STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425341	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Moultrie Nursing Home	1038 McGill Lane Saint Stephen, SC 29479

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 0578 Level of Harm - Immediate jeopardy to resident health or safety 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** 28270 Based on interview, record review, and facility policy review, the facility failed to ensure physician orders matched the resident's documented end of life wishes for one of 20 residents (Resident (R) 71) reviewed for code status out of a total sample of 20. Specifically, R71's representative chose for R71 to have a Do Not Resuscitate (no cardiopulmonary resuscitation (CPR) in case of a medical emergency) status. Five days later, R71 chose to have full code status (perform CPR in case of a medical emergency); however, the physician's orders were not updated to reflect the resident's choice. This placed R71 at risk of not receiving CPR in the event of a medical emergency and placed the resident at risk for serious harm, up to and including death. An Immediate Jeopardy was identified on [DATE] at F578 at a Scope and Severity of (S/S) of J was determined to exist on [DATE] when R71 changed his code status to Full Code and the facility did not update physician orders from DNR to Full Code. The Administrator was notified of the Immediate Jeopardy on [DATE] at 3:43 PM. The facility provided an acceptable plan of removal on [DATE] at 9:57 AM. The removal plan included completing chart audits on every resident and comparing advanced directives to physician orders for accuracy, scanning all advanced directives into the electronic medical record, and educating all licensed nurses on the facility's policy and procedure for initiating code status orders, the appropriate forms to be used, and the location of the code status for each resident in the EMR. The survey team validated the implementation of the removal plan on [DATE] at 3:20 PM, and the S/S was lowered to D, isolated with the potential for more than minimal harm. Findings Include: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Advanced Directives, revised [DATE], revealed, . information about whether or not the resident has executed an Advanced Directive shall be displayed prominently in the medical record . Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives . Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan . The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care . The plan of care of each resident will be consistent with his or her documented treatment preferences and/or advance directive . The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. 1. Review of R71's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R71 was admitted to the facility on [DATE]. Review of R71's Advanced Directives tab of his hard chart revealed a South Carolina Emergency Medical Services form, dated [DATE] and signed by the resident's representative and physician, which indicated no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest. Review of R71's Misc (miscellaneous) tab of the EMR revealed a Resuscitation Directive, dated [DATE], that indicated R71 requested all possible measures taken to revive me. It was recorded that the form was uploaded to the EMR on [DATE]. Review of R71's Order Recap Report, located in the Orders tab of the EMR, revealed a physician's orders, dated [DATE] to [DATE] and [DATE] to [DATE] for R71 to have a code status of DNR [Do Not Resuscitate]. On [DATE], an order was entered for R71 to have a Full Code status. Further review of the EMR revealed no signed request indicating if R71 wanted to have CPR performed or if R71 wanted DNR status until an interview with the SSD on [DATE]. Review of the Care Plan located under the Care Plan tab of the EMR revealed R71 had a focus area Do not do CPR [DNR] created on [DATE] and revised on [DATE] to Do CPR. Review of R71's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] and located in the MDS tab of the EMR, revealed R71 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R71 was cognitively intact. During an interview on [DATE] at 10:00 AM, Registered Nurse (RN) 1 was asked what she would do if a resident was found without a pulse or respirations. She stated she would check the EMR for the resident's code status. In addition, RN1 stated the facility was in the process of scanning the signed code status request forms into the EMR under Misc. RN1 was asked what she would do if the scanned form and the orders did not match. She stated, If they don't match, well that wouldn't be good. I would try to find the initial signed order. RN1 verified the advanced directives tab of the hard chart contained only a DNR code status request for R71, dated [DATE] and that Full Code orders were in the EMR. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:10 AM, the Assistant Director of Nursing (ADON) reported the Social Services Director (SSD) had residents/responsible parties sign a form revealing their wishes regarding code status. The ADON stated the DNR form was signed by two doctors and then given to the nurse to put orders into the EMR. She stated a different form was used for Full Code, with those orders also put into the EMR after a doctor signed. The ADON stated the signed requests were in the process of all being scanned into the EMR as the facility worked on going paperless. She stated that currently, the hard chart contained the forms. The ADON stated staff were to go to the EMR profile where the orders showed up revealing code status. The ADON stated the request and the orders should match. During an interview on [DATE] at 10:13 AM, the SSD reported she discussed code status wishes with the resident or family (if the resident was unable to make the decision) on admission and with any changes. The SSD stated she discovered on [DATE] that R71 had two signed requests, one for DNR dated [DATE] and one for Full Code dated [DATE]. The SSD stated the Full Code request that was signed by the resident and physician was in the business office file and not in the hard chart. The SSD stated she took the Full Code form to the nurse on [DATE] so that she could change the DNR orders to Full Code. The SSD stated she left the Full Code form with the nurse and kept a copy. The SSD provided the copy and scanned it into the Misc tab. The SSD stated R71 chose a full code status five days after admission to the facility when he was feeling better. The SSD stated the form should have been in his hard chart and provided to the nurse so orders could have been put in the EMR. During an interview on [DATE] at 10:26 AM, R71 commented, If you can save a life, why not try? He stated, If I'm good, they can help me [perform CPR]. During an interview on [DATE] at 10:32 AM, the SSD was asked when she had last verified R71's code status wishes with him. She stated it was when he signed the Full Code request in August. When asked if code status was discussed any other time, such as at care conferences, the SSD stated the residents were asked if they wanted any changes in their code status during care conferences. During an interview on [DATE] at 10:36 AM, the Administrator stated she expected the orders in the EMR to match the residents' wishes. During an interview on [DATE] at 11:07 AM, the Director of Nursing (DON) stated the SSD met with the resident or family member to determine code status. She stated once the form was signed, the SSD gave it to the nurse to ensure the order went into the EMR, and then the ward secretary was given the form to scan into the Misc tab of the EMR. The DON stated that not all code status requests were in the EMR since the facility was in the process of scanning the forms. The DON stated the current form was expected to be in the hard chart, if not scanned in, with orders in the EMR matching. She stated if the orders conflicted with the code status request form, staff were to check with the doctor. The DON stated she understood this could take time the facility did not have if a resident coded. Review of the facility's Removal Plan included the following: 1. Identification of Residents Affected or Likely to be Affected: Resident 71 had the potential for an adverse event relating to his advance directive which did not match physicians' orders. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility took the following actions to address the citation and prevent any other resident from having the potential to not have the correct code status. (Completion Date: [DATE]) -The Facility Medical Director was notified of the incident. -The DON or designee completed a chart audit on every audit on every resident and compared the advance directives to the physician order for accuracy. No other inaccuracies were noted. The Social Worker, Director of Nursing (DON), and ADON went through each medical record separately. They compared the order to the advanced directive and reviewed the care plan to reflect the current code status. The ward secretary and Social Service director scanned the advanced directives into the EMR. -Resident R71 was interviewed by the social worker on [DATE] to confirm the residents' wishes or his code status. The resident has a BIM score of 13 and competent to make his own decision. The resident confirned that he wished to have all possible measures taken to revive him. The residents' advance directive reflected his decision to be a Full Code. An order was obtained on [DATE] by LPN for residents to be full codee. The care plan was updated [DATE]. 2. Actions to Prevent Occurrent/Recurrence: The facility took the following actions to prevent a potential adverse event from occurring. (Completion Date: [DATE]) -The DON or designee educated all licensed nurses on duty in the facility [DATE] on facility's policy and procedure for initiating code status orders, the appropriate forms to be used for a full code or DNR, and location of the code status for each resident in the EMR. The Administrator educated the social worker on the Advanced Directive policy and procedure. Licensed nurses will not be permitted to work a shift until education is completed on resident's code status. Nurses on leave will receive education prior to their next scheduled shift. -Code status will be reviewed during quarterly and annual care plan meetings to address residents' current preference of code status. -A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented. DON to monitor code status compliance by interviewing licensed nurses about facility Advance Directive policy and procedure, as well as requesting return demonstration of Advance Directive process. Compliance checks will be conducted 2 times weekly for three months. Findings will be reported at a weekly ADHOC QAPI weekly x4 weeks then monthly QAPI Committee meeting to ensure that compliance is met. -DON or designee will audit new admission to compare the residents' advanced directives to the physician orders for accuracy. This audit will continue daily for three months and will be reviewed by the Administrator in the morning meeting x5 days Monday-Friday and the weekend RN Supervisor will review new admission on Saturday and Sunday. Facility asserts Likelihood for Serious Harm No Longer Exists: [DATE]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on record review, interviews, and facility policy review, the facility failed to ensure bruising to the chest was reported for one of one resident (Resident (R) 33) reviewed for injuries of unknown origin out of a total sample of 20. Specifically, staff failed to accurately report a bruise on R33's chest upon initial discovery as well as failed to accurately report the circumstances surrounding an event with R33 and Family Member (FM)2. This deficient practice had the potential to affect other residents at the facility that may have had unidentified pain, an injury of unknown origin, unwitnessed fall, or allegations of abuse. Findings include: Review of the facility's policy titled, Abuse: Reporting Abuse to Facility Management, revised December 2013, indicated, 1. Our facility does not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals . G. Injury of unknown source is defined as an injury that meets both of the following conditions: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident. 2. The injury is suspicious because of . location of the injury . Review of R33's Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with a diagnosis of dementia. Review of R33's Admission Minimum Date Set (MDS), under the MDS tab of the EMR and with an assessment reference date (ARD) of 11/04/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated severe cognitive impairment. The resident was coded as having hallucinations, displayed physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), and rejected evaluation or care. The resident was coded as needing partial to moderate assistance with eating and was dependent with all other Activities of Daily Living. Review of R33's Progress Notes, under the Progress Notes tab of the EMR, dated 01/08/25 at 1:39 PM, and written by Licensed Practical Nurse (LPN) 3, indicated, . Resident in the day room with FM2] 2 at her side assisting with feeding her lunch. Writer noted resident held [FM2] arms and [FM2] grabbing on to residents' arms saying, 'Give that to me you fool.' With the writer noting increased physical aggression from [FM2] and increased agitation noted from resident. Writer observed [FM2] push his fist into resident upper middle left chest wall where current bruising on the chest wall was noted yesterday. Resident stated, 'I'm scared.' This writer stepped in to finish the feeding. [FM2] was very angry with the situation - resident holding food in her hand which was [FM2]'s concern. Writer reported to [LPN2] and DON [Director of Nursing], for further F/U [follow up] . Review of R33's entire clinical record revealed no documentation related to the origin of the bruise to R33's chest or any investigation into the cause of the bruise. LPN3 was not available for interview at time of survey. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 01/21/25 at 3:15 PM, LPN2 stated, I was not there the day of the incident so I did not see it. I was told by [LPN3] that [FM2] was at the table with [R33] feeding her lunch. [R33] became aggressive and started swatting at him. [FM2] grabbed her hand and [R33]'s hand was flopping back and forth trying to protect herself. I was not told about [FM2] was striking her chest. I have never seen [FM2] be abusive to her. LPN2 stated she was not aware of the bruise on R33's chest as documented in the progress note. During an interview on 01/20/25 at 2:55 PM, the Administrator stated she was not aware of FM2 striking or pushing R33's chest. During a follow up interview on 01/20/25 at 3:44 PM, the Administrator stated, The only thing I know was [DON] said [FM2] would try to feed [R33] and [FM2] gets frustrated when she does not eat. When [FM2] sometimes voices his concerns about [R33] not eating, we explain interventions in place. He gets confused himself. The Administrator added that if she was told FM2 had struck R33 in the chest, she would investigate who saw it, review the progress note, and if she felt like he was being abusive, she would do a reportable. The Administrator stated, No staff has told me he has been abusive. The Administrator was informed of the note in the progress note. The Administrator reconfirmed she was not aware of the incident; therefore, she did not report it. During an interview on 01/20/25 at 2:57 PM, the DON revealed LPN3 came to her and stated FM2 was shaking at R33 trying to get her to eat. The DON stated LPN3 never reported FM2 touched R33. The DON stated they told FM2 if he got agitated while feeding her to stop and we would finish feeding her. The DON stated no other instances had been reported between FM2 and R33. The DON stated she did not review the progress notes; therefore, she was not aware of the bruise on R33's chest. During an interview on 01/20/25 at 3:16 PM, Certified Nursing Assistant (CNA)2 stated, On the day of the incident, [FM2] was like trying to feed her [R33] but she did not want to be fed. I saw [FM2] get agitated, so I went to get the nurses' attention but they saw it as well, so they were going to address the matter. I do not remember witting a statement about it. CNA2 stated she did not provide care for R33.

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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** 42440 Based on observation, interview, record review, and policy review, the facility failed to administer oxygen at the physician prescribed rate for one of three residents (Resident (R)9) reviewed for oxygen out of a total sample of 20. This had the potential to cause the resident respiratory distress. Findings include: Review of the facility's Oxygen Administration policy, dated 2020, revealed, . Oxygen is administered under orders of a physician except in the case of an emergency . Review of R9's Admitting Record, located in the Profile tab of the electronic medical record, (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, diabetes, and anxiety. Review of R9's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/24 and located under the MDS tab of the EMR, revealed R9 scored 12 out of 15 on her Brief Interview for Mental Status (BIMS), which indicated she had moderate cognitive impairment. It was recorded R9 used continuous oxygen therapy. Review of R9's Care Plan, dated 12/04/24 and located in the Care Plan tab of the EMR, revealed a focus, . The resident has oxygen therapy r/t [related to] shortness of breath. Interventions included,. Oxygen at 2 L [liters] per minute via nasal cannula to maintain O2 [oxygen] saturation above 92% and for shortness of breath . Review of R9's January 2025 Medication Administration Record (MAR), located in Orders tab of the EMR, revealed an order dated 12/04/24 for oxygen at two liters/minute via nasal cannula to maintain oxygen saturation above 92% and for shortness of breath. Nursing signed the order off on the MAR each twelve-hour shift and noted R9's oxygen saturation levels, which were all greater than 92%. During a concurrent observation and interview on 01/20/25 at 10:22 AM, R9 was observed lying in bed with oxygen flowing via a nasal cannula from a concentrator set at 3.5 liters per minute (LPM). R9 stated she had used supplemental oxygen for about two months but could not recall why it was used or the setting. During an observation on 01/21/25 at 11:25 AM, R9's oxygen concentrator was again set at 3.5 LPM as she sat in her wheelchair during an activity in a common area, utilizing oxygen from the concentrator. During a concurrent observation and interview on 01/21/25 at 12:45 PM, Registered Nurse (RN) 2 verified R9's oxygen concentrator was set at 3.5 LPM as R9 sat in her room in her wheelchair. RN2 verified the orders in the EMR and stated the oxygen orders were for 2 LPM. RN2 went to R9's room to adjust the concentrator to the ordered oxygen setting. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/21/25 at 1:36 PM, the Director of Nursing (DON) stated she expected that oxygen would be delivered at the rate ordered by the physician. She stated oxygen should not be turned up without a physician's order.