

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2024
NAME OF PROVIDER OR SUPPLIER  C M Tucker Jr Nursing Care Center Fewell and Stone		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Harden Street Columbia, SC 29203	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48214</p> <p>Based on interviews, record review, review of facility policy, and review of the facility's video surveillance the facility failed to provide appropriate supervision to prevent Resident (R)1's elopement from the facility.</p> <p>On 07/15/24 at 1:45 PM, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death.</p> <p>On 07/15/24 at 2:11 PM, the Administrator was notified that the failure to properly supervise a resident, resulting in a successful elopement from the facility, constituted Immediate Jeopardy (IJ) at F689.</p> <p>On 07/15/24 at 2:11 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 07/06/24. The IJ was related to 42 CFR 483.25 - Quality of Care.</p> <p>On 07/15/24 at approximately 4:45 PM, the facility provided an acceptable IJ Removal Plan. The survey team validated the facility's corrective actions and determined the facility put forth good faith attempts to address the non-compliance. The survey team considers the IJ at Past Non-Compliance with a correction date of 07/11/24.</p> <p>An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F689, constituting substandard quality of care.</p> <p>Findings Include:</p> <p>Review of the Facility's Policy titled, Missing Resident Procedures/Elopement last revised 09/23, stated, Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so (42 CFR, section 483.25).</p> <p>Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including but not limited to: wandering, lack of coordination, difficulty in walking, muscle weakness and a history of falling.</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>Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date of 07/03/24 revealed R1 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating R1 was moderately cognitively impaired. Further review of the MDS revealed there were no wandering behaviors exhibited.</p> <p>Review of R1's Physician Orders dated 06/27/24, revealed the following order wrist call light for resident.</p> <p>Review of R1's Progress Note dated 07/06/24 at 8:06 PM revealed, resident alert with confusion, Resident remain on close observation, safety maintain by staff. Took all meds whole and tolerated well. wonder guard intact to right ankle. resting in bed with call light in reach.</p> <p>Review of R1's Progress Note dated 07/06/24 at 11:43 PM revealed, At approx. 2200 staff reported to this nurse that resident was not found in his assigned room. At approx. 2210 resident was found by staff outside in courtyard and brought back inside facility. Per resident he said, I was looking for my truck When asked how he got out of the door, resident said, I held the door for 15 seconds just like the sign says No apparent injuries noted. Small indentations and abrasions noted on bilat knees. Wander guard in place to resident right ankle and functioning.</p> <p>Review of R1's Elopement Risk Tool dated 06/27/24 revealed, R1 had noted wandering behaviors occurring for 1 to 3 days. R1 was noted as having a risk of getting to dangerous places. Furthermore, it revealed that R1 had verbalized intent to the facility and was actively exhibiting exit-seeking behaviors.</p> <p>During an interview on 07/15/24 at 11:15 AM, R1 stated that he escaped this place. R1 stated that he just went up to the door and held it for 15 seconds because that is what it says on the door and then he went out. R1 stated he thought his car was in the parking lot and was trying to get to it. R1 then stated that he fell .</p> <p>During an observation and interview on 07/15/24 at 11:57 AM, with the Director of Nursing (DON) and Facility Administrator (FA), the route R1 took to exit the facility was walked through. The DON stated that R1 was new to the facility, and they weren't aware of any exit seeking behaviors.</p> <p>During an interview on 07/15/24 at 12:10 PM, Certified Nursing Assistant (CNA)2 stated that R1 was wearing a black shirt with black shorts. CNA2 could not recall if R1 was wearing shoes or socks. CNA2 also stated that upon R1's return into the facility, he was laughing as he stated that he escaped the VA Hospital.</p> <p>During an observation of the Facility's Surveillance Camera on 07/15/24 at 12:50 PM, it was revealed that, On 07/06/24 at 9:59 PM, R1 was sitting in his wheelchair in the common area near the nurse's station of hall 100. At approximately 10:01 PM, R1 can be seen rolling himself down the hallway and at approximately 10:03 PM, R1 enters the hall for the secured unit. R1 then tries to open and enter the secured unit but is unsuccessful. At 10:06 PM, R1 can be seen entering a door on the secured hall which leads to a canteen like room and a door that leads to outside the facility. Staff members can be seen on footage entering that canteen room at approximately 10:22 PM, and then wheeling R1 back into the hall at approximately 10:27 PM. R1 was noted to be wearing a tee shirt, shorts and yellow non-slip socks.</p> <p>(continued on next page)</p>		

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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>During an interview on 07/15/24 at 4:07 PM, CNA1 stated, R1 was moved up front and was last watching television when she saw him. CNA1 reported that during her last rounds is when she noticed that R1 was not up front and proceeded to R1's room, where he was also not. CNA1 then reported to another staff member that R1 was missing, and she began searching for him. CNA1 stated that she checked each hall, the cafe and even any door she walked past. Furthermore, CNA1 stated that she heard the buzzing, however, she didn't think anything of it. CNA1 reported that upon checking the entrance to the secured unit, she heard the alarm buzzing in the canteen room, where she noticed that the door in there was alarming, and she realized that R1 was outside and alerted the staff member with her to get help. CNA1 found R1 down the sidewalk, past the entrance, on his knees. R1 was then helped back into the facility.</p> <p>According to the Weather Channel, on 07/06/24, the high was 96 F with a low of 74 F.</p> <p>On 07/15/24 at approximately 4:45 PM, the facility provided a removal plan, which included the following: Resident was assessed for injury and was returned to unit for further evaluation and close observation Line of Sight. The resident will be placed on a secure unit for additional evaluation and stay Resident has a wander guard safety monitor. Education was completed with working staff on situational awareness, leadership was contacted, and the film was reviewed. The facility has provided education regarding elopement and reporting. Policy on Code [NAME] and Elopement was shared. Training was provided by the Director of Nursing and lead nursing staff. Residents residing on the open units were assessed for elopement additionally. Residents are assessed for elopement risk quarterly. These assessments are done quarterly per resident's care/treatment team dates. An additional assessment was done considering this event. Fire and Life Safety staff evaluated door to determine that it was functioning properly. Incident discussion with CMT Stone interdepartmental team held via teams 9:00am. Facility entrance codes will be changed every 90 days to ensure integrity of security or as needed. Last dated 6-17-24. The measures associated with this infraction will be included in the facility's monthly Quality Assurance Performance Improvement Meeting report. This meeting is held monthly. The report will include the updated CMS definition of elopement. The report will include updates regarding monitoring of quarterly assessments for elopement reports for 90 days. The facility mitigation plan will be fully completed by 7/11/2024.</p>		