

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER L.M.C.- Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 815 Old Cherokee Road Lexington, SC 29072	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>48835</p> <p>Based on review of facility policy, record review, and interview, the facility failed to ensure Resident (R)20 was free from verbal abuse for 1 of 4 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Review of the facility policy dated 10/21/22 and titled Alleged Abuse/Incident of Unknown Origin/Accident-Injury Complaint Responsibilities/Obligation to Report revealed under the policy, Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance, regardless of their age, ability to comprehend or disability. Examples include threats of harm or saying things to frighten a resident.</p> <p>Review of the facility Customer Service Training, no date, titled, Excellent Customer Service Matters, Internal vs. External revealed under the training, Going above and beyond to ensure customers are happy and satisfied with their products and services. It involves being timely, pleasant, and efficient, and building strong relationships with customers. It also means exceeding expectations, rather than just meeting them. Residents were listed as the first customers in a list of who are our customers. Under Customer Service Attitude, revealed under the training, Your voice, tone, word usage. It's not what you say, but how you say it, and body language.</p> <p>Review of R20's Face Sheet revealed the facility admitted R20 on 09/09/22 with diagnoses including but not limited to: essential hypertension, muscle weakness, anemia, chronic systolic congestive heart failure, and mild dementia.</p> <p>Review of R20's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/18/24, revealed R20 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment.</p> <p>Review of R20's Progress Note dated 04/17/24 at 5:15 PM, revealed, Nurse Supervisor: Notified by daughter that resident called her and was upset.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/19/24 at 1:55 PM, R20's daughter stated, My mom called me and she was mad. She told me an aid told her, She wished she would go home and die. I called the facility right after and I think I spoke to the head nurse. I don't remember the facility calling me back with their findings.</p> <p>During an interview on 06/19/24 at 2:20 PM, the Interim Director of Nursing (IDON) stated, The CNA no longer works here due to customer service. She was not reported for abuse.</p> <p>During an interview on 06/19/24 at 3:00 PM, the Social Worker (SW) stated, I remember this. Something happened with the CNA saying some words to [R20]. I also interviewed [R20], she was able to tell me what the staff member said and what she looked like, I knew who the perpetrator was by her description. A few days later, [R20] was still able to recall what the CNA had said to her. This was verbal abuse, demoralization, and putting the resident down.</p> <p>During an interview on 06/19/24 at 4:24 PM, Licensed Practical Nurse (LPN)1 stated, I took the call that day, it was [R20's] daughter. She asked for the nurse manager. She said, my mom called me and said someone came in her room and said, I wish you would go home and die. I put her on hold and went to [R20's] room. [R20] repeated what her daughter said. I came back up the hall, spoke to her daughter and told her that her mom repeated what she had told her. I then contacted the nursing supervisor who was still here, so I transferred the phone to her. The resident said, I think its the CNA who was behind me when I went to her room. I've not known [R20] to complain like that.</p> <p>During an interview on 06/20/24 at 11:45 AM, IDON stated, We do not tolerate abuse. We have to report to our supervisor, ensure the patient is safe. We would remove the person from the building and immediately begin in-services and investigation. We will call the board if the person is found guilty, we report to the agency responsible for licensing.</p> <p>During an interview on 07/03/24 at 2:03 PM, the Director of Nursing (DON) stated, The 3-11 supervisor got a phone call from [R20's] daughter. It was reported to her the CNA said she should just die and get out of here. We went ahead and decided it was a reportable and I decided to send the CNA home. [R20] had never reported anything to that extent. After reviewing her file, I noted this is a trend here with poor customer service. So we decided to go ahead and terminate her. It's hard to say if it happened, but there was a trend here. I don't know if she was just burned out or what. She was terminated for poor customer service.</p> <p>During an interview on 07/03/24 at 2:28 PM, Supervisor Registered Nurse (RN) stated, I got a phone call from [R20's] daughter. She said she had a few concerns. One was they were trying to get her (mom) in bed and get her in her pajama's and she did not want to change into them then. She went on to say her mom said, the CNA told me Why don't you just leave and die. I went down to the unit and spoke to [R20]. She was laying on the bed, she again repeated what her daughter said, almost verbatim, Why don't you just leave and die. It occurred at 5-5:30 PM. I discussed this with my DON. The CNA was suspended. The CNA told me she had gone to the resident, to put her in her pajama's and she refused and she put her in bed without changing into her pajama's. The CNA did not know it, but I had already spoke to [R20], she told me the exact same thing, it matched exactly. [R20] was so clear about it. For her to tell me almost verbatim says something.</p> <p>During an interview on 07/03/24 at 3:10 PM, R20 stated she could not remember what happened, but said, The facility took care of it.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/03/24 at 2:58 PM, the CNA stated she was terminated for customer service, and also stated, I did not say that to her.		