STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake City Scranton Healthcare Center	1940 Boyd Road Scranton, SC 29591

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 29015 Based on interviews, record review, and facility policy review, the facility failed to ensure residents were free from abuse for two of four residents (Resident (R) 66 and R11) reviewed for abuse and neglect of 29 sampled residents. This had the potential to affect resident safety at the facility. Findings include: Review of the facility's policy titled, Abuse, Neglect, Exploitation, or Mistreatment, dated 10/01/20, documented The facility's leadership prohibits neglect, mental, physical, and/or verbal abuse . Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 1.a. Review of R66's undated Face Sheet located in the electronic medical record (EMR), under the Face Sheet tab, indicated R66 was admitted to the facility on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation, closed fracture of left radius, and diabetes mellitus. Review of R66's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/20/24, located in R66's EMR under the Resident Assessment Instrument (RAI) tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicted the resident was cognitively intact. There were no behaviors identified during this seven-day look back assessment. b. Review of R235's undated Face Sheet located in the EMR under the Face Sheet tab, indicated the resident was admitted on [DATE], with diagnoses including paraplegia, hypertension, and depression. Review of R235's annual MDS with an ARD of 01/22/24 located in the EMR under the RAI tab, revealed the resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. There were no behaviors identified during this seven-day look back period. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's initial Facility Reportable Incident, dated 02/11/24 and provided by the facility, revealed On 02/11/24, at approximately 10:15 PM, NHA [Nursing Home Administrator] was notified by direct care staff of a resident-to-resident altercation in the facility. Staff reported that the altercation started off as verbal, to which multiple staff members promptly responded to. Staff found two residents, [R235], and [R66], arguing loudly. As staff members were separating the residents, [R235] swung his arm at R66 and grazed his face. Staff members immediately continued to separate the residents and monitor them for injury. They then commenced with moving [R235] to another room, as the two residents were roommates and friends. No interaction was noted between the two residents prior to this incident, and once separated and calmed by staff, no other action occurred. During an interview conducted on 05/22/24 at 3:30 PM, R66 was questioned concerning what happened between him and R235 on 02/11/24. R66 responded that R235 and himself were in the dining area, and he said B give me my lighter back R235 became upset, and they started arguing, then R235 took a swing at him. The staff came in and separated them. During a telephone interview conducted on 05/23/24 at 10:44 AM, Licensed Practical Nurse (LPN)3 was asked if she witnessed the altercation between R66 and R235, and what happened. LPN3 responded that she did witness it, R235 hit R66 then backed away. LPN3 stated R66 instigated it, he was taunting R235. She added that R235 was normally a very sweet and patient person, this was the first time this had happened. During a telephone interview conducted on 05/23/24 at 11:38 AM, Certified Nurse Aide (CNA)6, was asked if she recalled the incident between R66 and R235. CNA6 responded she did not feel comfortable talking about the incident over the phone, but to refer to her written statement provided to the facility. Review of CNA6's written Witness Statement, dated 02/11/24, revealed CNA6 documented I was in the back at the nurse station and overheard yelling and cursing. I jumped up and ran to the dining area. I arrived in the dining room to see [R235] and [R66] arguing. I asked what was going on and they said it started over a lighter. I began trying to deescalate the situation. It kept going then [R235] hit [R66] in the face on his left side. We pulled them apart. Then he began to call staff b*****s and f**k you to me and other staff. We separated them and [R235] kept coming back arguing and trying to keep the argument going. During an interview conducted with the Director of Nursing (DON) on 05/23/24 at 11:22 AM, the DON was questioned concerning the incident between R66 and R235. The DON responded that the staff had not witnessed the incident but were informed by R66 of what happened. The DON stated both residents were examined and there were no injuries. The DON notified the Administrator at that time of the incident. The DON stated the police, physician, state, and ombudsman were also notified. 2. Review of R11's undated Face Sheet located in the resident's EMR, under the Face Sheet tab, indicated R11 was admitted to the facility on [DATE], with diagnoses including severe dementia with behavioral disturbances, hypertension, and chronic obstructive pulmonary disease. Review of R11's admission MDS with an ARD of 04/03/24, located in R11's EMR, under the RAI tab, revealed the resident's BIMS score was a six out of 15, which indicated the resident was severely cognitively impaired. R11 was assessed as exhibiting behavioral symptoms, that included physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, and grabbing others), and verbal behavioral symptoms directed toward others(e.g., threatening others, screaming at others, cursing at others) that occurred one to three days during the seven-day look back period. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R11's Care Plan, dated 04/01/24 and located in the EMR under the RAI tab, revealed at risk for having mood and behavior needs due to diagnosis of dementia as evidenced by periods of agitation, physically aggressive, verbally aggressive, refusing care, and not easily redirected during behavioral episodes .becomes combative towards staff and residents .uses profanity towards staff and residents . Interventions included: on 03/21/24-altercation with roommate-residents separated, room change and sent to ER [emergency room] for evaluation, attempt non-pharmacological interventions .ensure physical needs are met .if resident becomes physically agitated and aggressive remove from other residents to safe, less stimulating environment. Set firm limits by telling them to stop current behavior. Review of the facility's initial Facility Reportable Incident, dated 04/22/24 and provided by the facility, revealed R66 was in the dining hall when R11 began accusing him of stealing her gray purse. R11 took the snack that R66 was eating from him and threw it on the floor. R11 then began slapping R66 on his stomach, chest, and face. During an interview on 05/22/24 at 3:30 PM, R66 was questioned as to what happened between him and R11. R66 stated that he was plugging his cellphone in the wall to charge by the table that R11 was sitting at, and said I'll be right back. I went to my own table, R11 proceeded to come up to me and began to yell and hit me. R11 stated I stole her purse. I reported it to the nurse. 3. Review of R187's undated Face Sheet located in the EMR, under the Face Sheet tab, indicated R187 was admitted to the facility on [DATE], with diagnosis of unspecified dementia, moderate with psychotic disturbance. Review of R187's quarterly MDS with an ARD of 02/06/24, located in R187's EMR under the RAI tab, revealed the resident had a BIMS score of seven out of 15, which indicated the resident was severely cognitively impaired. There were no behaviors identified during this seven-day look back assessment. Review of the facility's initial Facility Reportable Incident, dated 03/31/24 and provided by the facility, revealed On 03/31/24, at approximately 5:00 PM, the DON was notified of a resident-to-resident altercation which occurred between R187 and R11. R187 was observed to be standing over her roommate, R11 and swatting/hitting motions towards R11's face and head. There were red scratches and red marks visible to the direct care staff. The staff immediately separated the residents and assessments were performed by the nursing staff. The facility on call doctor was notified and received orders for R11 to be transferred to the emergency room . R11 returned to the facility later that evening and was moved to a different room on a different hallway than R187. The next of kin and police were notified. During a phone interview on 05/22/24 at 2:20 PM, Registered Nurse (RN)1 stated the Nurse Practitioner had decreased R187's medication and that was when R187 had started again being bossy and nosey with the other residents. RN1 also reported there were no behaviors such as hitting other residents before this incident occurred. During a phone interview on 05/22/24 at 2:52 PM, LPN5 stated, The nurse for the hallway was on break so I was covering the floor. R11 had been telling R187 to go back into the hallway because R11 did not want her in the room. Then R187 was seen swatting at R11 in the face and on the right side of R11's head. There were some red marks noted. We called the DON, the doctor on call, the next of kin, and the police.

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 28306

Based on record review, interview, and policy review, the facility failed to conduct a thorough investigation for an alleged incident of resident-to-resident altercation for two of four residents reviewed out of 29 sampled residents (Resident (R) 187 and R11). This had the potential to affect resident safety at the facility.

Findings include:

Review of the facility's policy titled, Abuse, Neglect, Exploitation, or Mistreatment, dated 10/01/20, revealed Determine the type of abuse and where/ when incident occurred. Interview individuals having firsthand knowledge of the incident and write summaries of the interviews. NOTE: Employees/witnesses are not to write out statements. Employees/witnesses will be interviewed by designated facility staff and the interviewer will record all witness accounts in a document, written, dated, and signed by the interviewer. Social Service will provide support services to the resident/patient and implement an interdisciplinary care plan. Depending on the incident, other residents in the facility may be interviewed. The Director of Nursing or his/her designee will review the resident's medical record. Establish findings, outcomes, resolutions, and corrective actions necessary to prevent further incidents Unless otherwise directed by the Legal Department, document investigation activities, findings, outcomes, resolutions, and corrective actions taken to prevent further incidents and maintain in the Administrator's office.

1. Review of R187's undated Face Sheet located in the electronic medical record (EMR), under the Face Sheet tab, indicated R187 was admitted to the facility on [DATE], with diagnosis of unspecified dementia, moderate with psychotic disturbance.

Review of R187's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/06/24, located in R187's EMR under the Resident Assessment Instrument (RAI) tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicted the resident was severely cognitively impaired. There were no behaviors identified during this seven-day look back assessment.

Review of R187's care plan, dated 11/13/23 and located in the EMR under the Care Plan tab, revealed [R187] is at risk for having mood and behavior needs as evidenced by periods of combative and resistive behaviors related to diagnosis of dementia with psychotic disturbance. Interventions put into place revealed, Communicate resident status via 24-hour report as needed. Notify the family of changes in resident status or of new or escalated behaviors. Get their input as to suggestions or recommendations of interventions/approaches.

2. Review of R11's undated Face Sheet located in the EMR under the Face Sheet tab, indicated the resident was admitted on [DATE], with diagnosis of unspecified dementia, unspecified severity, with psychotic disturbances.

Review of R11's admission MDS with an ARD of 04/03/24 located in the EMR under the RAI tab, revealed the resident had a BIMS score of six out of 15, which indicated the resident was severely cognitively impaired. There were no behaviors identified during this seven-day look back period.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the five day Facility Reportable Incident, dated 04/03/24 and provided by the facility, the summary did not include the date or time of the resident-to-resident altercation. There were only two witness statements included in the investigation, Certified Nursing Assistant (CNA)3 and Licensed Practical Nurse (LPN)5. There was no date, time, or signature of the staff person performing the body audits/interviews. During a phone interview on 05/22/24 at 2:20 PM, Registered Nurse (RN)1 stated the Nurse Practitioner had decreased R187's medication and that was when R187 had started again being bossy and nosey with the other residents. RN1 also reported there were no behaviors such as hitting other residents before this incident occurred. During a phone interview on 05/22/24 at 2:32 PM, CNA3 stated, I didn't see [R187] being physical with [R11], but the two ladies had been arguing about something all shift. I helped [R187] to the bathroom and on the way out of the bathroom, R187 was saying stuff to [R11]. [R187] said she wanted to sit on the side of the bed with her back towards the roommate's curtain. I left the room and heard [R11] say She hit me. During an interview with the Director of Nursing (DON) on 05/23/24 at 11:23 AM, when asked if staff had made her aware of R187 and R11 arguing on 03/31/24 before the altercation occurred, the DON stated, In hindsight, Yes it probably would have been better (to have been notified prior to the incident of the roommates arguing), but I didn't get any communication of this happening before this incident occurred. During an interview with the Administrator on 05/23/24 at 1:17 PM, the Administrator stated, I did the five-day summary to the state on an outdated form that was not used anymore. I interviewed the two employees that were assigned to R187 and R11 on 03/31/24. When asked if there had been a history of behaviors exhibited by R187 the Administrator stated, R187 has been picking on other residents but this resident is hard because she doesn't have behaviors.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013 Based on observations, interview, record review, and facility policy review, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL) assistance received services for one of one resident (Resident (R) 33) reviewed for fingernail care in a total sample of 29 residents. This failure placed residents at risk for diminished self-worth, self-esteem, feelings of embarrassment, and/or medical issues. Findings include: Review of the facility's policy titled, Activities of Daily Living (ADL), revised on 05/05/23, documented .The facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene . Review of the undated Face Sheet located in the electronic medical record (EMR) under the Resident tab, documented R33 was admitted to the facility on [DATE] and had diagnoses that included Alzheimer's disease and diabetes mellitus. Review of the Care Plan in the EMR under the Resident tab and dated 03/22/22, related to ADL/self-care deficit, revealed [R33] required assistance from staff for grooming related to weakness, decreased mobility, and cognitive impairment. Review of the quarterly Minimum Data Set (MDS) assessment located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 05/01/24, documented R33 was rarely/never understood, required maximum assistance with personal hygiene, and had no behaviors. Review of ADL documentation, provided by the facility, dated 05/01/24 to 05/23/24, revealed personal care and ADL care was consistently provided. Observations conducted on 05/21/24 at 11:11 AM and on 05/22/24 at 11:01 AM and 4:24 PM revealed R33 was sitting in a recliner chair in the hallway. R33 had long fingernails, black material under all of her nails, and needed nail care. During an interview on 05/22/24 at 4:27 PM, Licensed Practical Nurse (LPN)1 stated R33 had dementia, was cooperative with nail care, and the staff provided her nail care. LPN1 acknowledged that R33's fingernails were very long and dirty.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013 Based on observation, interview, and record review, the facility failed to ensure the oxygen units were cleaned and sanitary for three of three residents (Resident (R) 68, R69, and R42) reviewed for respiratory care of 29 sampled residents. This failed practice has the potential to cause respiratory and other infections for residents. Findings include: 1. Review of R68's undated Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, documented R68 was admitted to the facility on [DATE]. Review of R68's quarterly Minimum Data Set (MDS) assessment located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 03/11/24, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R68 had intact cognition and oxygen usage. Review of the Physician Orders located in the EMR under the Orders tab and dated 03/13/24, revealed an order for Oxygen at 2 liters per minute via nasal cannula as needed (prn) for shortness of breath (SOB). Observations conducted on 05/21/24 at 10:26 AM and on 05/22/24 at 10:18 AM and at 4:05 PM, revealed R68's oxygen unit was soiled with gray grim and there was caked dust on the oxygen filter. During an interview on 05/22/24 at 4:13 PM, Licensed Practical Nurse (LPN) 7 confirmed R68's oxygen unit and filter were dirty with grime and dust. 2. Review of R69's undated Face Sheet located in the EMR under the Face Sheet tab, documented R69 was admitted to the facility on [DATE]. Review of R69's quarterly MDS assessment located in the EMR under the MDS tab with an ARD of 04/24/24, revealed a BIMS score of 99, which indicated severe cognitive impairment and oxygen usage. Review of the Physician Orders located in the EMR under the Orders tab and dated 11/23/23, revealed an order for oxygen at 3 liters per minute continuous. Observations conducted on 05/21/24 at 9:48 AM and at 4:30 PM and on 05/22/24 at 10:10 AM and 4:00 PM, revealed R69's oxygen unit was soiled with light gray grime and there was a large amount of caked on dust on the oxygen filter. 3. Review of R42's undated Face Sheet located in the EMR under the Face Sheet tab, indicated the resident was admitted to the facility on [DATE], with diagnoses including respiratory failure, congestive heart failure, and diabetes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R42's admission MDS with an ARD of 02/28/24, located in the EMR under the MDS tab, revealed the residents BIMS score was a 15 out of 15, indicating the resident was cognitively intact. Further review of the MDS indicated R42 received oxygen therapy continuously and bilevel positive airway pressure (BiPap) at night. Review of R42's Physician Orders, dated 02/22/24, located in the EMR under the Orders tab, revealed O2 [oxygen] at 2 L/min [liters per minute] per NC [nasal cannula] continuously. During observations conducted on 05/21/24 at 11:58 AM and on 05/22/24 at 9:30 AM, R42's oxygen concentrator located next to her bed an unknown brown substance on the filter area located on the back of concentrator. During an observation and interview on 05/22/24 at 4:10 PM, the unsanitary oxygen units were reviewed with the Director of Nurses (DON). The DON stated the oxygen units and filters for R68, R69, and R42 were unsanitary, and the filters had a lot of dust. The DON stated the housekeeping staff were to clean the outside of the oxygen units as needed during resident room cleaning and the Unit Manager was to ensure oxygen filters were cleaned. She stated the issue would be addressed. 29015