STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Marion Nursing Facility	1527 Urbana Road Summerton, SC 29148

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 - Immediate jeopardy to resident health or safety 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** 46934 Based on review of facility policy, record review, and interviews, the facility failed to ensure Residents (R)73, R10, and R479 were free from physical abuse by Certified Nursing Assistant (CNA)1 on 07/30/24 and 08/02/24. On 09/20/24 at 11:04 AM, the Administrator and the Director of Nursing (DON) were notified that the failure to protect multiple residents from from physical abuse constituted Immediate Jeopardy (IJ) at F600. On 09/20/24 at 11:04 AM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 07/30/24. The IJ were related to 42 CFR 483. 12- Freedom from Abuse, Neglect, and Exploitation. On 09/20/24 at 2:40 PM, the facility provided an acceptable IJ Removal Plan. On 09/20/24 at 2:43 PM, the survey team validated the facility's corrective actions and verified the facility had corrected their noncompliance and the IJ was identified at Past Non Compliance (PNC) as of 08/07/24. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F600, constituting substandard Quality of Care. Findings include: A review of the facility policy titled Abuse Policy with a revision date of 11/2017, revealed, This facility recognizes that each resident has the right to be free from all types of abuse including verbal, sexual, physical . The facility also recognizes that the residents must not be subjected to abuse by anyone, including, but not limited to facility staff . 5. PHYSICAL ABUSE includes but is not limited to, hitting, slapping, punching, biting, and kicking. Review of R73's Face Sheet revealed R73 was admitted to the facility on [DATE], with diagnoses including, but not limited to: dementia, moderate, with other behavioral disturbance symptoms and signs involving cognitive functions following cerebrovascular disease, major depressive disorder, pseudobulbar affect, and mood disorder. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R73's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/24, revealed R73 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severe cognitive impairment. Review of R10's Face Sheet revealed R10 was admitted to the facility on [DATE], with diagnoses including, but not limited to: dementia with behavioral disturbance, diabetes mellitus, chronic pain, anxiety disorder, and major depressive disorder. Review of R10's Quarterly MDS with an ARD of 08/30/24, revealed a BIMS score of 99, indicating severe cognitive impairment. Review of R479's Face Sheet revealed R479 was admitted to the facility on [DATE], with diagnoses including, but not limited to: chronic pain, schizophrenia, unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence, and insomnia. Review of R479's Admission MDS with an ARD of 07/18/24, revealed a BIMS score of 10 out of 15 indicating moderately impaired cognition. Review of the Local Sheriff's Office Incident Report dated 08/02/24 revealed, Offense - Simple Assault. On 08/03/2024, a Deputy with the Local Sheriff's Office was dispatched to 1527 Urbana Rd (Lake [NAME] Nursing Care Facility) in the [NAME] area of Clarendon County SC in reference to an Assault. Upon arrival, the Deputy contacted [Licensed Practical Nurse (LPN)4] the head nurse of the facility at the time. [LPN4] stated that 3 of her co-workers came to her to report an assault on a resident by another co-worker. The co-worker who assaulted the resident was identified as [CNA1]. Deputy identified the 3 co-workers as [CNA2], [CNA3], and [CNA4] that were witnesses to the assault . The case is active for offenses of Simple assault. A review of witness statements revealed the following: On 08/02/24, CNA2 revealed, [R73] didn't want to get in the shower after he pooped on himself. [CNA1 and CNA3] and I was trying to talk to him to get in the shower, but he was very stubborn. Me and [CNA3] started to talk to him calmly. [CNA1] grabbed his hand to assist him in the shower. As I was getting more gloves, I saw [R73] on the floor. He started to cry. Me and [CNA3] got him off the floor and [R73] stated, I don't want him [CNA1] around me. After we calmed him down, I had no choice but to clean him up. [R73] finally calmed down and had a great night. Registered Nurse (RN)1's statement revealed, On the above date (7.29.2024 7A-7P), a little after supper [CNA2 and CNA4] pulled me into an empty room. They proceeded to tell me that they witnessed (orderly) [CNA1] being abusive towards residents. They stated that the orderly hit the resident in 107A in the face with a closed fist and also saw him hit the resident in 111 in the face with his gloves. I immediately took them both to the unit manager's office so that they could make her aware of what they witnessed, I have not personally witnessed or heard any physical or verbal abuse towards residents during my shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA4's statement dated 08/02/24, revealed, On August 1st, 2024, [CNA1] assisted me with changing [R10], and in the process, he [CNA1] punched [R10] on the head with his fist. I thought it was a mix-up or something, so I didn't report it that night. The following day August 2nd 2024, [CNA3], [CNA1] and I changed [R10] and again, he [CNA1] punched her on the head with his fist. Another incident happened that night while attempting to change [R479], as she is a 3-person assist. [CNA1] hit her with the bed remote and slapped her in the face with his gloves. CNA3's statement dated 08/02/24, revealed, [R73] has messed [sic] in his pants and did not want to take a shower for [CNA1]. [CNA2] and I were there for assistance. [R73] was refusing to take a shower and [CNA1] grabbed [R73] by the arm to back in the shower when [R73] had fallen to the floor. While on the floor, [CNA1] hit [R73] on the side of his face. [R73] was crying and stated he never wants [CNA1] to touch him again. [CNA2] stayed with [R73]. [CNA1] apologized and said it would not happen again and feeling sorry for him and his circumstances I did not immediately report the incident. However, there was another incident, and I did report it. Review of a second employee statement form written by CNA3 dated 08/02/24, revealed, Tonight while assisting [CNA4] with [R10]. [CNA1] entered the room to help us, while in the room [CNA1] hit [R10] on the side of her head with his fist. Also, tonight while assisting [CNA1] with [R479], [CNA1] hit [R479] with the bed remote and hit her with his gloves in her face. Review of CNA1's statement dated 08/05/24, revealed an interview with CNA1 conducted face to-face with the Director of Nursing (DON) and Administrator. CNA1 was placed on administrative leave Friday 08/02/24, after allegations of abuse were reported. He verbalized assisting with the care of R73 in the shower, he reports catching the resident's arm in an attempt to keep him from falling but denies striking him in any way. Regarding R10, he reports assisting with changing her clothes and getting her ready for bed and denies hitting her in the head. In the care of R479, he reports assisting with getting her in the bed via Hoyer, denies hitting her in the head with the bed remote, and slapping her in the face with his gloves. An attempted interview on 09/19/24 at 9:29 AM, with R479 was unsuccessful as the resident is non-interviewable. An attempted interview on 09/19/24 at 9:39 AM, with R10 was unsuccessful as the resident is non-interviewable. During an interview on 09/19/24 at 9:55 AM, CNA3 verified and confirmed the allegations of abuse in her statement. Attempt to interview via phone with CNA2 on 09/19/2024 at 11:08 AM, was unsuccessful. Attempt to interview via phone with RN1 on 09/19/2024 at 11:10 AM, was unsuccessful. Attempt to interview via phone with CNA4 on 09/19/2024 at 12:06 PM, was unsuccessful. Attempt to interview with CNA1 via phone on 09/19/2024 at 12:24 PM, was unsuccessful. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 09/18/24 at 11:01 AM, R73's daughter revealed, There is one staff member there that I've always had questions about. One Sunday, not too long ago, my brother and I went to visit my dad in his room. I asked the CNA, if my dad has gotten a shower, the CNA closed the door to his room and replied to my brother and I, when I make him. R73's daughter further stated, I thought that was kind of strange the way he said it. His name is [CNA1's first name]. My dad was abused at the previous facility by staff, and this just rubbed me the wrong way when he said that. During an interview on 09/19/24 at 12:39 PM, LPN4 revealed, CNA1 was starting to act unusual, and nervous, with his bookbag. It was almost like he knew something was up. LPN4 stated she let him go after telling CNA1 he was under investigation, for an allegation of abuse, and someone would be contacting him including police and administrative staff. LPN4 further stated the facility Administrator gave phone orders, to call the police and have them come to the facility to do a report. LPN4 stated he told him to pack his things, and he needed to call someone to pick him up because he could not be on the property. LPN4 stated CNA1 was asking questions such as What did I do, and that's all he said, he didn't argue, he called his mom and left. LPN4 stated as soon as CNA1 left she ran in the building and locked the door. The deputy came onsite and interviewed LPN4 as to why he was being dispatched. The deputy interviewed all witnesses separately. LPN4 stated all the residents involved were not cognitive enough to replay the encounter with the alleged perpetrator. During an interview on 09/19/24 at 1:30 PM, with the Administrator and Director of Nursing (DON). The Administrator revealed a call was received from LPN4, stating that CNA3 and CNA4 had reported that CNA1 tapped several residents on the head. At that time, the tap was reported on R73 and R10. The Administrator stated she asked LPN4 what do the staff mean by tap, LPN4 replied, I'm not sure, however, the witnesses are in the office. The Administrator stated she requested CNA3 to get on the phone and CNA3 described tap as a punch. The Administrator told LPN4 to try to keep CNA1 in the building and call law enforcement to have them come out to the facility. The Administrator stated that CNA1 was gone when law enforcement arrived. The deputy interviewed all witnesses, separately. The Administrator further stated she doesn't believe the abuse occurred and to her knowledge, there was no bad blood within the CNAs. CNA1 denied the physical abuse, however, confirmed that he did provide care to the three residents. On 09/20/24 at 2:40 PM, the facility provided an IJ Removal Plan, which included the following: 1. Residents #10, #73, and #479 were assessed by the Assistant Director of Nursing and another License Nurse on 8/2/2024 to verify injury. No signs or symptoms of abuse were present . CNA1, the accused, was removed from the facility on 08/02/2024 and has not been in the facility since then. He was placed on immediate suspension pending the results of the investigation. On 08/05/2024, CNA1, who was on a probationary period, was terminated from employment related to work performance. 2. The facility has determined that all residents have the potential to be affected by alleged abuse. All residents with who had ever been assigned to or near the accused CNA were interviewed on 8/3/2024 by the Administrator to assess any further allegations of abuse. There were no further concerns reported by any residents. On 8/2/2024, body audits were completed by the Assistant Director of Nursing and a Licensed nurse to assess all residents for any signs or symptoms of abuse, with no findings of injury. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. On 8/3/2024, an in-service education program was conducted by the Director of Nursing Services and the Administrator with all direct care staff regarding abuse prevention, including the types of abuse, and burnout, as well as addressing circumstances that require reporting including appropriate timeframes. On 8/7/2024, after completion of the investigation, CNAs 3 and 4 were provided additional one-to-one education and disciplinary actions regarding failure to report a suspicion or allegation of abuse immediately. Both CNAs expressed an understanding of this requirement. 4. The Director of Nursing Services, or designee, will continue to conduct audits of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any allegations of abuse are identified, properly investigated and reported to the appropriate people. Further feedback and assurance will be solicited via the facility grievance process and Resident Council. Any findings, allegations, or suspicions of abuse will be immediately reported and investigated per Federal and State regulations. Results of audits and resident feedback will be monitored by the facility QAPI team to ensure compliance is maintained. Corrective action completion date: 8/7/2024.

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934 Based on review of facility policy, record review, and interviews, the facility failed to protect residents from further abuse, after multiple staff witnessed Certified Nursing Assistant (CNA)1 physically abuse multiple residents and did not report the physical abuse. On 09/20/24 at 11:04 AM, the Administrator and the DON were additionally notified that the failure of staff to report an initial incident of physical abuse, which resulted in further physical abuse, constituted IJ at F609. On 09/20/24 at 11:04 AM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 07/30/24. The IJ was related to 42 CFR 483. 12- Freedom from Abuse, Neglect, and Exploitation. On 09/20/24 at 2:40 PM, the facility provided an acceptable IJ Removal Plan. On 09/20/24 at 2:43 PM, the survey team validated the facility's corrective actions and verified the facility had corrected their noncompliance and the IJ was identified at Past Non Compliance (PNC) as of 08/07/24. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F609, constituting substandard Quality of Care. Findings include: Review of the facility policy titled Abuse Policy with a revision date of 11/2017, revealed, 1. All reported allegations of suspected abuse will be investigated immediately. I. REPORTING OF ALLEGED VIOLATIONS 1. All alleged violations (including mistreatment, neglect or abuse, injuries of unknown origin, and misappropriation of resident property) shall be reported immediately to the administrator the state agency, and other agencies as required. Review of R73's Face Sheet revealed R73 was admitted to the facility on [DATE], with diagnoses including, but not limited to: dementia, moderate, with other behavioral disturbance symptoms and signs involving cognitive functions following cerebrovascular disease, major depressive disorder, pseudobulbar affect, and mood disorder. Review of R10's Face Sheet revealed R10 was admitted to the facility on [DATE], with diagnoses including, but not limited to: dementia with behavioral disturbance, diabetes mellitus, chronic pain, anxiety disorder, and major depressive disorder. Review of R479's Face Sheet revealed R479 was admitted to the facility on [DATE], with diagnoses including, but not limited to: chronic pain, schizophrenia, unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence, and insomnia. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 09/18/2024 at 11:01 AM, R73's daughter revealed, she received a phone call from Licensed Practical Nurse (LPN)4 that an allegation of abuse had occurred on the unit back in August 2024. R73's daughter stated it was not forthcoming that R73 was a victim of abuse. R73's daughter stated a few days later, after the fact, the facility administrator called her and stated she had been the victim of an alleged abuse, body checks were done on R73 and showed nothing. During a phone interview on 09/20/24 at 12:59 PM, R10's son revealed, the facility called him to report that there is an allegation of abuse being investigated in the facility, the day of the allegation in question. R10's son stated the facility did not inform him that his mother was one of the victims during this time. R10's son reveals that 4 to 5 days after the initial contact, the facility informed him that his mother was one of the victims of the alleged abuse investigation. R10's son concluded he would have liked to have been informed of his mother's involvement the day the incident allegedly happened. During a phone interview on 09/20/24 at 12:24 PM, R479's husband and daughter revealed, the only notification he received came from his wife, while the daughter expressed that this was the first time she had heard about the allegation. Review of CNA4's Statement dated 08/02/24, revealed, On August 1st, 2024, [CNA1] assisted me with changing [R10], and in the process, he [CNA1] punched [R10] on the head with his fist. I thought it was a mix-up or something, so I didn't report it that night. The following day August 2nd 2024, [CNA3], [CNA1] and I changed [R10] and again, he [CNA1] punched her on the head with his fist. Another incident happened that night while attempting to change [R479], as she is a 3-person assist. [CNA1] hit her with the bed remote and slapped her in the face with his gloves. Attempt to interview CNA4 on 09/19/24 at 12:06 PM, was unsuccessful. Review of CNA3's statement dated 08/02/24, revealed, [R73] has messed [sic] in his pants and did not want to take a shower for [CNA1]. [CNA2] and I were there for assistance. [R73] was refusing to take a shower and [CNA1] grabbed [R73] by the arm to back in the shower when [R73] had fallen to the floor. While on the floor, [CNA1] hit [R73] on the side of his face. [R73] was crying and stated he never wants [CNA1] to touch him again. [CNA2] stayed with [R73]. [CNA1] apologized and said it would not happen again and feeling sorry for him and his circumstances I did not immediately report the incident. However, there was another incident, and I did report it. Review of a second employee statement form written by CNA3 dated 08/02/24, revealed, Tonight while assisting [CNA4] with [R10]. [CNA1] entered the room to help us, while in the room [CNA1] hit [R10] on the side of her head with his fist. Also, tonight while assisting [CNA1] with [R479], [CNA1] hit [R479] with the bed remote and hit her with his gloves in her face. During an interview on 09/19/24 at 9:55 AM, CNA3 verified and confirmed the allegations of abuse in her statement. During an interview on 09/19/24 at 1:30 PM, the Administrator revealed she asked CNA3 why she didn't report the abuse the first time on 07/30/24 and CNA3 stated she felt sorry for CNA1 because he was homeless and lived in a hotel. The Administrator stated she doesn't believe the abuse occurred. The Administrator further stated her expectation for staff is to immediately report to a supervisor to ensure residents are safe. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/20/24 at 2:40 PM, the facility provided an IJ Removal Plan, which included the following: 1. Residents #10, #73, and #479 were assessed by the Assistant Director of Nursing and another License Nurse on 8/2/2024 to verify injury. No signs or symptoms of abuse were present . CNA1, the accused, was removed from the facility on 08/02/2024 and has not been in the facility since then. He was placed on immediate suspension pending the results of the investigation. On 08/05/2024, CNA1, who was on a probationary period, was terminated from employment related to work performance. 2. The facility has determined that all residents have the potential to be affected by alleged abuse. All residents with who had ever been assigned to or near the accused CNA were interviewed on 8/3/2024 by the Administrator to assess any further allegations of abuse. There were no further concerns reported by any residents. On 8/2/2024, body audits were completed by the Assistant Director of Nursing and a Licensed nurse to assess all residents for any signs or symptoms of abuse, with no findings of injury. 3. On 8/3/2024, an in-service education program was conducted by the Director of Nursing Services and the Administrator with all direct care staff regarding abuse prevention, including the types of abuse, and burnout, as well as addressing circumstances that require reporting including appropriate timeframes. On 8/7/2024, after completion of the investigation, CNAs 3 and 4 were provided additional one-to-one education and disciplinary actions regarding failure to report a suspicion or allegation of abuse immediately. Both CNAs expressed an understanding of this requirement. 4. The Director of Nursing Services, or designee, will continue to conduct audits of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any allegations of abuse are identified, properly investigated and reported to the appropriate people. Further feedback and assurance will be solicited via the facility grievance process and Resident Council. Any findings, allegations, or suspicions of abuse will be immediately reported and investigated per Federal and State regulations. Results of audits and resident feedback will be monitored by the facility QAPI team to ensure compliance is maintained. Corrective action completion date: 8/7/2024.