STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425351	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broad Creek Care Center	801 Lemon Grass Court Hilton Head Island, SC 29928

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 interview, record review, and facility policy review, the facility failed to ensure that Resident (R)1 had adequate supervision to prevent a successful elopement on 02/18/26, for 1 of 3 residents reviewed for accidents/hazards/supervision. Specifically, R1 was observed by facility staff outside the facility in the parking lot at approximately 9:00 PM.On 03/17/26 at 5:21 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 03/17/26 at 5:21 PM, the Administrator was notified that the failure to provide a resident with appropriate supervision, resulting in the resident successfully eloping from the facility, constituted Immediate Jeopardy (IJ) at F689.On 03/17/26 at 5:21 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 02/18/26. The IJ was related to 483.25 - Quality of Care.On 03/18/26 at 1:15 PM, the facility provided an acceptable IJ Removal Plan. On 03/18/26, the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the non-compliance. The SA is considering the IJ at Past Non-Compliance as of 02/19/2026.Findings include:Review of the facility policy titled, Wandering and Elopement last revised December 2017, revealed wandering is defined as a resident moving about inside or outside of the community without an appreciation for personal safety. A wander is a cognitively impaired resident who is not capable of protecting himself/herself from harm, when leaving the community unsupervised. Elopement is defined as an unassisted, unsupervised and unscheduled departure from the community by a resident. All staff who work in the licensed care venue receive training, regarding elopement, and elopement and wandering prevention during orientation and during elopement drills. Interventions are implemented for any resident who is identified as being at risk for elopement. These interventions are discussed with the resident and their family/responsible agent and documented in the resident's care plan. The effectiveness of the interventions is monitored. Elopement attempts by a resident are identified as Code Gold. Code Gold drills are conducted quarterly, as per the Elopement Protocol, these drills are evaluated and the results discussed at the Safety Committee Meetings. After an elopement attempt or successful elopement, the Resident Evaluation Committee and/or Interdisciplinary Team, assess whether the community can continue to meet resident's needs and the care plan is adjusted accordingly.Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with the diagnoses including but not limited to, traumatic subdural hemorrhage without loss of consciousness, muscle weakness, difficulty in walking, and need for assistance with personal care.Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/04/26, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated R1 had moderate cognitive impairment. Further review of the MDS revealed R1 utilized a wheelchair for mobility and needed substantial assistance for most transfers (rolling left and right/toileting) related to Activities of Daily Living (ADL).Review of R1's Physician Order Report dated 01/29/26 - 03/09/26 (admission - discharge date s), revealed an order dated 01/30/26 - (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	02/19/26 (admission - Elopement Dates) for Check Wander Guard for effectiveness and function every shift.Review of R1's Physician Order Report dated 01/29/26 - 03/09/26 revealed an order dated 02/19/26 - 03/09/26 (Elopement - discharge date s) for Check Wander Guard for effectiveness and function every shift, right lower extremity every shift.Review of R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 01/01/26 - 01/31/26, revealed no documentation related to the physician order to check the wander guard for effectiveness each shift. Review of R1's MAR/TAR dated 02/01/26 - 02/28/26, revealed an order to check R1's wander guard for effectiveness every shift, with a start date of 01/30/26 - 02/19/26; this order was only completed/signed on 02/19/26 (Date of Elopement) for Shift One. Review of R1's MAR/TAR dated 02/01/26 - 02/28/26, revealed an order to check R1's wander guard for effectiveness and function every shift right lower extremity, with a start dated of 02/19/26 - 03/09/26, this order was signed off each shift after the resident eloped from the facility until his discharge date . Review of R1's Progress Notes dated 02/06/26 at 3:30 PM, revealed, Resident needs frequent redirection because he wanders in and out of resident rooms. Spoke with [R1's Resident Representative (RR)] to see if there was an option to get a sitter for a few hours per day. [RR] stated that he was busy at the moment and could not talk but gave the facility staff permission to redirect [R1] by yelling. Informed [RR] that we could not yell at [R1] but will redirect him and for him to think about the information I gave him related to a sitter.Review of R1's Progress Notes dated 02/06/26 at 3:53 PM, revealed, Spoke with staffing agency, they stated that they may be able to provide a sitter from 12 PM - 8 PM, [RR] will visit tonight.Review of R1's Progress Note dated 02/08/26 at 1:15 AM, revealed, [Certified Nursing Assistant (CNA)] reported to nurse that resident was sitting on the floor. Nurse responded to the resident's room; he was seated on the fall mat with his back resting against his bed. Call light attached to bed 1/4 side rail, resident Level of Consciousness (LOC) and Range of Motion (ROM) remained at baseline, no injuries noted. Resident stated that he got out of bed to take the pictures off the wall and pack his bag. Resident denied falling or hitting his head . Review of R1's Progress Notes dated 02/19/26 at 2:02 AM, revealed, Resident was found wandering in the parking lot, and he was brought back in by the CNA. The door alarm wasn't going off, resident was put in bed, and Activities of Daily Living (ADL) care was provided. This writer/nurse performed a skin assessment, and no injury was noted, will continue to monitor every hour, and the Medical Doctor (MD) and Administration notified. Review of R1's Care Plan with a Start Date of 01/29/26 and revised on 02/19/26, revealed, Behavioral symptoms, wandering, and elopement related to traumatic subdural hemorrhage, impaired cognition, impulsivity. Interventions/approaches directed staff to, avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents); convey an attitude of acceptance towards the resident; follow familiar routines; identify contributing factors - for example elopement attempts in the past, type of wandering pattern, angry and combative, verbally abusive; type of diagnoses; Involve in appropriate therapeutic recreational activities; maintain a calm environment; Wander Guard. Equip [R1] with a device that alarms when the resident wanders upon admission for 48 hours. Reevaluate the need for the device after that time period. Check for the proper functioning of the device every shift; when resident begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.)During a phone interview on 03/17/26 at 12:41 PM, R1's RR revealed that the facility made him aware of the resident's elopement on 02/19/26. R1's RR further stated that he was made aware by facility staff and by another family member that the front door of the facility was and possibly still is not working properly. R1's RR stated that R1 had on a wander guard device that should have locked the door when he eloped but because it was not working correctly, R1 was able to get outside of the building. R1 did not suffer any injuries, but also attempted to leave the building on another occasion after this incident, which prompted the facility and family to want to discharge the resident to a memory care facility to better supervise R1 and manage his wandering behaviors.During a phone interview on 03/17/26 at 1:39 PM, Certified Nursing Assistant (CNA)1 revealed that she is an agency CNA and was unfamiliar with the resident until that night (02/18/26 - 02/19/26). CNA1 stated (continued on next page)

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