ensure bath basins were labeled and cover for 3 of 4 residents.</p> <p>Findings include:</p> <p>Review of R2's Electronic Medical Record (EMR) revealed R2 had an admitted [DATE], with diagnoses including but not limited to: unspecified sequelae of cerebral infarction, spinal stenosis, cervical region, and major depressive disorder, single episode.</p> <p>Review of R2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/03/24, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicates R2 was moderately cognitively impaired.</p> <p>Review of R3's EMR revealed R3 had an admitted [DATE], with diagnoses including but not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, type 2 diabetes mellitus with unspecified complications, major depressive disorder, recurrent, mild, and muscle weakness.</p> <p>Review of R3's MDS with an ARD of 12/18/24, revealed R3 had a BIMS score of 14 out of 15, which indicates R3 was cognitively intact.</p> <p>Review of R5's EMR revealed R5 had an admitted [DATE], with diagnoses including but not limited to: hemiplegia and hemiparesis following cerebral infarction and diffuse traumatic brain injury.</p> <p>Review of R5's MDS with an ARD of 03/11/25, revealed R5 was not able to complete the BIMS.</p> <p>Review of R6's EMR revealed R6 had an admitted [DATE], with diagnoses including but not limited to: muscle wasting and atrophy and muscle weakness.</p> <p>Review of R6's MDS with an ARD of 07/23/24, revealed R6 had a BIMS score of 8 out of 15, which indicates moderate cognitive impairment.</p> <p>During an observation on 04/15/25 at 12:15 PM, revealed staff did not offer to assist R2 with hand hygiene before and/or after meals.</p> <p>During an observation on 04/15/25 at 12:28 PM, revealed uncovered/unlabeled bath basins under the vanity sink of R3, which was shared by two residents. Further observation revealed staff did not offer to assist R3 with hand hygiene before and/or after meals.</p> <p>During an observation on 04/15/25 at 12:34 PM, revealed uncovered/unlabeled bath basins under the vanity sink of R6, which was shared by two residents. Further observation revealed staff did not offer to assist R6 with hand hygiene before and/or after meals.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 04/16/25 at 9:37 AM, revealed uncovered/unlabeled bath basins under the vanity sink of R5, which was shared by two residents. Further observation revealed staff did not offer to assist R5 with hand hygiene before and/or after meals.</p> <p>During an interview on 04/16/25 at 3:19 PM, the Director of Nursing (DON) stated it is the procedure that basins should be labeled and covered with plastic. The thermometer should be labeled. The DON further stated in regards to residents hand hygiene before and after meals, residents should be assisted with cleaning their hands before and after meals.</p>