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	09/05/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to ensure staff maintained documented evidence of a thorough investigation of alleged misappropriation for 1 (Resident (R)25) of 5 residents reviewed for unnecessary medications. Findings include: Review of a facility policy titled Discrepancies, Loss And/Or Diversion of Medications revised on 02/25/25 revealed, . A. Immediately upon the discovery or suspicion of a discrepancy, suspected loss or diversion, the director of nursing or supervisor is immediately notified. The nurse(s) noting the discrepancy should remain on duty until relieved by the director of nursing or supervisor. The director of nursing, or in the director's absence the designee, investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents and reports irreconcilable differences to the administrator and consultant pharmacist. 1) The information should not be discussed with other individuals outside of administrative staff. 2) During the process, the Consultant Pharmacist may be available to verify suspected loss. The policy further revealed, C. Loss of supply of medication, included, 3) Document the loss and the investigation process. Review of R25's admission Record revealed the facility admitted R25 on 07/22/24. According to the admission Record, the resident had a medical history that included, but was not limited to, diagnoses of colostomy, osteoarthritis, and rheumatoid arthritis. Review of R25's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/17/25, revealed R25 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident had intact cognition. Review of R25's Care Plan Report included a focus area revised on 02/04/25 that indicated the resident was at risk for unrelieved or worsening pain due to the effects of rheumatoid arthritis, osteoarthritis, and ostomy. Interventions directed staff to administer medication as ordered for osteoarthritis (initiated 07/22/24) and administer medication as ordered for rheumatoid arthritis (initiated 07/22/24). Review of R25's Order Recap [Recapitulation] Report contained an order dated 12/27/24 for hydrocodone-acetaminophen 5-325 milligram (mg), with instructions to give one tablet three times a day. Review of Pharmacy Consolidated Delivery Sheets dated 07/17/25 indicated the pharmacy delivered 90 tablets of R25's hydrocodone-acetaminophen 5-325 mg.Review of R25's Accountability Record revealed a handwritten note that stated 60 of (to indicate 60 of 90 tablets to be accounted for on the Accountability Record). The Accountability Record revealed that on 07/17/25 there were 60 tablets remaining. Further review revealed there was no Accountability Record for the additional 30 tablets to account for a total of 90 tablets that were dispensed per the Consolidated Delivery Sheets. Review of R25's Progress Notes dated 08/09/25 at 5:24 PM revealed R25 had enough hydrocodone-acetaminophen (5-325 mg) available until the next morning. The notes revealed the facility on-call pharmacy was notified for additional medication, and the pharmacy revealed that on 07/17/25 a 30-day supply was dispensed, and the medication could not be refilled until 08/16/25. Review of a Five-Day Follow-Up Report, dated 08/18/25, revealed that after an investigation the facility could not find 30 tablets of R25's hydrocodone-acetaminophen 5-325 mg. During an interview on 09/05/25 at 11:10 AM, the Administrator stated that all residents had been audited on narcotics by the consultant pharmacist on Tuesday (08/12/25) after the incident. She stated the consultant pharmacist audited everyone who administered narcotics. During an interview on 09/05/25 at 11:42 AM, the Consultant Pharmacist stated she made copies of all of the tracker sheets for all residents on narcotics but did not have documentation of the residents who were reviewed. She stated she reviewed every scheduled and as-needed medication for the residents with the names of the individuals who dispensed the medication to see if a nurse was giving more medication. During an interview on 09/05/25 at 12:34 PM, the Chief Clinical Officer (CCO) stated the folder supplied to the surveyor was all the information that had been investigated. The folder contained the initial notification to the State Agency, 5-Day follow up investigation, three witness statements, accountability records (narcotic sheet) for R2, R25, and R70, and a copy of a medication pill pack for R70. There was no documentation of the audit performed by the Consultant Pharmacist.