STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425075	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lila Doyle Post Acute	101 Lila Doyle Drive Seneca, SC 29672

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to assess a resident to determine the level of supervision required while outside and ensure the environment was safe. On 11/22/2025, Resident (R)4, a resident with severe cognitive impairment, was taken outside by a staff member and left without direct supervision of staff. The staff failed to ensure the gate that enclosed the area was secured and the resident's wheelchair brakes were locked. R4 rolled down a hill, fell out of their wheelchair, and sustained an impacted left femoral neck fracture. The facility failed to ensure fall risk interventions were implemented for R2 and R8. These deficient practices affected 3 (R2, R4, and R8) of 6 sampled residents reviewed for accidents.Findings included: A facility policy titled, Fall Management System revised 04/2025, revealed, This facility is committed to promoting resident autonomy by providing an environment remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents. Policy: It is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. 1. An admission Record revealed the facility admitted R4 on 10/01/2016. According to the admission Record, the resident had a medical history that included diagnoses of vascular dementia, arthritis, and aphasia. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/23/2025, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. R4‘s Care Plan Report included a focus area initiated 11/18/2022 and revised 02/25/2025, that indicated the resident was at risk for falls related to gait/balance problems, unaware of safety needs, muscle weakness, vision/hearing impairment, and benign essential tremors. R4's Fall Risk Evaluation dated 10/20/2025, indicated the resident was at high risk for falls. R4's nursing Progress Notes electronically signed by Licensed Practical Nurse (LPN)5 and dated 11/22/2025, indicated as LPN5 exited the facility at approximately 2:21 PM, she noticed a commotion on the walkway with R4 on the ground. The nursing Progress Notes indicated R4 had an unwitnessed fall to the ground from their wheelchair and was observed grimacing and tearful and expressed pain/discomfort. The nursing Progress Notes indicated the resident was assessed to have an elevated blood pressure and pulse, a skin tear to their left elbow and left index finger, unable to move their left leg, and stated all over my bottom when they described the location of their pain. Per the nursing Progress Note, the resident was being transported by way of emergency medical services (EMS) to the local hospital for further evaluation and treatment. R4's ED [Emergency Department] Provider Note dated 11/22/2025, revealed the resident presented by EMS from a nursing home for evaluation of a fall. The ED Provider Note indicated, Patient [R4] is a resident of a local skilled nursing facility. [He/She] apparently was placed outside in a wheelchair to enjoy the very pleasant weather we were experiencing today and staff found (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	[him/her] on the ground where [he/she] apparently fell. Patient has advanced dementia and as such is unable to provide a history. Per the ED Provider Note, Patient had an unwitnessed fall from [his/her] wheelchair and was complaining of pain on left side. Patient not on blood thinners and has been in [his/her] usual state of health prior to the fall. Imaging reviewed and impacted left femoral neck fracture. Blood work declined by family. After discussion with orthopedic surgery, no surgical intervention at this time; family elected to pursue comfort care and hospice. R4's nursing Progress Notes electronically signed by the Director of Nursing (DON) and dated 11/23/2025, revealed the interdisciplinary team (IDT) reviewed the resident's recent fall and determined the resident fell outside while monitored line of site by staff. The nursing Progress Notes indicated the IDT recommended R4 have 1:1 accompaniment by either staff or family member when outside when the resident returned to the facility. During an interview on 01/17/2026 at 12:21 PM, LPN5 stated she was assigned to care for R4 on 11/22/2025. LPN5 stated she left the unit for a break at the time R4 was assisted downstairs by LPN4. LPN5 stated when she returned to the unit, LPN4 notified her that she took R4 downstairs and let the resident sit outside with R5 and R6. LPN5 stated she told LPN4 that R4 was not supposed to go outside except with family or staff. LPN5 stated she immediately left the unit to go check on R4. LPN5 stated when she arrived at the front door to check on the resident, she saw multiple staff down the walkway that led away from the facility with the resident who was approximately 30 yards from the front door. LPN5 stated she approached the other staff and found the resident on the ground. LPN5 stated she was immediately notified that the resident had been found with their wheelchair flipped on top of them when LPN2 and LPN3 initially reached the resident. LPN5 stated R4 complained of severe pain in their buttocks and left hip pain and had skin tears to the left upper extremity. LPN5 stated she called 911 while the other nurses managed R4's skin tears. During an interview on 01/16/2026 at 4:00 PM, R5 stated they and R6 wanted to go outside on the day of R4's fall. R5 stated a hall nurse assisted them into the elevator along with R4 and took them outside. R5 stated they were outside approximately 15 minutes when they noticed R4 had their wheelchair turned in the direction of the gazebo and began to quickly roll down the hill. R5 stated R4 fell on the sidewalk. R5 stated they were not sure of the distance R4 got from them but the resident fell about halfway down the sidewalk from them. R5 stated that luckily the resident's wheelchair turned slightly to the right side and hit the curb which caused R4's wheelchair to stop. Per R5, R4 fell and their wheelchair landed on top of them. R5 stated R4 began screaming and they stood up from their own wheelchair and began screaming for help. R5 stated, after a few minutes, staff came out and assisted the resident until the ambulance arrived. R5 then pointed to their roommate, R6, as the other resident outside with them at the time of the incident. R5 stated R6 witnessed the events as well. R6 was then asked if there was anything they wished to add or modify from R5's recollection of the events described by R5. R6 stated they did not have anything more to add to the account other than they heard the resident screaming but could not see them from their line of sight. A quarterly MDS, with an ARD of 11/25/2025, revealed R5 had a BIMS score of 15, which indicated the resident had intact cognition. A quarterly MDS, with an ARD of 12/04/2025, revealed R6 had a BIMS score of 15, which indicated the resident had intact cognition. During an interview on 01/17/2026 at 12:40 PM, LPN4 stated she was on duty when R4 fell outside. LPN4 stated she was not assigned to R4 on that date; however, she was assigned to R5 and R6 who had both requested to go outside to enjoy the nice day. LPN4 stated she assisted R4, R5, and R6 on the elevator and took them to sit outside the facility near the front lobby desk. LPN4 stated after the residents were outside, she returned to the unit. LPN4 stated when R4's nurse (LPN5) returned to the unit from a break, she informed the nurse that she took the resident outside. LPN4 stated LPN5 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	told her that R4 could be outside only if the resident was with a staff member. According to LPN4, LPN5 notified her that she was going to check on the resident. LPN4 stated immediately after LPN5 left the unit, she received a telephone call from LPN2 that R4 had fallen outside. LPN4 stated she was aware R4 had confusion; however, she was not aware R4 could not go outside without supervision and verified she did not ask the resident's assigned nurse before she took the resident outside. During a follow-up interview on 02/03/2026 at 1:28 PM, LPN4 stated on 11/22/2025 when she assisted R4 to sit outside with R5 and R6, she parked R6 closest to the front lobby door directly in front of the first glass panel. LPN4 stated she left R4 sitting in front of R5 and R6 and did not lock the resident's wheelchair brakes because R4 self-propelled their wheelchair independently. During an interview on 01/16/2026 at 2:05 PM, LPN2 stated on 01/10/2026 she was at the nurses' station when she heard the receptionist scream for help. LPN2 stated both she and LPN3 immediately went to assist Receptionist #1. LPN2 stated when they reached the front door, they could see R4 down the sidewalk towards the gazebo. LPN2 stated the resident was lying on their left side and their wheelchair had flipped on top of them. LPN2 stated R4 had a skin tear to the left arm and was screaming about pain to their bottom. Per LPN2, when R4 was rolled to their back, they saw the resident's left leg was externally rotated and immediately called 911. LPN2 stated the resident resided on the second floor of the facility at the time and she was unsure how or when the resident was allowed outside of the facility. LPN2 stated R4 was highly impaired in their cognition and used a wheelchair for mobility. During an interview on 01/16/2026 at 1:43 PM, Receptionist #1 stated sometime after lunch on 11/22/2025, LPN4 from the second floor brought R4 downstairs from the unit on the second floor of the facility and left the resident outside with two other residents. Receptionist #1 stated LPN4 left the residents outside and returned to the facility. Receptionist #1 stated she began assisting visitors at the front desk after the residents were outside and became occupied with them for about 20 minutes or so when she looked up and noticed one of the residents standing up from their wheelchair which was unusual for the resident. Receptionist #1 stated the resident who stood up appeared to be trying to see something, so she got up from the desk, went outside and found R4 lying on their left side on the ground on a sloped walkway towards the gazebo. Receptionist #1 stated R4 was screaming out in pain and their wheelchair appeared to have flipped on top of them during the fall. Receptionist #1 stated she immediately ran inside the building and screamed for help. Receptionist #1 stated two nurses from the first floor responded and came outside to assist the resident. Receptionist #1 stated the resident was screaming in pain to their left lower extremity and had blood on their left arm. During an interview on 01/16/2026 at 3:14 PM, LPN3 stated she and LPN2 were notified by Receptionist #1 that help was needed. LPN3 stated when she and LPN2 approached the front door, they saw R4 on their left side screaming in pain. LPN3 stated R4 had rolled down a sidewalk towards a gazebo. LPN3 stated the resident was approximately 55 feet from the front door and had their wheelchair lying on top of them at the time. Per LPN3, R4 had a skin tear to the left arm and when they turned the resident over, they noticed the resident's left leg was externally rotated. LPN3 stated they immediately called EMS. LPN3 stated the resident was not appropriate to be left unattended due to their cognition. LPN3 stated Receptionist #1 notified her that the only reason she looked up to realize something was wrong was because another resident stood up from their wheelchair. During a follow-up interview on 01/31/2026 at 1:04 PM, LPN3 stated when she responded to R4's fall on 11/22/2025, the gate which was at the side of the patio at the front entrance did not contain a lock. During an interview on 02/02/2026 at 9:05 AM, the Maintenance Director stated he was familiar with R4's fall outside and stated at the time of the fall, the facility did not utilize the pad lock for security except during high windstorms. During an (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	interview on 01/17/2026 at 11:11 AM, R4's responsible party (RP) stated they received a telephone call that there had been an accident and R4 fell after being left outside the facility unattended. The RP stated they rushed to the hospital where they found R4 in a lot of pain. The RP stated R4 was never allowed to go outside unattended because it would be like taking a two-year-old outside and saying do not go near the road, because [R4] had no concept of what they were doing. During an interview on 01/31/2026 at 10:44 AM, the Director of Nursing (DON) stated the facility did not have a policy on supervision. The DON stated if a resident required increased supervision, the facility would obtain and transcribe an order into the resident's electronic medical record. During a follow-up interview on 02/03/2026 at 2:55 PM, the DON stated in 11/2025, the facility allowed all residents to go outside per their resident's rights and confirmed the facility did not have a policy in place that outlined which residents could or could not go outdoors alone or established criteria to determine different levels of supervision to differentiate between the need for direct supervision of a staff member verses line of sight required for residents based on their individual needs. The DON stated he thought a receptionist should be able to maintain eye of sight supervision of residents when they were outside alone and continue to complete their other assigned duties such as answering telephone calls and assisting visitors at the receptionist desk. The DON stated he was not at the facility on 11/22/2025 when R4 fell from their wheelchair; however, he received a telephone call from LPN2 who notified him the resident had a fall outdoors and complained of hip pain and EMS was enroute. The DON stated the facility's investigation determined LPN4 took R4 off the unit and allowed the resident to go outside without a staff member present. The DON stated he was notified R4 rolled out of view of the receptionist and the receptionist responded by going outdoors and found that R4 fell. The DON stated his knowledge of the event was that the receptionist acknowledged the residents were outside and was to be supervising the residents in her line of sight. The DON stated it was determined during the investigation that the gate that aided in securing the patio sitting area was not latched when R4 was left outdoors without a staff member. The DON stated he was not aware that LPN4 did not lock R4's wheelchair brakes before the resident was left outside. Per the DON, locking a residents' brakes was a standard practice despite the resident's ability to self-propel their wheelchair. During an interview on 02/03/2026 at 9:05 AM, Nurse Practitioner (NP)52 stated she was familiar with R4, the resident had severe vascular dementia, and an inability to effectively communicate due to severe cognitive impairment. NP52 stated R4 was not an appropriate candidate to be left outdoors without direct observation and supervision of a staff member at all times and would not be appropriate to be monitored from the receptionist's desk. During an interview on 02/03/2026 at 11:48 AM, NP53 stated R4 was not an appropriate candidate to be outside without a staff member present. During an interview on 01/18/2026 at 4:07 PM, the Administrator stated she was notified R4 had a fall outside. The Administrator stated at the time of the accident, the facility allowed residents to go outside to sit if they were in the line of sight of a staff member. The Administrator stated she would have expected a more formal acknowledgement between the nurse and receptionist that the residents would be outside and were required to be watched. The Administrator stated residents with severe dementia always required direct observation. 2. An admission Record revealed the facility admitted R2 on 06/20/2025. According to the admission Record, the resident had a medical history that included diagnoses of aphasia, cerebrovascular accident, muscle weakness, abnormalities of gait, unsteadiness on feet, and dementia. R2's Care Plan Report included a focus area initiated 06/20//2025 and revised 09/18/2025, that indicated the resident was at risk for falls related to previous frequent falls, incontinence, unsteadiness, cognitive impairment, weakness, and pain and recent falls (with and without injury). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions directed staff to place a sensor alarm in the resident's wheelchair per the family request (initiated 09/23/2025). R2's Fall Risk Evaluation dated 09/13/2025, indicated the resident was at high risk for falls. A quarterly MDS, with an ARD of 12/11/2025, revealed R2 had a BIMS score of 0, which indicated the resident had severe cognitive impairment. R2's incident report prepared by Registered Nurse (RN)11 and dated 01/10/2026, indicated a certified nursing assistant (CNA) reported the resident was standing in the common area at supper time and fell. Per the incident report, the CNA reported the resident hit their head on the floor. The incident report indicated the resident lost consciousness and had a large bruise on the left side of their forehead. The incident report revealed that when the resident regained consciousness, they complained of left hip pain, emergency medical services was called to transport the resident to the local hospital for further evaluation. R2's hospital After Visit Summary dated 01/10/2026 revealed the resident has a nondisplaced pubic [pubis] body fracture (pelvis). This is a non-operative fracture and [he/she] can weight bear as tolerated. During an interview on 01/16/2026 at 4:15 PM, CNA6 stated she was on duty on 01/10/2026 during supper time when she heard a loud bang but found R2 on the floor unconscious. CNA6 stated both she and CNA14 checked R2's chair alarm after the fall and discovered the sensor chair pad alarm box was not in the on position and therefore did not sound when R2 stood up. During an interview on 01/17/2026 at 9:33 AM, CNA14 stated she was on duty at the time of R2's fall on 01/10/2026. CNA14 stated she checked R2's sensor chair pad alarm because it did not sound when the resident fell and discovered the alarm was turned off. CNA14 stated she notified RN11 that the chair alarm had been off. During an interview on 01/17/2026 at 8:56 AM, RN11 stated around supper on 01/10/2026, she was on A hall assisting a resident with their meal when she heard someone say, [R2, sit down. RN11 stated she initially did not think much of what she heard because staff frequently reminded R2 not to stand up. RN11 stated when she saw R2, the resident's head was being held off the floor by CNA14 and CNA6 was attempting to get the resident to wake up. RN11 stated R2 was found to be unconscious, and it took several minutes for the resident to come around. RN11 stated she discovered R2's sensor chair pad alarm was not on at the time of the fall. According to RN11, CNA15 toileted the resident prior to the supper meal and did not turn the chair sensor pad alarm back on. During an interview on 01/17/2026 at 10:00 AM, CNA15 stated she was assigned to R2 on 01/10/2026 and had toileted the resident shortly before the evening meal (supper) was served. CNA15 stated R2's chair alarm did not sound at the time of the fall. During an interview on 01/17/2026 at 10:20 AM, R2's family member stated they were notified the resident's chair alarm did not sound when the resident fell this past weekend (on 01/10/2026). During an interview on 01/18/2026 at 2:31 PM, the Assistant DON stated R2's chair alarm should always be on when the resident was in their chair. During a follow-up interview on 02/04/2026 at 10:45 AM, the DON stated he would expect the staff to follow all care planned interventions. During an interview on 02/04/2026 at 11:05 AM, the Administrator stated she expected staff to follow interventions listed on a resident's care plan. 3. An admission Record revealed the facility admitted R8 on 08/31/2022. According to the admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, dementia, lack of coordination, need for assistance with personal care, muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. A quarterly MDS, with an ARD of 10/30/2025, revealed R8 had a BIMS score of 2, which indicated the resident had severe cognitive impairment. The MDS revealed R8 used a chair alarm daily. R8's Care Plan Report included a focus area initiated 12/16/2022 and revised 05/02/2025, that indicated the resident was at risk for falls related to limited mobility, impaired balance, disc disorder, osteoarthritis, Parkinson's disease, poor safety awareness, impulsivity, a history of falls, and a recent fall without major injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions directed staff to provide fall sensor alarms in the residents' bed and chair per family request (initiated 07/16/2025). R8's Order Summary Report with active orders as of 01/31/2026, revealed an order dated 07/16/2025, that specified may have sensor pads in bed and wheelchair to remind the resident not to get up unassisted every shift for safety. During an observation on 01/31/2026 at 2:21 PM and 2:50 PM, R8 was seated in a scoot chair in the common area and had a sensor chair pad alarm in place. The sensor chair pad alarm box revealed the switch on the bottom of the box was in the off position. During a concurrent observation and interview on 01/31/2026 at 2:54 PM, LPN36 stated she was assigned to care for R8 on 01/31/2026. LPN36 stated the sensor chair pad alarm was in place for R8 as it was used to alert staff when the residents lifted themselves or shifted their weight before the residents would fall. LPN36 observed the sensor chair pad alarm box and verified the switch was in the off position. LPN36 stated when the switch was in the off position, the sensor chair pad alarm was ineffective to alert staff before the resident attempted to get up. During an interview on 02/03/2026 at 2:55 PM, the DON stated R8 had a sensor chair pad alarm that was used to alert staff when the resident's weight was shifted in their chair. The DON stated if the switch was in the off position, it would not alert staff before the resident attempted to get up. During a follow-up interview on 02/04/2026 at 10:45 AM, the DON stated he would expect the staff to follow all care planned interventions. During an interview on 02/04/2026 at 11:05 AM, the Administrator stated she expected staff to follow interventions listed on a resident's care plan.