

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Faith Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 617 West Marion Street Florence, SC 29501	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and staff interview, the facility failed to provide adequate supervision for 1 of 1 resident reviewed. Specifically, on 09/01/25 a demented, confused resident was found across the street, approximately 500 feet, from the nursing home facility by a citizen passing by in a car. This citizen contacted 911 emergency services, detailing that a young lady was on the ground in front of a local grocery store. On 09/04/25 at 7:45PM, the State Agency determined that the facility's noncompliance with one or more federal health, safety, and/or quality regulations had caused or was likely to cause serious harm, psychosocial harm, serious impairment or death. On 09/04/25 at 7:45 PM, the Administrator was notified that the failure to provide appropriate supervision to Resident (R)1, resulting in a successful elopement from the facility, constituted Immediate Jeopardy (IJ) at F689. On 09/04/25 at 7:45 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 09/01/25. The IJ was related to 42 CFR 483.25 - Free of Accident Hazards, Supervision, and Devices. On 09/05/25 at 2:00 PM, the facility provided an acceptable IJ Removal Plan. The survey team verified that the facility put forth due diligence in addressing this non-compliance. The SA is considering the IJ at Past Non-Compliance as of 09/02/25. An extended survey was conducted in conjunction with the Compliant Survey for non-compliance at F689, constituting substandard quality of care. Findings Include: Review of the facility policy titled Elopement with a complete revision date of 11/01/17, revealed, Policy: To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. The Facility will determine a signal code, e.g. Code [NAME] to designate a missing patient/resident. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, Alzheimer's dementia, depression, anxiety disorder, multiple falls, muscle weakness, and impaired gait and mobility. Review of R1's Quarterly Minimum Data Set (MDS) Nursing assessment dated [DATE] revealed R1 has a short-term memory problem, and her decision-making ability is moderately impaired. R1 shows little interest or pleasure in doing things and can be short-tempered. R1 was noted to wander, which placed resident at significant risk of getting to a potentially dangerous place. R1 uses a walker and has an impairment of her left upper extremity. R1 had one fall in the prior 31-180 days. R1's balance was not steady, but she was able to stabilize without human assistance. R1 is on anticoagulant therapy. Review of R1's Care Plan revealed R1 is at risk for unwanted side effects of antianxiety medication prescribed for treatment of anxiety, insomnia, behaviors associated with Alzheimer's Dementia with agitation. Further review of the Care Plan revealed on 01/21/25 it was identified the resident wanders through out the facility, on 09/19/24 she is unaware of her surroundings, very confused and unable to make decisions related to Alzheimer's Disease and she has potential for falls and injuries. Review of R1's Assessments reveals R1 had an Elopement assessment completed on 09/01/25, and she was at risk for elopement/wandering as evidenced by, Resident wanders in the facility and went out of an exit door. There were no prior Elopement assessments completed. Review of R1's Nurse's Note on 09/01/25 revealed the resident left the building at 2:36 PM, she was found by a local grocery store and was taken to the hospital by EMS (emergency medical services). Resident returned to the facility at around 5:49 PM. Body audit was conducted skin was warm and dry with no apparent issues. Resident was pleasant and calm. Lungs were clear and there were no signs and symptoms of pain or being in stress. No acute changes of condition. During an observation on 09/04/25 at an unspecified time revealed the local grocery store is located on a busy street. There were two abandoned houses that neighbor the facility doors, and across the street was a house that had demolished material in a large trash container. The local grocery store was closed due to the holiday. According to a weather report the temperature for the day of the elopement was 82 degrees Fahrenheit. During an interview on 09/04/25 at 11:22 AM, the Facility Administrator (FA) revealed the facility does not have wander guards for their residents. They have an elopement book that is kept at each nurse's station and one at the front desk. During an interview on 09/04/25 at 12:38 PM, the Minimum Data Set (MDS) Coordinator 1 revealed that they are located on D hall with the business office, supply room, social services director, classrooms, and therapy. She includes that deliveries are received at that door, and one would have to have a key and a code to open the door. The supply room has a key to open the door. The MDS Coordinator 1 stated that she was off that day, so she was informed of the incident upon her return on Tuesday. She also includes that maintenance has been working on the door, and they have received a</p>		