STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425170	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calhoun Convalescent Center	601 Dantzler Street Saint Matthews, SC 29135

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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48214 Based on interviews, record review, and review of facility policy, the facility failed to provide appropriate supervision to prevent Resident (R)1's elopement from the facility. On 06/14/24 at 1:28 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. On 06/14/24 at 1:28 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 06/11/24. The IJ was related to 42 CFR 483. 25 - Quality of Care. On 06/14/24 at approximately 2:18 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 as of 06/12/24. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F689, constituting substandard quality of care. Findings include: Review of the facility's policy titled Elopement last revised 11/01/17, stated, 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: vascular dementia, abnormalities of gait and mobility, lack of coordination, difficulty in walking, unsteadiness on feet, reduced mobility, altered mental status, fall from bed, neurocognitive disorder with Lewy bodies, and depression. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 05/08/24, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, indicating R1 was severely cognitively impaired. Further review of the MDS revealed that wandering behaviors occurred 1 to 3 days. (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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Elopement Risk Tool dated 05/02/24, revealed R1 is not alert and oriented. R1 is confused and does not have safe decision-making capabilities. R1 has a history of wandering and has previously attempted to leave the health care center. Further review revealed, R1 has diagnoses that requires supervision. Review of R1's Physician Orders dated 08/01/23, revealed the following order, Wander guard to right ankle; check placement and function Q shift. Review of R1's Progress Note dated 06/11/24 at 7:21 PM, revealed, At 6:30 resident attempt to go out of building doors was opened, but I the nurse and staff re-direct her back into the building. Review of R1's Progress Note dated 06/11/24 at 9:32 PM revealed, At 7.18pm this nurse was in the med room. when i got out of the med room I saw other nurses running towards the back door. This nurse left the stuff she was carrying in the cart and rushed to where the other nurses where running to. Upon going out, this nurse saw that it was her resident who was on the ground. Assessment done on resident she reported she hit her head . During an interview on 06/14/24 at 11:59 AM, Licensed Practical Nurse (LPN)1 stated that on the night of 06/11/24 at approximately 7:15 PM, the door alarm/wander guard system alarm went off, LPN1 then went to check the panel to see which door it was, it was 2B, LPN1 then went down the hall, however it was the wrong hall. LPN1 then went down E hall and out the door and found R1 lying on the ground in the parking lot next to a light pole. LPN1 states that R1 reported to her that she fell and hit her head. 911 was then called for R1. During an interview on 06/14/24 at 12:09 PM, R1 stated that she wanted to go to the white house across the street, so just got up and walked out the door. R1 further stated that she fell in the parking lot on a curb and hit her head and was sent to the emergency room . During an interview on 06/14/24 at 12:45 PM, LPN2 stated that R1 was wearing a white top, pink pants and non-slip socks, when she was found in the parking lot. According to the Weather Channel, on 06/11/24, the high was 89 degrees Fahrenheit with a low of 63 degrees Fahrenheit. On 06/14/24 at approximately 2:18 PM, the facility provided a removal plan, which included the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident R1 had fall, possibly hitting head. Sent to ED for evaluation as precaution. Elopement risk evaluation repeated. Resident had Wandergard in place and properly functioning at time of incident. MD/RP notified. Administrator and CSD notified of incident. Residents at risk of elopement have the potential to be affected. Elopement risk evaluations done in the past 90 days on current residents in facility reviewed by nursing managers for accuracy. Residents identified at risk will be reviewed for appropriate interventions. All doors check for auditory alarm; found to be in working order. Educate facility staff the expectation that if a door is noticed to be alarming, immediately report to door to verify no resident has eloped then do a facility wide head count of residents. If door is found to be malfunctioning, administrator to be notified immediately and an employee posted at the door until otherwise indicated and redirected by a member of management. Licensed nurses will be re-educated on the elopement risk assessment process/accuracy and putting interventions in place based on the risks identified. Staff will be reeducated on appropriate response to alarms. This re-education will be initiated on 06/11/2024 and completed by 06/12/2024. Any member of target audience not receiving this by this date will receive prior to next scheduled shift. New admissions will be reviewed in morning meeting daily Monday thru Friday as part of the clinical morning meeting process. Elopement risks assessments will be reviewed for accuracy and interventions validated if indicated. Quarterly assessments will be reviewed as part of the MDS/Care planning process. The Director of Nursing or designee will randomly audit a minimum of 5 elopement assessments weekly for 4 weeks then monthly for 2 additional months to validate accuracy. The maintenance director will inspect facility doors 3 times weekly for 4 weeks then weekly for 2 additional months. The Administrator or designee will make rounds weekly for 4 weeks then monthly for 2 additional months to validate that doors are functioning properly. The maintenance director or designee will activate a door alarm once a month on each shift to validate appropriate response for 3 months or until compliance. Ad hoc QAPI held on 06/12/2024. Medical Director was notified of the incident and plan for improvement on 06/12/2024. This process will be reviewed in QAPI for a minimum of 3 months.