STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425303	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Emory Post Acute Care	59 Blackstock Road Inman, SC 29349

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 observations, record reviews, interviews, and policy review, the facility failed to provide adequate supervision and maintain an environment free from accidental hazards for one (1) of two (2) residents reviewed for falls (Resident (R)15). R15 had ten documented falls between August 24, 2025, and December 12, 2025, three (3) of which resulted in fractures. A fall on August 24, 2025, resulted in a nasal fracture, and a fall on September 10, 2025, resulted in a subdural hematoma and right clavicle fracture. Specifically, the facility failed to identify an environmental hazard for a resident with a known history of falls. On December 12, 2025 at 3:20 p.m., the facility failed to identify an environmental hazard for a resident with a known history of falls. The facility staff left a grey rolling trash can near the resident's room; when the resident tried to use the trash can for support, it rolled away, causing the resident to fall and sustain a right femur fracture. Findings include:The facility's policy, Accident/Incident Reporting, revised 11/1/17, defined an incident as any adverse outcome directly resulting from treatment or care, and an accident as any unexpected, unintended event that can result in bodily injury.During the initial tour, on 1/21/26 at 9:25 a.m., of the C Hallway, R15's room was observed to have the resident's name displayed. The room was located near the outside exit door closest to the blue trash dumpsters and far from the nurse's station.On 1/21/26 at 10:00 a.m., observation of a church service revealed R15 in a wheelchair with anti-tippers, a cushion, and portable oxygen. The resident was wearing weather-appropriate clothing and non-skid footwear. At 11:30 a.m., the resident was observed in a wheelchair in front of the nurse's desk.On 1/22/26 at 8:40 a.m., the resident was seen in the common area of C Hallway eating breakfast, with staff visible in the hallway.The facility admitted R15 on 11/14/24 with diagnoses including a displaced left humerus fracture, severe dementia with anxiety, and muscle weakness. The resident's Morse Fall Scale score, dated 8/2/25, was 50, indicating a high risk of falls.The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/25, prior to the 8/24/25 nasal fracture, showed a Brief Interview for Mental Status (BIMS) score of 00/15, indicating R15 had severe impairment, signaling the highest level of cognitive struggle. The facility assessed the resident as having minimal hearing difficulty, unclear speech, and disorganized thinking, along with daily wandering and delusional behaviors. R15 had upper extremity impairment, but no lower extremity impairment. The resident was functionally independent but required set-up assistance with toilet transfers and partial to moderate assistance with showering. The MDS noted two prior non-injury falls.A Significant Change MDS, with an Assessment Reference Date (ARD) of 9/25/25, revealed that R15 re-entered the facility on 9/12/25 following an acute hospital stay. The resident's BIMS score was 99, indicating the resident was unable to complete the interview.R15 exhibited both short-term and long-term memory loss and was severely impaired. The resident also demonstrated inattention and disorganization. The Patient Health Questionnaire-9 (PHQ-9) assessment showed the resident had little interest or pleasure in activities, along with feelings of sadness, depression, or hopelessness. R15 displayed daily wandering (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	behavior.R15 required partial to moderate assistance with toileting hygiene, showering/bathing, and dressing both upper and lower body and required supervision or physical assistance with eating and oral hygiene, and set-up assistance for footwear and personal hygiene. There was no range of motion impairment in the upper or lower extremities. The resident used a walker and was independent with making two turns once seated in the wheelchair. R15's Fall Care Plan, dated 11/14/24, identified falling as a problem related to, but not limited to, immobility, muscle weakness, and vision. The goal was to keep the resident free from injury. Fall interventions included: 1) ensuring proper pants length, 2) using nonskid strips, 3) offering redirecting activities, and 4) placing a resident identifier outside the room. The Care Plan was updated on 9/15/25, after the 9/12/25 fall with major injury, with a new approach to remove slippers from the resident's room. The fall Care Plan, updated on 12/18/25, defined the problem as the resident being non-compliant with x1 assist. The goal was the resident would experience no more injuries until the next review. The approaches included: staff will assist the resident when seen walking without assistance, and will attempt to redirect the resident.Review of R15's Progress Note dated 8/24/25 at 11:05 p.m. (late entry recorded on 8/25/25 at 3:24 a.m.) showed the resident had an unwitnessed fall in another resident's room and was found on the floor near the bedside table with a facial injury to the forehead, an open area on the nasal bridge, and bruising under both eyes. Increased nasal swelling was noted, and the resident was transferred to the emergency room, where a closed displaced fracture of the nasal bone was diagnosed.On 8/30/25 at 4:40 p.m., a Progress Note indicated the resident fell while staff were attempting to walk the resident to the shower room; the resident leaned back, fell, and hit his/her head.On 9/10/25 at 7:54 p.m., a Progress Note documented the resident was behind the nurse's station, was leaning forward and sliding face-first. The facility assessed a silver dollar-sized laceration on the forehead, and the resident was sent to the hospital. The hospital record dated 9/15/25 confirmed a subdural hemorrhage and a closed displaced fracture of the right clavicle.On 10/6/25 at 9:24 p.m., a Progress Note indicated the resident was found in front of her wheelchair in the dining room, with no injury noted.On 10/8/25 at 6:51 p.m., a Progress Note indicated the resident was observed at the nurse's station falling backward.On 11/18/25, a late entry at 7:28 p.m., showed the resident was found on the floor at 1:00 p.m.; the resident denied pain and no visible injuries were noted.On 11/25/25 at 4:00 p.m., a Progress Note revealed the resident attempted to stand and slid from the wheelchair to the floor, not hitting his/her head and with no visible injuries.On 11/29/25 at 10:10 p.m. (late entry on 11/30/25), a Progress Note described an unwitnessed fall; the resident was found on the hallway floor with no injuries.On 12/12/25 at 3:20 p.m., a Progress Note indicated R15 was observed walking in the hallway and fell, hitting his/her head on the rail and shouting, ouch, ouch, while holding his/her right upper thigh.An interview, on 1/21/26 at 11:05 a.m,. with Certified Nursing Assistant (CNA)1, revealed familiarity with R15's care needs, describing the resident as active, ambulatory, and impulsive. The CNA reported witnessing the 12/12/25 fall, explaining that at the end of a shift, staff typically collect residents' trash in a large grey rolling receptacle, which was kept in the shower room and taken outside to the dumpsters. However, on 12/12/25, someone left the receptacle in the hallway; the resident held onto the trash can, which rolled, causing him/her to fall. The CNA stated an in-service was conducted to re-educate staff not to leave the trash receptacle in the hallway.A telephone interview, on 1/21/26 at 8:30 p.m., with CNA2, confirmed knowledge of R15's care needs, describing the resident as impulsive and prone to attempting to stand or ambulate without assistance, requiring consistent redirection. The CNA recalled the 12/12/25 fall occurred near the end of the shift, with the grey rolling trash can near the exit door by the resident's room. The CNA saw the resident exit (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	his/her room, attempt to hold the trash can, and fall when it rolled away.An interview in the A-Hallway shower room on 1/22/26 at 9:25 a.m. with CNA4 revealed training upon hire that the grey rolling trash can must be kept in the shower room and never left in hallways, except when being emptied into the dumpster.An interview, on 1/22/26 at 9:25 a.m., in the surveyors' conference room with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Clinical Service Director addressed the 12/12/25 fall. The DON acknowledged the resident's impulsive behavior and Dementia diagnosis, and agreed that the rolling trash can should not have been left in the hallway. The DON further stated an in-service was conducted to re-educate staff on this policy.During the administrative group interview on 1/22/26 at 9:24 a.m., the Administrator stated that falls and related interventions were discussed at the morning meeting. The Administrator confirmed the facility was aware of R15's multiple falls which resulted in three (3) major injuries. When the surveyor asked whether the facility had considered implementing one-on-one (1:1) supervision, the Administrator responded that 1:1 intervention was typically used for residents with behavioral issues. Upon further questioning about the purpose of 1:1 intervention, the Administrator stated that its goal is to ensure resident safety.