STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425321	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L.M.C.- Extended Care	815 Old Cherokee Road Lexington, SC 29072

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure a privacy bag was provided to Resident (R)178's catheter bag, for 1 of 5 residents reviewed. The deficiency disregarded the resident's privacy, dignity, and respect and had the potential to cause psychosocial harm. Findings include: Review of the facility's policy titled, Standard Policy/Procedure with Subject: Catheterization of Female/Male with an approved by date of 07/13/12, revealed, Procedure- 4. Explain the procedure to the patient. Perform hand hygiene. Maintain the patient's privacy and dignity. Review of R178's Face Sheet revealed R178 was admitted to the facility on [DATE], with diagnoses including but not limited to: paroxysmal atrial fibrillation, depression, chronic combined systolic (congestive) and diastolic (congestive) heart failure, retention of urine, acute respiratory failure with hypoxia, atherosclerotic heart disease of native coronary artery with other forms of angina pectoris, and essential (primary) hypertension. Review of R178's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out 15, indicating R178 is cognitively intact. Review of R178's Physician Orders dated 06/12/24, indicated, Indwelling catheter/suprapubic, 18 FR/10 ml, for urinary retention. During an observation on 06/18/24 at 12:21 PM, R178's foley catheter bag was observed without a privacy bag in R178's room. During an observation on 06/20/24 at 10:14 AM, R178's foley catheter bag, still did not have a privacy bag. During an interview on 06/20/24 at 10:16 AM, Certified Nursing Assistant (CNA)9 revealed the bag should be covered when the resident is up in the chair. CNA9 did not know if the foley catheter bag should be covered when the resident is in the bed. CNA9 confirmed that R178's foley catheter bag was not covered. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/24 at 10:19 AM, Licensed Practical Nurse (LPN)9 verified that to maintain dignity for a resident with a foley catheter a privacy bag would be used. This would be used no matter where the resident is located, either in their room or outside their room. During an interview on 06/20/24 at 10:22 AM, LPN9 verified that R178's foley catheter bag was not covered. During an interview on 06/20/24 at 10:49 AM, Registered Nurse (RN)3 stated that to provide dignity to a resident with a foley catheter, the bag should be covered. During an interview on 06/20/24 at 11:02 AM, the Assistant Director of Nursing (ADON) stated staff expectations would be to provide a dignity bag for any residents with a foley catheter. It was confirmed that the dignity bag for privacy should be in place whether the resident is inside or outside of their room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on record review, facility policy review, and interviews, the facility failed to ensure Resident (R)73 and R96 had a physician's order for the code status of 2 of 5 residents reviewed for Advance Directives. Findings include: Review of the facility's policy titled, Do Not Resuscitate (DNR) with an approved by date of 09/08/23, revealed, Procedure: 1. On admission, the Social Worker will determine the desires of the resident and responsible party related to the DNR status. 2. The Social Worker/Speech Therapist will establish resident cognitive status by completing the BIMs tool. 3. If the resident or his/her legal representative wishes to initiate a DNR order, the Code Status form and Emergency Medical Services DNR order will be initiated. 4. If the resident is not considered their own responsible party and has a BIMS score of =<12, then the responsible party as well as two physician signatures are required to establish DNR status. 5. If the resident is considered competent and has a BIMS score of =>13 then only one physician's signature is required. 6. A written order will be obtained from the physician. The physician will sign the Code Status form at this time. 1. Review of R73's Face Sheet revealed R73 was admitted to the facility on [DATE], with diagnoses including but not limited to: acute respiratory failure with hypoxia and generalized anxiety disorder. Review of R73's Physician Order initially revealed no order for Code Status. Further review of R73's Physician Order revealed an order with a start date of 06/19/24, which documented, CODE STATUS: DNR. The order for code status was updated during the survey. 2. Review of R96's Face Sheet revealed R96 was admitted to the facility on [DATE], with diagnoses including but not limited to: depression. Review of R96's Physician Order initially revealed no order for Code Status. Further review of R96's Physician Order revealed an order with a start date of 06/19/24, which documented, CODE STATUS: DNR. The order for code status was updated during the survey. During an interview on 06/19/24 at 9:26 AM, the Assistant Director of Nursing (ADON)1 stated all residents are considered full code upon admission until a code status can be determined. Orders should be completed on the same day as the Code Status form. The ADON1 reviewed R73's chart and did not see the DNR order listed, although there was a signed Code Status Form and the banner indicated DNR. The ADON1 asked Licensed Practical Nurse (LPN)2 to review the orders section and LPN2 stated I don't see it. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/24 at 10:57 AM, the ADON1 stated she had spoken to the Director of Nursing (DON), who was out sick, and no order is written for full code residents. The Administrator stated that the Code Status form served as the physician's order and Medical Doctor (MD) had 30 days to write the order. The Administrator then reported that the order for R73 was able to be found, but in review, the order was created on 06/19/24 at 10:23 AM (during the survey).

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure medications were properly stored for Resident (R)73 for 1 of 2 residents reviewed. Findings include: Review of the facility policy titled, Subject: Medication Guidelines with an approved by date of 04/25/23 revealed, Policy: Medications are given per physician's order to treat resident's acute and chronic illness. Handling of Non-Controlled Medication: 28. Residents may self-administer a medication based upon physician order, self-administration assessment completed by nurse and review and approval by the interdisciplinary team which determines appropriateness. Review of the undated facility policy titled, Self-Administration of Medications revealed, A. Policy: The facility shall permit residents who are competent and physically able to self-administer their medications if the following conditions are met: 1. Self-administration of medications by residents is permitted only on the specific written orders of the resident's physician or other legally authorized prescriber and documented in the resident's medical record . B. Procedure: 1. Residents who request approval to self-administer shall be assessed by the interdisciplinary team to determine if the resident is competent. 2.The interdisciplinary team will assess the resident's cognitive, physical, and visual ability to carry out this responsibility. Facility staff may use the medication self-administration form (Form #161) or a facility developed mechanism to document this assessment. If the team determines that the resident is competent, the attending physician shall be contacted to request a specific order for self-administration of the medication. 3. If the resident demonstrates the ability to self-administer medications, a further assessment of the safety of the bedside medication storage shall be done. Bedside medication storage is only permitted when it does not present a risk to confused residents who wander into the rooms of or who room with residents who self-administer. 5. Medications stored at bedside shall be secure from other residents. The medications provided to the residents for bedside storage are kept in containers dispensed by the provider pharmacy. Self-administration of medications by residents is verified by direct contact with the resident by a licensed nurse and recorded on the MAR by that same person. Verification and documentation shall occur at the same frequency as the medication is taken. The MAR will reflect self-administration orders and will be addressed in the care plan. Facilities may elect to prohibit self-administration. The facility shall not allow residents to self-administer controlled substances. Review of R73's Face Sheet revealed R73 was admitted to the facility on [DATE], with diagnoses including but not limited to: acute respiratory failure with hypoxia and generalized anxiety disorder. Review of R73's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/05/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R73's cognition is intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/18/24 at 1:29 PM, Systane Hydration drops (a medication is used to relieve dry, irritated eyes) was on the overbed table in the emesis basin. During an interview on 06/18/24 at 1:39 PM, Licensed Practical Nurse (LPN)10 verified there were no order for the Systane Hydration drops. LPN10 also verified the medication in R73's room and stated, It's eye drops. R73 stated, I have no idea where it came from. You can buy them over the counter at the drug store. LPN10 removed the medication and asked if the resident would allow her to check the drawers. Upon opening the top drawer, LPN10 retrieved Tums Chewy Bites Assorted Berries Extra Strength 750 mg. During an interview on 06/20/24 at 12:38 PM, the Assistant Director of Nursing (ADON)1 stated medications should not be left at the bedside. If the resident is able to self-administer medications, they must be assessed to ensure self-administration is appropriate. Next, the physician would be notified for an order. The ADON1 confirmed that even over the counter (OTC) medications should not be left at bedside even if they are not ordered for the resident. It was confirmed that it is not acceptable for the family to leave medications at the bedside and if observed the nurse should check the drawers in the resident's room as an intervention. The medications would need to be removed and education would be needed for the resident and or family.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49801 Based on review of facility policy, record review, observation, and interview, the facility failed to proper store and label respiratory equipment for 3 of 5 residents reviewed for respiratory care, Resident (R)73, R99, R263. Findings include: Review of the facility's policy titled, Subject: Oxygen Therapy Protocol with an approved by date of 05/12/11, revealed, Protocol: 1. The Oxygen Protocol will be initiated on residents by a written order from the physician for any type of oxygen therapy . Routine Oxygen Administration and Documentation: .Documentation will be done by nursing on the Medication Administration Record . Review of R73s Face Sheet revealed R73 was admitted to the facility on [DATE], with diagnoses including but not limited to: acute respiratory failure with hypoxia and generalized anxiety disorder. Review of R73's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/05/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R73 was cognitively intact. Review of R73's Medication Administration Record (MAR) for 06/01/24 - 06/18/24, revealed an order: O2 @ 2L VIA NASAL CANNULA at rest and may increase to 3L with activity D/T HYPOXIA and Shortness of Breath and Change O2 tubing and humidifier bottle weekly on Sunday. Review of R73's Care Plan with a start date of 05/30/24, documented, Problem: Potential for alteration in respiratory status r/t hypoxia. Documented goal, Will be free of complications r/t disease process through next review. Documented approach revealed, O2 as ordered. Monitor O2 sats and keep above 90%. Review of R73's Physician Order with a start date of 06/04/24 documented, O2 @ 2L VIA NASAL CANNULA at rest and may increase to 3L with activity D/T HYPOXIA and Shortness of Breath and another physician order with a start date of 05/30/24, documented, Change O2 tubing and humidifier bottle weekly on Sunday. During an observation on 06/18/24 at 1:29 PM, R73 was observed with oxygen at 3L/min via NC, however the oxygen tubing was not labeled. An oxygen tank was also observed across from the bed in a holder with tubing that was not covered. During an observation and interview on 06/18/24 at 1:39 PM, Licensed Practical Nurse (LPN)10 confirmed that oxygen tubing was not labeled. LPN10 also confirmed that the oxygen tank in its holder should not have tubing hanging from the holder but instead should be covered. During an interview 06/20/24 at 12:36 PM, the Assistant Director of Nursing (ADON)1 stated the oxygen tubing is changed every week on Sunday and tubing should be dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R99's Face Sheet revealed R99 was admitted to the facility on [DATE], with diagnoses including but not limited to: acute respiratory failure with hypoxia pulmonary hypertension, chronic diastolic (congestive) heart failure, unspecified atrial fibrillation, anxiety disorder, other specified chronic obstructive pulmonary disease, and obstructive sleep apnea. Review of R99's Admission MDS with an ARD of 06/12/24, revealed a BIMS score of 14 out of 15, indicating R99 was cognitively intact. Review of R99's MAR for 06/01/24 - 06/20/24, revealed an order for O2 2L via NC at HS for hypoxia with an order date of 06/06/24. Review of R99's Care Plan with a start date of 06/06/24 documented, Problem: Potential for alteration in respiratory status r/t acute on chronic resp failure, pna, copd, osa and pulmonary htn. Documented goal revealed, Will be free of complications r/t disease process through next review. Documented approach revealed, O2 AS ORDERED. MONITOR O2 SATS AND KEEP ABOVE 90%. Review of R99's Physician Order with a start date of 06/06/24 documented, O2 2L via NC at HS for hypoxia. During an observation on 6/18/24 at 1:45 PM, R99's oxygen was at 2L/min. via NC. Oxygen tubing was observed not dated. During an observation and interview on 06/18/24 at 1:52 PM, oxygen was observed at 2 L/min via nasal canula, and tubing was not dated. LPN10 confirmed that tubing was not dated. R99 stated that oxygen tubing was changed on Sunday night. LPN10 confirmed that the tubing should have been dated when changed. During an interview 06/20/24 at 12:36 PM, ADON1 stated the oxygen tubing is changed every week on Sunday and tubing should be dated. Review of R263s Face Sheet revealed R263 was admitted to the facility on [DATE], with diagnoses including but not limited to: chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and shortness of breath. Review of R263's Admission MDS with an ARD of 05/13/24, revealed a BIMS score of 15 out of 15, indicating R263 was cognitively intact. Review of R263's MAR for 06/01/24 - 06/20/24, revealed an order for Change nebulizer tubing and administration set every Sunday. Special Instructions: on night shift; ensure machine is covered with a bag when not in use. Review of R263's Care Plan with a start date of 06/10/24 and target date of 06/30/24 documented, problem Potential for alteration in respiratory status r/t COPD, asthma, OSA, emphysema. Documented goal revealed, will be free of complications r/t disease process through next review. o2 at 2L min via NC. Documented intervention revealed, o2 as ordered. Monitor o2 sats and keep above 90%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R263's Physician Order with a start date of 06/07/24 documented, Change nebulizer tubing and administration set every Sunday. Special Instructions: on night shift; ensure machine is covered with a bag when not in use. During an observation on 06/18/24 at 11:30 AM, the nebulizer mask was observed to be dated for 06/09/24 and in a bag. During an observation on 06/20/24 at 10:24 AM, the nebulizer mask was observed to be dated for 06/09/24 and not in bag. During an interview on 06/20/24 at 10:26 AM, LPN8 verified that the resident had an order for nebulizer treatments and the medication had been administered this morning. LPN8 stated that the mask should be kept in a bag daily and tubing and mask was to be changed weekly. The mask should be rinsed after each use then placed in a bag. LPN8 verified order to change nebulizer mask weekly on Sunday. During an interview and observation on 06/20/24 at 10:40 AM, Registered Nurse (RN)3 reported that nebulizer masks and tubing is changed on Sundays on nightshift. Staff should take a new mask/tubing set to the room and be sure to dispose of the previous mask/tubing set to complete the ordered task. Once the new mask/tubing is replaced the nurse performing the task should date the tubing. RN3 stated that the date should reflect either 06/16/24 or 06/17/24 depending on the time the task was completed on nightshift. Upon entering the room, RN3 confirmed that the mask was not in the bag and the date on the mask was 06/09/24. RN3 stated that it looked like the mask/tubing was not changed on last Sunday. RN3 verified on the administration history that a nurse signed on 06/16/24 as completing the task. During an interview on 06/20/24 at 11:05 AM, the Assistant Director of Nursing (ADON)1 and ADON2 verified that the nebulizer mask/tubing is changed weekly usually on Sunday and as needed. ADON1 confirmed that during the task of changing the mask/tubing, the staff is to write the date on the mask. 50085

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on facility policy review, observation, and interview, the facility failed to label/store and ensure medications were not expired for 3 of 4 units observed for medication storage. Findings include: Review of the facility policy titled, Nursing Medication Guidelines dated [DATE], revealed under the policy, Medication labels must be correct and legible, check medications for expiration dates and return to the pharmacy. Review of the facility policy titled, Medication Storage dated ,d+[DATE], revealed under the policy, The temperature of the refrigerators containing medication shall be maintained between ,d+[DATE] degrees F. On [DATE] at 9:10 AM, an observation of [NAME] Place Unit Medication Room with Registered Nurse (RN)2 revealed the medication refrigerator checklist dated [DATE] had 5 days that the refrigerator temperature was not checked, they were blank. The blank dates were [DATE], [DATE], [DATE], [DATE] and [DATE]. RN2 confirmed the dates were blank. RN2 stated, I was off on some of these dates. I am the one who checks these. Further observation revealed the treatment cart located in the medication room was observed to have Cotton Tipped Applicator with an expired date of ,d+[DATE], Lot #92499, 5 packets of 2 in each packet. Stock medication Vitamin D with an expiration date of ,d+[DATE], lot #133353, of 3 bottles. RN2 confirmed the expiration dates and stated these should have been pulled from the medication room and destroyed or sent back. On [DATE] at 9:30 AM, an observation on Crews Pointe Unit Medication Room with RN1 revealed a bottle of Tuberculin Purified Protein Derivative Dilute Aplisol, 5 TU/0.1 ml in the original box with an open date of [DATE]. RN1 stated, This expires 30 days after opening it. RN1 agreed it was expired and removed it from the refrigerator to discard. Additionally, on top of the treatment cart located in the medication room revealed, 5 vacutainers with Lot #3111759 with expiration date of [DATE], a Light Blue Top vacutainers with Lot #3111759 expired on [DATE], Purple Top Vacutainers x2 with Lot #2259029 with expiration date [DATE]. An opened bottle containing an unknown substance without a label, no name, date or lot number. RN1 stated, This appears to be betadine, this should be labeled with something. RN1 removed the opened bottle from the treatment cart. On [DATE] at 10:15 AM, an observation on Lexington Place Unit with Licensed Practical Nurse (LPN)3 revealed, Assure Dose Control Solution, Lot #00523A with no open date. LPN3 confirmed there was not a date and stated it should be dated when opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:45 AM, the Interim Director of Nurses stated, All medication and treatments should have a label to identify what is in the bottle, or else how would you know what is in it. All of the medication and treatment carts supplies have to be within date, or else if it is expired and it needs to be discarded. I expect the nurses to check for expired meds daily. Everything should be dated after opened as well. The med room refrigerators should be checked daily for the temperature. We have a range to be sure the temperature in within that range, if not, if it's low, what did you do and who did you tell, the same for the high temperatures, what did you do and who did you tell? I expect the nurses to tell someone, the unit managers, so we can get someone to look at it. Medications have to be in a certain range and we need to ensure we are meeting that range.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on facility policy review, observation, and interview, the facility failed to ensure staff served meal trays under sanitary conditions to prevent the spread of disease and infection. Findings include: Review of the facility policy dated 12/23/20, titled, Nursing Hand Hygiene: Staff and Residents revealed under the policy, Situations that require staff hygiene; before and after handling food, after performing your own personal hygiene, before and after assisting a resident with meals. Review of the facility policy dated 10/01/97, titled, Nursing Uniforms revealed under the policy, Hair of any length must be neatly trimmed, hair must not contaminate the work environment. During an observation on 06/18/24 at 12:07 PM, Certified Nursing Assistant (CNA)5 was passing meal trays, on the lower number 200 hall. While CNA5 took trays from the food cart, her hair touched the tops of the items on each of the meal trays. This continued for all the meal trays CNA5 delivered to the rooms. CNA5 touched her hair after sanitizing her hands, then took the meal tray into room [ROOM NUMBER]. CNA5 needed assistance with pulling the resident up in bed. CNA5 put on gloves to assist. After the resident was assisted up in the bed, CNA5 kept the gloves on and began to feed the resident. During an interview on 06/18/24 at 12:25 PM, CNA5 stated, I'm supposed to tie my hair back, but my rubber band broke. I'm supposed to sanitize my hands after I touch my hair. During an interview on 06/18/24 at 12:32 PM, Registered Nurse (RN)1 stated, It is not ok for [CNA5]'s hair to touch and fall into the meal trays as she is passing trays. She should also sanitize her hands after she touches the meal trays. I will educate her on that. During an interview on 06/20/24 at 3:55 PM, the Interim Director of Nurses stated, The staff are supposed to pull their hair up when they are passing meal trays or providing care. They should wash their hands after they touch their hair, before they pull another meal tray.