STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425179	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodruff Manor	1114 East Georgia Road Woodruff, SC 29388

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** 43322 Based on review of facility policy, record review, and interviews, the facility failed to properly supervise Resident (R)1, resulting in R1's successful elopement from the facility. Specifically, on 05/24/24 at approximately 9:00 PM, R1 crawled through the window in his room to elope from the facility. R1 was found by local law enforcement on a highway and sent to the local hospital. R1 suffered a skin tear to the right forearm, while crawling out of the window. On 05/29/24 at 1:07 PM, the Administrator and the Director of Nursing (DON) were notified that the failure to properly supervise a resident, resulting in a successful elopement from the facility, constituted Immediate Jeopardy (IJ) at F689. On 05/29/24 at 1:07 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 05/24/24. The IJ was related to 42 CFR 483. 25 - Quality of Care. On 05/29/24 at approximately 2:30 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 05/28/24. 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 policy titled Resident Check/Elopement Policy with an effective date of 10/23, revealed, 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. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle . (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 Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including but not limited to: acute respiratory failure with hypoxia, dementia, lack of coordination, bipolar disorder, anxiety disorder, major depressive disorder, Type 2 diabetes, and dizziness and giddiness. Review of R1's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/22/24, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R1 was cognitively intact. Further review of the MDS revealed R1 wandering behaviors were not exhibited. Review of R1's Elopement Risk Took dated 02/29/24, revealed diagnoses that may increase the risk of elopement: depression, bipolar disorder with mania, and Dementia. Further review revealed, Resident has been found to be at risk for elopement . Review of R1's Progress Note dated 05/25/24 at 3:31 AM, revealed, Note entry for 1230 AM, Law enforcement from [local police dept.] arrived at front door of facility. The officer stated, We found [R1] on Hwy 101. Do you know him? This writer answered, Yes and asked if he was injured. Officer stated, He is ok, no injury. We have ems taking him to the hospital. Review of R1's Progress Note dated 05/25/24 at 5:22 AM, revealed, Late entry for 415 am. [R1] had returned from ER with son . Body audit completed . Skin assessed with findings of a discoloration to right outer aspect of forearm. It is irregular in shape, approx. 4 cm long. Per [R1], he hit it on the window sill. He is not c/o in that arm. The bottom of his feet are reddened, friction r/t wearing croc slip on shoes with no socks. Review of R1's Care Plan revealed no Care Plan, related to wandering/elopement, was in place prior to the elopement. Review of the facility's undated Resident Check/Elopement Policy revealed R1 was last seen at 9:30 PM, going to his room with a cup of ice. Immediate eyes on head count of all residents completed by staff. Facility parking lot and grounds search completed. R1 was not located during eyes on count. Elopement determined date documented 05/25/24 at 12:45 AM. Review of a Witness Statement dated 05/25/24, written by Nurse Supervisor revealed, Last saw [R1] going to his room at 915 PM after asking for water. I continued to chart at the desk on unit one. No activity was noted coming from room [ROOM NUMBER]P. No alarms for doors or beds were sounding. Review of a Witness Statement dated 05/25/24, written by an unidentified Nurse revealed, At about 1245 am I was sitting at the nurses station and saw blue lights piercing through the front double doors. A police officer was outside and notified us of resident found out there on the highway. As I entered the resident's room, noted his window was wide open and the gate outside was also open. Review of a Witness Statement dated 05/25/24, written by Certified Nursing Assistant (CNA)2 revealed, I witnessed the police at the door, the doorbell rung and I was headed to answer but the nurse beat me. As I was walking the police asked if we had a [R1] and we went to his room and he was gone and the window was open. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Witness Statement dated 05/25/24, written by CNA1 revealed, I was assigned to [R1] I gave [R1] his meds and treatment at 804 PM. [R1] was calm and standing at nursing station when I left him and continued med pass. [R1] was last seen by nurse when he asked aide for water around 9:15 PM. Review of Google Maps revealed, the entrance to Highway 101 is approximately 3 miles from the facility, however the exact location that R1 was found on Highway 101 was undetermined. Review of the Weather Channel revealed on 05/24/24, the high was 88 degrees Fahrenheit and the low was 65 degrees Fahrenheit. And on 05/25/24, the high was 83 degrees Fahrenheit and the low was 61 degrees Fahrenheit. During an interview on 05/29/24 at 10:51 AM, R1 revealed, I went out the window in my room. The window slides open, and I got it to work. I hurt my arm; I got a little scratch on my arm crawling out the window. I walked from [NAME] down to McDonalds and got on Highway 101, there was a lot of traffic. I was trying to get home to [NAME] [[NAME], South Carolina]. A deputy sheriff stopped me and questioned me, and they took me to the [local hospital]. I left because I don't like this place. I feel like a puppy dog trapped in a cage. I've told several nurses. I walked for about 3 hours. It was about 9:00 PM when I left and the sheriff stopped me around 12:00 AM. I still feel like I want to leave, I want to be home. I was wearing a dark blue t-shirt, khaki shorts, and crocs with no socks. During an interview on 05/29/24 at 10:59 AM, Registered Nurse (RN)1 revealed that R1 does say that he wants to go home and be with his wife, but R1 seems happy and content. RN1 stated, I didn't take him (R1) seriously when he made those comments. During an interview on 05/29/24 at 11:02 AM, Licensed Practical Nurse (LPN)1 revealed that R1 likes it here, but he wants to be home. He always tells us that he is capable of being home. LPN1 further stated, I never thought he would try and do something like that. During an interview on 05/29/24 at 11:06 AM, Social Services (SS) revealed that after the elopement, R1 stated he was planning to do this. He wanted to go home with his wife and didn't understand why he was here. SS further stated, I never thought he would do that. During an interview on 05/29/24 at 11:37 AM, the Administrator and DON revealed R1 was found about 3 miles away. The DON stated, R1 had a small discoloration on his arm and R1 told her that his feet were hurting, but felt fine after about an hour. The DON revealed nurses are supposed to generally do rounds every 2-4 hours, depending on the need of the resident. The Administrator stated, [R1] is independent and he isn't one that they would have to check on very frequently. The DON stated R1 left the facility about 9:30 PM and the police notified the facility about 12:30 AM, that they found R1 on Highway 101. The Administrator stated that R1 did say that he would like to spend time with his family and go home every once in a while. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/29/24 at 11:45 AM, the Nursing Supervisor (NS) revealed, I was doing some charting on Unit 1, the Certified Nursing Assistants (CNA)s were putting residents to bed and nurses were passing meds. [R1] did not appear to be nervous or exit seeking or upset. Around 9:30 PM the resident asked for a glass of ice and the CNA got it for him. I was still charting and [R1] went to his room. Around 12:30 AM we hear the door bell ring. The staff answered the door and told me the police were here. The police officer asked if I know a [R1] and I said yes. I thought the resident called 911. The officer stated no and that we found him on Highway 101. The officer said they were taking him to the hospital. I asked the staff to check the residents and check his room. they came back to me and told me the window and gate were open. [R1] wasn't the happiest to be here. I didn't think he would try to elope. On 05/29/24 at approximately 2:30 PM, the facility provided a removal plan, which included the following: Resident sent to ER for evaluation when located. Resident assessed with no major injury. Resident returned safely to facility. Post-elopement procedures initiated on 05/25/24 and family at bedside. Resident window secured to prevent exit. Resident relocated to interior, courtyard-view room for safety. Resident care plan has been reviewed and revised as needed. Resident evaluated by in-house provider and Lifesource Psychiatry on 05/28/24 for follow up. All residents are at risk. Resident check completed for all residents at 12:45 am 5/25/24. All resident windows were assessed and secured to prevent exit by 10:30 am 5/25/24. This includes all resident room windows and common area windows. All resident and common area windows were assessed and secured to prevent resident exit on 5/25/24. Added a motion detector alarm to the exterior gate. Staff educated on motion detector alarm initiated on 5/29/24 by Administrator, DON, or designee. Staff education on Wander/Elopement risk; Precautions and missing resident powerpoint and Resident check/Elopement policy 100.149 initiated on 5/28/24 by SNF Educator or designee. Audits for window security were initiated on 5/25/24 and will continue daily for 4 weeks, then weekly by 4 weeks, then 3 times per week for 4 weeks. Continue elopement drills daily for 4 weeks, then weekly by 4 weeks, then 3 times per week for 4 weeks. Correction action will be completed 5/28/24.