

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 04/08/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46934</p> <p>Based on review of the facility policy, record reviews and interviews, the facility failed to ensure Resident (R)3 was treated with respect and dignity when Licensed Practical Nurse (LPN)2, used profanity in and/or around the resident's presence.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse/Neglect/Misappropriation/Elder Abuse, last revised 10/21/22, states: . All staff is expected to be in control of their own behavior, behave professionally and appropriately, and understand how to work with the nursing home population. Any substantiated incident will result in employee discipline, which may include termination from the job.</p> <p>Review of R3's Face Sheet revealed, R3 was admitted to the facility on [DATE] with diagnoses including but not limited to: dementia, severe with agitation, osteoarthritis, anxiety disorder, type 2 diabetes mellitus with hyperglycemia, and disorientation.</p> <p>Review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/24 revealed R3's Brief Interview for Mental Status (BIMS) could not be assessed due to being rarely/never understood.</p> <p>Review of R3's care plan with a revision date of 03/27/25, revealed, Potential for behavior problems [Related to] r/t dx unspecified dementia with behaviors as evidenced by [History] hx eloping from home, altercation with other residents, combative with staff, packs up her belongings, declines [Activities of Daily Living] ads and weights .02/09/23- Resident has become aggressive and combative every morning with staff providing care.</p> <p>Review of Certified Nurse Aide (CNA)1's Witness Statement Form dated 03/02/25 revealed, I was giving care to another resident when I heard some noise next door. I step in the doorway and see the nurse (LPN2) fighting with the resident (RM120) . He then mumbled something about her children, and she said if he messed with me or my children, she was going to f--- him up. I called [CNA2] to witness what was going on, and we both checked on the resident to see if she was alright and she said again that if he messed with her kids (her dolls), she was going to f--- him up, and she was breathing hard and was upset. We wrote statements and reported to the supervisor .</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Two attempts were made to contact CNA1 on 04/08/25 at 11:09 AM and 11:18 AM, which were unsuccessful. A detailed message was left for a return phone call.</p> <p>Review of LPN1's Witness Statement Form dated 03/02/25 revealed, To whom it may concern: This morning during shift change, CNA2 came into the supervisor's office and handed me 2 handwritten statements. I read the statements, then asked CNA2 to tell me what he saw aloud, he stated the same as his statement that he overheard the nurse LPN2, call the resident [R3] a b----. I called the unit LPN2 was assigned to, Palmetto Lane, to find out if he was still in the building. He was handing his assignment over to the oncoming shift. I instructed him to come to the supervisor's office immediately. When he came in the office, the oncoming supervisor and I questioned him about the alleged events, he stated he may have said something under his breath. We informed him that he was suspended pending the investigation and that he would have to leave the building immediately. He signed his suspension paperwork and wrote his statement then exited the facility. The [Director of Nursing] DON and [Assistant Director of Nursing] ADON were notified via phone. The dayshift supervisor and I went to the patient's room to ensure her safety and interview her r/t the alleged events. Resident was sitting up in bed eating her breakfast in pleasant mood. Body Audit completed. Notes collected. [Resident Representative] RP was notified via phone call. On call [Medical Director] MD notified, no new orders. Public safety notified and case number requested.</p> <p>During a phone interview on 04/08/25 at 2:11 PM, LPN1 confirmed her witness statement. According to LPN1, the resident could not recall the incident and was unable to describe exactly what happened.</p> <p>Review of CNA2's Witness Statement Form dated 03/03/25, revealed, At around 0600, on Palmetto Lane, I was waived over to RM120 due to some commotion between the resident and the assigned nurse [LPN2]. I didn't hear the entire conversation, but I clearly heard him call the resident a b---- because he was trying to wrasse her arm for blood sugar, and she refused. Followed up with the resident for her safety .</p> <p>During a phone interview on 04/08/25 at 3:24 PM CNA2 confirmed her witness statement. CNA2 stated that was the first occurrence he witnessed with LPN2 and the resident. CNA2 stated that LPN2 sounded annoyed because he could not obtain a finger stick.</p> <p>Review of LPN2's staff file revealed a Suspension Anecdotal Record for Misconduct dated 03/02/25 revealed, supporting details: report of possible abuse situation, witnessed by 2 staff members. Supervisor Recommendation: Immediate suspension, pending investigation.</p> <p>Review of LPN2's Discharge Anecdotal Record for Misconduct dated 3/13/25 revealed, [LPN2], on 03/02/25, you were suspended pending investigation of an alleged abuse. During the seek to understand, you stated that you may have used profanity words in the presence of the residents; two witnesses overheard you cursing at or around a resident. To ensure all employees share in their responsibility for keeping the facility in full compliance with all applicable laws, regulations, and policies governing business practices. You have violated this code of conduct by not keeping with the basic principles and standards of behavior expected in the workplace. This is a violation of our Service Expectations policy. [LPN2] is being released from Lexington Medical Center Extended Care immediately for violation of policy.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/08/25 at 11:40 AM, RN1 stated, the perpetrator (LPN2) was asked what happened and was informed he was going to be suspended pending investigation. RN1 stated that LPN2 made a broad statement and stated he was attempting to get a blood sugar on the resident and that she had spilled juice on him. RN1 stated that LPN2 was dumbfounded and was unaware of what the situation was. RN1 further stated the resident was assessed, she was fine, no injuries, and didn't remember what the situation was. RN1 stated she was unsure what happened to the perpetrator, and to her knowledge, he did not return.</p> <p>During an interview on 04/08/25 at 11:53 AM, the DON stated, on 03/02/25, staff reported an alleged abuse to the supervisor, stating a nurse called a resident b----. The DON stated she spoke with the alleged perpetrator, and he stated the resident became resistant and combative and was grabbing and pulling on his lab coat. LPN2 stated he was trying to encourage her to be compliant with her blood sugar and offered her apple juice to distract her. The resident slapped the juice out of the LPN2's hand, knocking it all over him causing a startled reaction mumbling Son of a B---- under his breath. The DON stated she spoke to the witnesses, and both stated they heard the perpetrator call her b----. [LPN2] was suspended and let go for customer service concerns.</p> <p>During an interview on 4/08/25 at 4:24 PM, the Facility Administrator (FA) stated, LPN2 could not recall what he mumbled under his breath in front of a resident, LPN2 thought he said, Son of a b----. The FA stated that either way, staff overheard him use the word 'b----'. FA stated they were unsure if [LPN2] directed it at [R3] or said it aloud. Regardless, he should not use that language in front of residents. He was terminated for customer service concerns.</p> <p>During an interview on 04/08/25 at 4:29 PM, the Social Worker (SW) revealed she had knowledge of the event. The SW stated the Unit Manager and supervisor told her that a reportable was made, and she needed to follow up on it. The SW stated she followed up with the resident for three days. The resident is not alert and oriented, and she stated she was doing well and spoke with staff but didn't report anything new. The SW stated she asked the resident what occurred, and she could not recall for all three days what happened with the staff member.</p> <p>Three attempts were made to contact LPN2 on 04/08/25 at 12:32 PM, 12:37 PM and 1:10 PM, all which were unsuccessful. A detailed message was left for a return phone call.</p>		