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	03/30/2026

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** Based on review of the facility policy, record review, and interview, the facility failed to ensure that Resident (R)1 received appropriate supervision to prevent a successful elopement from the facility on 03/22/26.On 03/30/26 at 2:37 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. On 03/30/26 at 2:37 PM the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 03/22/26. The IJ was related to 42 CFR 483.25 - Free of Accident Hazards/Supervision/Devices. On 03/30/26 at 4:07 PM, the facility provided an acceptable IJ Removal Plan. 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 at Past Non-Compliance as of 03/24/26. 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 revised on 11/01/2017, revealed, 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 . Procedures: 1. Once it has been established that a patient/resident is missing, all employees are notified immediately by paging overhead ______ (insert code name). 2. The DON/designee completes a missing resident profile . 4. The entire search process of the facility and grounds, from the time the patient/resident is missing, will be completed within (30) thirty minutes.Review of R1's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses including but not limited to, dementia, unspecified severity, muscle weakness (generalized), unsteadiness on feet, other abnormities of gait and mobility.Review R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/25, revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating R1 suffered from severe cognitive impairment. Further review of the MDS, revealed R1 had no impairments of the upper or lower extremities, at risk for falls, and need partial/moderate assistance for sit to stand mobility, to walk 10 feet and walking 50 feet with two turns as not attempted due to medical condition or safety concerns.Review of R1's Progress Notes dated 03/24/2026 at 9:33 PM, revealed, Resident seen today for follow-up after recent elopement event. Since last evaluation, the patient remains ambulatory with good strength and endurance and continues to exhibit impaired judgment and poor safety awareness in the setting of vascular dementia. Nursing reports ongoing need for close supervision due to continued exit-seeking behaviors. No new elopement episodes reported since implementation of 1:1 supervision. The patient remains pleasantly confused at baseline and is unable to reliably provide history.Review of R1's Care Plan with a problem start date of 10/17/2025, under the category behavioral symptoms, revealed, R1 wanders through out the facility, is a risk for 1. Elopement and has had a recent elopement 2. Increased fall risk.Review of R1's Nursing- Elopement Risk Observation dated 03/20/26, indicated, (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	Does the patient/resident have safe decision-making capabilities? This question is answered as No.Review of R1's PATIENT/RESIDENT INCIDENT/ACCIDENT INVESTIGATION WORKSHEET revealed under NOTIFICATIONS AND TREATMENTS: Transferred to Hospital or emergency room by police. DESCRIBE EXACTLY WHAT HAPPENED: Elopement from facility. Please see timeline/summary.Timeline/Summary of events/incident:5:30-5:40pm: Resident observed by staff in safe environment at ambulating in facility which is baseline in behavior.5:40-6:00pm: Alarm sounded at fire exit near dietary department. re-engaged alarm and returned to kitchen.5:50-6:05pm: [R1's] CNA noticed he wasn't in his room to receive his dinner tray and started to look for him. Census head count initiated.6:08-6:39pm: Employee that was leaving work in his car thought he saw the resident near the Dollar General store. The staff member called the workplace and informed staff he thought he saw [R1]. Staff in facility started a search for the resident.A nurse went to Dollar General in her car to retrieve the resident but he was not at the store when she arrived.Dollar General apparently notified police.Police called facility and validated we were missing a resident. They noted him walking on the corner of [NAME] and Mills. Police stated they would take the resident to the Emergency Department to be checked out.During this process the Administrator and DON (Director of Nursing) were informed.Census headcount completed with all residents except for [R1] account for.6:39pm: Administrator notified Clinical Services Director of incident.6:39pm: Administrator notified Clinical Services Director of incident.6:42pm: SVP notified of incident by CSD.1:1 education completed with identified dietary employee.Re-education started for staff in the facility.Review of the local police department incident report with a dispatched date of 03/22/2026, revealed the following:INCIDENT TYPE. 1. 901 - RUNAWAYDISP DATE: 03/22/2026 DISP. TIME 1821 TIME ARRIVED 1825DATE/TIME OF OFFENSE 03/22/2026. 1821Offenses: RUNAWAYON 03/22/2026, OFFICERS WERE DISPATCHED OUT IN REFERENCE TO LOCATE A SUSPICIOUS PERSON WALKING WITH A HOSPITAL BRACELET ON. OFFICERS CONDUCTED AN AREA SEARCH AND LOCATED THE SUBJECT ON FR [NAME]/ MILL ST. THE SUBJECT APPEA [sic] TO BE IN A DELIRIOUS STATE, DISORIENTED, AND UNABLE TO PROVIDE COHERENT RESPONSES. DUE TO THE SUBJECT'S CONDITIO [sic] EMS WAS REQUESTED TO THE SCENE. EMS ARRIVED AND ASSESSED THE SUBJECT. BASED ON THEIR EVALUATION, THE SUBJECT V [sic] TRANSPORTED TO MUSC ORANGEBURG HOSPITAL FOR FURTHER MEDICAL TREATMENT. DISPATCH WAS CONTACTED BY HOSPITAL PERSONNEL FOR CONFIRMATION OF RESIDENCY. OFFICERS WERE DISPATCHED TO 601 [NAME] ST ([NAME] CONVALESCENT CENTER) TO CONFIRM IF THEY HOUSED A PATIENT BY THE NAME OF [R1]. ONCE CONFIRMED THE FACILITY WAS INFORMED TO CONTACT HOSPITAL PERSONNEL. NO FURTHER INCIDENTS WERE REPORTED AT THIS TIME.During an interview on 03/30/26 at 9:25 AM, R1 revealed that he did not recall exiting the building.During an interview on 03/30/26 at 9:25 AM, Certified Nursing Assistant (CNA)1 revealed that she was assigned for 1:1 care for the resident for the day. CNA1 states that this was her first day working with the resident in this capacity, however she could not confirm how long the resident had been on 1:1 care.During a follow up interview on 03/30/26 at 10:05 AM, CNA1 explained that R1 was on 1:1 care because he had got out of the building.During an interview on 03/30/26 at 10:10 AM, CNA2 revealed that she completed her orientation with the facility on March 17, 2026. CNA2 stated that she had not received any in-service training related to elopements and today was her first time hearing about R1 exiting the building.During an interview on 03/30/26 at 11:15 AM, the [NAME] stated that on the day of the incident, between 5:00 PM and 6:00 PM, the dietary staff heard the alarm of the dining room door going off. Dietary Aide (DA)1 was sent to check the alarm and reported that he looked and did not see anyone. He then shut the alarm off and returned to the kitchen. The [NAME] stated that staff were unaware how long the alarm had been going off before they heard it, as it is difficult to hear in the kitchen.During an interview on 03/30/26 at 11:52 AM, Licensed Practical Nurse (LPN)1 stated that R1 was on thirty-minute checks due to prior wandering behaviors. She reported that R1 was in bed most of the day until about 5:00 PM, when a Certified Nursing Assistant took him to get a shower. Around (continued on next page)

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