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	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L.M.C.- Extended Care	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)
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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of facility policy, record reviews, and interviews the facility failed to complete a thorough investigation for allegations of staff-to-resident abuse for 1 Resident (R)21 of 6 sampled residents reviewed for abuse. Specifically, the facility investigation did not include staff interviews from the unit where the resident resided.Review of a facility policy titled, Standard Policy/Procedure, approved 10/21/22, revealed the section titled, DHEC [Department of Health and Environmental Control] Certification and the facility Administrator shall be notified immediately but not later than 2 hours after alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source or misappropriation of resident property are made if the events that cause the allegation involve abuse or result in serious bodily injury. Review of R21's Face Sheet revealed the facility admitted R21 on 11/22/24. According toR21's Face Sheet, the resident had a medical history that included diagnoses of depression, cognitive communication deficit, transient ischemic attack, cerebral infarction, and malignant neoplasm of the left breast and brain. Review of R21's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/31/25, revealed R21 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial assistance with most activities of daily living (ADLs) except the resident required partial/moderate assistance with upper body dressing and set-up help with eating. R21's Care Plan included a problem statement dated 07/09/25, that indicated the resident required the use of psychotropic/psychoactive medications for diagnoses of depression and glioblastoma brain cancer. Interventions initiated 03/11/25 directed staff to observe and document any changes in cognitive status, which included changes in mood and behavior (i); provide support and monitor for psychosocial concerns; and schedule a psychological consult as needed. R21's Care Plan, included a problem statement dated 06/16/25, that indicated the resident had the potential for behaviors related to a diagnosis of glioblastoma, which included refusal of baths/showers, refusal of meals, making sexual comments about themself and their spouse, delusions, and fabricated stories about staff. Interventions directed staff to approach the resident in a calm and non-threatening manner (initiated 02/17/25); do not place the resident near another resident who may increase agitation, behavior, and mood (initiated 02/17/25); redirect the resident if they express sexual comments or are aggressive or combative and try to channel the resident in constructive physical and social activities as needed (initiated 03/05/25); two staff members to assist with ADL care (initiated 06/06/25); and redirect and reassure the resident when the resident states, Make sure that resident doesn't get in my bed, when nobody was in their room (initiated 06/13/25). Review of a Five-Day Follow-Up Report, dated 06/10/25, revealed R21 had reported allegations of physical and sexual abuse. The Five-Day Follow-Up Report indicated Certified Nursing Assistant (CNA)1 and Licensed Practical Nurse (LPN)2 were the alleged perpetrators. The Report indicated that on 06/06/25 R21 reported some concerns to Social Worker (SW)12, and SW12 brought LPN8 with her to hear what the resident had to say. R21 stated that they had been talking to a staff member's boyfriend, everyone was talking about it, the staff member learned that R21 was talking to the staff member's boyfriend, and the staff member pinched R21 while providing care. During the investigation of physical abuse, the Assistant Director of Nursing (ADON) 5, who was the Abuse Coordinator, and the Staff Development Director interviewed R21, where R21 repeated the physical abuse allegation and added an allegation of sexual abuse. During this interview, R21 stated that a week or two prior, when the resident used their call light for assistance to be changed, the boyfriend came to their room and while changing the resident's brief fondled the resident. When ADON5 asked R21 the boyfriend's name the resident was unable to state the name; however, R21 described the boyfriend and stated he was a nurse. LPN2 was suspended. The facility's investigation file for R21's allegations of abuse included statements from the two alleged perpetrators, CNA1 and LPN2, and written statements from SW12 and LPN8 related to the interview they conducted with the resident. The facility's investigation included 20 signed statements from the residents who lived on the same unit as R21. The facility's investigation file did not include any interviews from other staff who had recently worked on the unit where R21 lived. During an interview on 07/24/25 at 11:50 AM, ADON5 stated as far as staff interviews, she only interviewed the alleged perpetrators, CNA1 and LPN2. ADON5 stated SW12 and LPN8 wrote statements about what R21 reported to them concerning the allegation. During an interview on 07/24/25 at 2:16 PM, SW12 revealed she wrote a statement about her interview with R21. During an interview on 07/25/25 at 4:01 PM, the Administrator stated that after an allegation they normally interviewed the staff who

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to refer Resident (R)4 for a Preadmission Screening and Resident Review (PASARR) Level II, after the resident received a new diagnosis of a severe mental illness, for 1 of 2 residents reviewed for PASARR.Review of R4's Face Sheet indicated the facility admitted R4 on 09/30/2019. According to the Face Sheet, the R4 had a diagnosis of bipolar disorder, dated 07/30/21. Review of R4's significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/25, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. The MDS indicated R4 had a diagnosis of bipolar disorder. Review of R4's Care Plan, included a problem statement started 12/12/2023, that indicated the resident had diagnoses of a cardiovascular accident (CVA), bipolar disorder, anxiety, and dementia that required the use of psychotropic/psychoactive medications. Interventions directed staff to administer medications as ordered; approach the resident in a calm, non-threatening manner; observe and document any changes in cognitive status, including changes in mood and behavior necessitating medications; observe for side effects; provide comfort measures and distractions prior to administering as-needed medications; provide support and monitor for psycho-social concerns; schedule psychiatric consultations as needed and follow-up as indicated; and review medications monthly and as needed, provide medication trial reductions every six months and as needed. A South Carolina Department of Health and Human Services PASARR Level I Screening Form, dated 09/23/19, indicated R4 had no diagnosis of a mental illness. During an interview on 07/24/25 at 11:00 AM, the Director of Nurses (DON) stated the hospitals were responsible for completing the Level I PASARRs, and if they needed to be updated the facility's social services took care of that. During a follow-up interview on 07/25/25 at 11:59 AM, the DON stated R4's original admission date was 09/30/19, and their mental illness diagnosis after admission should have been updated on the Level I PASARR and resubmitted to the state. The DON indicated that she had a new Director of Social Services who was responsible for the process currently. During an interview on 07/25/25 at 12:10 PM, the Administrator stated the Level I PASARR for R4 should have been updated with the new mental illness diagnosis and resubmitted to the state.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on review of facility policy, record reviews and interviews, the facility failed to ensure Resident (R)191's medical record included documentation they were offered the pneumonia vaccine for 1 of 5 sampled residents reviewed for immunizations.Review of a facility policy titled, Immunization, dated 05/1123, specified, [Facility Name] will offer the pneumonia immunization at admission if there is no history of prior immunization; and immunize against pneumonia unless medically contraindicated or immunization is refused by the resident or the resident's legal representative. Review of R191's Face Sheet revealed the facility admitted R191on 02/23/24. According to R191's Face Sheet, the resident had a medical history that included diagnoses of dementia and chronic obstructive pulmonary disease. Review of R191's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/01/25, revealed R191had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. Review of R191's Continuity of Care Document, created 07/25/25, revealed no indication the resident had a pneumococcal immunization. During an interview on 07/25/25 at 11:26 AM, the Infection Preventionist (IP) stated she looked at the immunization record of residents when they were admitted to the facility and paid close attention to the Centers for Disease Control (CDC) guidance about pneumonia vaccines. The IP stated she did not have the pneumonia vaccine consent for R191 as the consent was mailed out. The IP stated that R191 not receiving the pneumonia vaccine was a significant failure. During an interview on 07/25/25 at 1:07 PM, the Director of Nursing (DON) stated that a consent or a refusal for a vaccine came from the resident or the responsible party if the resident was not their own person. The DON stated a letter, and education was sent to the responsible party, and the responsible party would either mail the consent back to the facility or drop it off when they visited the resident. The DON stated the facility would continue to try to reach out to R191's responsible party to obtain the consent. The DON stated her expectation was for the consent to be done and the follow-up to be completed.