STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425319	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlyle Senior Care of Blackville	1612 Jones Bridge Road Blackville, SC 29817

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** 47075 Based on review of facility policy, record review, and interview, the facility failed to ensure adequate supervision of Resident (R)4 to prevent elopement from the facility on 02/24/24 at approximately 6:30 AM. On 04/05/24 at 4:11 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 04/05/24 at 4:11 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 02/24/24. The IJ was related to 42 CFR 483.25 - Quality of Care. On 04/05/24 the facility provided an acceptable IJ Removal Plan. On 04/05/24 the survey team, validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. The IJ is considered at Past Non-Complaince as of 02/27/24. 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 undated facility policy titled, Elopements and Wandering Residents revealed, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Definitions: 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. Under policy and explanation and compliance guidelines states under section D, Adequate supervision will be provided to help prevent accidents or elopements. Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE] with diagnoses including but not limited to: Schizophrenia, nontraumatic subdural hemorrhage, insomnia, anorexia, bacterial meningitis, severe sepsis with septic shock, and muscle weakness. (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 R4's unspecified Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/28/24, revealed R4 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15, indicating R4 had moderate cognitive impairment. Further review of the MDS revealed R4 had wandering behaviors. The MDS also indicated R4 is at risk for falls r/t (related to) confusion, deconditioning, gait/balance problems, incontinence, unaware of safety needs, wandering, and hx (history) of falls. Review of R4's Elopement Risk assessment dated [DATE] revealed the following: resident is disoriented daily, complacent, ambulatory or able to self propel W/C (wheelchair), full mobility, medications that alter mental status, and wanders the building but does not try to leave. Total Score: 10 or greater elopement risk. Further review of the assessment did not indicate a score. The heading of the assessment under the score section, indicated NA. Review of R4's Care Plan initiated on 02/02/24, revealed, The resident is an elopement risk r/t Disoriented to place, impaired safety awareness, wandering behavior noted, schizophrenia, impaired cognitive status. The goals of the care plan documented, The resident's safety will be maintained through the review date. The resident will demonstrate happiness with daily routine through the review date. The resident will not leave facility unattended through the review date. Interventions included but were not limited to, Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book . Review of R4's Body Audit Sheet dated 02/24/24, revealed a picture of a front view and back view of the human body. The back view revealed R4 suffered skin tears on both elbows and swelling/laceration to the back of the head. Review of R4's Discharge Summary [local hospital] with an admitted [DATE] and discharge date of [DATE], revealed R4 was admitted due to subdural hematoma (a pool of blood between the brain and its outermost covering. Usually caused by a head injury strong enough to burst blood vessels) from a fall. Further review of the Discharge Summary revealed, multiple fractures of ribs, right side, other specified fracture of right pubis, and fracture of other specified skull and facial bones, right side. Review of Weatherunderground.com revealed the weather on the morning of 02/24/24 at approximately 6:45 AM, was 43 degrees Fahrenheit. During an interview on 04/05/24 at 10:04 AM, Environmental Services (ES) stated she arrived to work at approximately 7:00 AM, and was sitting in the office. ES stated she heard another employee yell that R4 was outside. ES stated she held the door for them to bring R4 back into the facility. ES further stated R4 was unsteady when walking. During an interview on 04/05/24 at 10:08 AM, Licensed Practical Nurse (LPN)3 stated she arrived at work at 7:00 AM and was getting the morning report from another nurse when a staff member notified her that R4 was outside. LPN3 assessed R4 and noted scratches and bleeding and she called 911. LPN3 stated the alarm is loud and staff are to check the door when the alarm sounds. LPN3 further stated with the wander guard she does not believe the door should open, that morning she did not check for R4's wander guard. She was focused on getting him medical attention. During an interview on 04/05/24 at 10:16 AM, LPN2 stated, I last saw [R4] when I was passing 6:00 AM meds, I am unaware if he had his wander guard. I do recall hearing a noise and asking a CNA [certified nursing assistance] about it. (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 04/05/24 at 10:38 AM, the Housekeeper stated, I arrived to work around 7:00 AM and clocked in. When I went outside to get my cart, I saw [R4] sitting at the picnic table, he was cold and bleeding. I went into the facility to get help and the nurse came and called 911. The door alarms are loud at the facility and any staff can check when the door alarms. During an interview on 04/05/24 at 12:11 PM, Certified Nursing Assistant (CNA)2 stated, I worked the 11:00 PM - 7:00 AM shift that day, I changed [R4] between 6:00 AM - 6:25 AM, after that he was sitting in the back living room area like he always did. [R4] is normally always walking around, if he is near the door staff redirect. During an interview on 04/05/24 at 2:58 PM, CNA1 stated R4 was wearing pants, t-shirt, and skid-socks. During an interview on 04/05/24 at 4:03 PM, the Administrator revealed the emergency fire door that R4 exited the building through has an alarm system that when pushed an alarm will sound for 15 seconds and the door will open after the 15 seconds. On 04/05/24 the facility provided an acceptable IJ Removal Plan, which included: 1. What was done for resident affected - The wander guard of [initials](R#4) had been checked on 2/23/24 on 7p/7a and was present and functional per MAR. - The doors had been checked by the maintenance supervisor on 2/22/24 and were all functional per his wander guard log. - Resident [initials](R#4) was given first aid by the nurse and was sent out to the hospital 2/24/24. - Resident [initials](R#4) returned to the facility on [DATE] and was placed on 15 minute checks x 72 hours. - A therapy referral was made for resident [initials]#4 to be assessed. - Resident [initials](R#4) had another wander guard applied when he returned to the facility and his care plan was updated to reflect fall and wandering/elopement risk. 2. How to identify other residents with potential to be affected - All other residents with wander guards were checked to assure they had their wander guards intact and they were functional. - The head count was done all other residents to assure all were in the building. - All doors were checked to assure that they were functioning, and all were. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- An audit was completed on all residents to identify residents who had risk assessments for potential of elopement and to assure interventions such as wander guards were in place. - Staff were placed at exit doors to monitor doors until wander guard system on doors were properly functioning. (the alarm was adjusted so it did not self silence its self) - Residents with wander guards were placed on 15 minute checks until wander guard system on doors was properly functioning. (the alarm was adjusted so it did not self silence its self) 1. Actions to Prevent Occurrence/Recurrence: - The wander guard system to the doors was adjusted so that it could only be turned off by staff and would not silence its self. This was completed on 02/27/24. - The development and wandering residents' policy was reviewed no revision required. - All nursing staff on all shifts received education on resident safety checking alarms and checking guards from the DON or designee(s). Any staff on leave will receive education on their next scheduled workday. Agency staff will also be educated on resident safety and checking alarms and wander guards prior to work. All newly hired staff will receive training during orientation regarding monitoring wander guards, responding to alarms and resident safety. - The DON or designee will audit new admissions for elopement risk and ensure appropriate interventions are in place. - The maintenance supervisor will monitor doors to assure that alarms are functioning properly. The results of this monitoring will be reviewed monthly by the administrator. - New hires will receive education on wandering, elopement, and resident safety by the DON or designee, - A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented to review and interpret all audit findings to determine root cause. Root cause findings were identified to be an issue with the wander guard alarm silencing its self after only a few seconds (15) of sounding. The issue was resolved 2/27/24. 2. How ill you ensure the deficient practice is not likely to recur? All findings will be discussed at the monthly QAA meeting for a minimum of three months and then quarterly until the pattern of compliance is maintained. Date of completion 2/27/24