| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 425156 | A. Building<br>B. Wing | 07/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oakbrook Health and Rehabilitation Center | 920 Travelers Boulevard<br>Summerville, SC 29485 |

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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to provide appropriate supervision for Resident (R)1, resulting in R1 successfully eloping from the facility on 06/22/25.On 07/15/25 at 1:51 PM, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations had caused or was likely to cause serious injury, serious harm, serious impairment, or death.On 07/15/25 at 1:55 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility that IJ existed as of 6/22/25. The IJ was related to 42 CFR 483.25 - Free of Accident Hazards/Supervision/Devices.On 07/15/25 at 4:17 PM, the facility provided an acceptable IJ Removal Plan. On 07/15/25 at 4:17 PM, the survey team validated the facility's corrective actions and determined the facility put forth due diligence in identifying and addressing the non-compliance. The SA is considering this as Past Non-Compliance as of 06/23/25.An Extended Survey was conducted in addition to the Complaint Survey for F689, constituting substandard quality of care. Findings Include:Review of the facility policy titled Elopement with a complete revision date of 11/01/17, states, To safely and timely redirect patients/residents to a safe environment.Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to: other speech and language deficits following cerebral infarction, symptoms and signs involving cognitive functions following cerebral infarction, orthostatic hypotension, cognitive communication deficit, unsteadiness on feet, and abnormalities of gait and mobility. Review of R1's Quarterly Minimal Data Set (MDS) with an Assessment Reference Date of 06/10/25, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated R1 had severe cognitive impairment. Further review of the MDS revealed that R1 had wandering behaviors during the assessment period.Review of Quarterly Nursing - Elopement Risk Observation dated 6/11/25, revealed R1 requires frequent redirection.Review of R1's Care Plan with revealed the following active problems, [R1] is at risk for falls R/T wondering the halls DX: decreased cognion, CVA, Seizures with a start date of 06/16/25, [R1] has displayed signs or symptoms of delirium: New or ACUTELY worsening confusion, disorderly expressions of thought, change in level of consciousness or hallucinations with a start date of 06/16/25, [R1] wanders throughout the facility and recently displayed exit seeking behavior, as evidenced by exiting facility, is a risk for 1. Elopement 2. Entering into others private space 3. Increased fall risk. Related to diagnosis of CVA. with a start date of 06/12/25.Review of R1's Progress Notes dated 06/22/25 revealed, 9:43 PM- At approximately 8:10 PM Staff left resident outside to sit on the porch; resident sat in rocking chair. After a few minutes staff seen resident get up and walk across the lawn to stand on the sidewalk. CNA reported to this nurse that resident was outside on the sidewalk walking, this nurse and other staff immediately went outside to assist resident back into the building. Resident was easily redirected and was brought back in the facility. NP did a skin assessment NAD. Upon speaking with resident NP had concerns regarding resident mental status, flat facial affect NP noted resident began staring blankly at her, hands trembling, body shaking. NP sent resident out for a psych evaluation. Resident left facility via stretcher at 9:35 PM DON aware. Resident's brother made aware of resident's transfer to TRMC for psych eval.Review of R1's Progress Notes dated 06/22/25 at 3:00 PM, revealed, Progress note to clarify events of 6/22/25 after interviews and further investigation. Event: an employee exited the facility front doors after entering the code. A visitor entered the facility before the doors automatically lock down. After the visitor entered, the resident got up from his wheelchair and exited the building sitting in a rocking chair on the front porch. The witness was an alert and oriented resident. The alert resident stated R1 wheeled up to the front lobby and stated to the alert resident he was 'going home'. The alert res stated he told [R1] he shouldn't leave. The alert resident stated [R1] exited before he could stop him. The alert resident alerted staff who in turn alerted nursing staff who immediately went out of the facility to retrieve [R1]. The alert resident stated [R1] sat on the porch then got up and started walking to the front (driveway). The resident did walk down the side of the road for a short distance before staff could stop him. A nursing staff member picked up the resident in her car due to unsteady gate and risk for fall. [R1] was returned to the facility without incident. A skin assessment was completed. NP was in facility and examined the resident. Order received to transfer to ER due to resident's behavior: blank stare, flat affect, and body shaking. Returned from ER with no new orders and with 1:1 supervision.During a phone interview with Certified Nursing Assistant (CNA)1 on 07/15/25 at 11:23 AM, CNA1 revealed that she was the CNA assigned to R1 on the day of the incident. She |