STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425396	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home of South Carolina-Columbia	700 Davega Drive Lexington, SC 29073

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 - Actual harm 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 facility policy, observation, record review, and interview, the facility failed to ensure adequate supervision for a cognitively impaired resident at risk for elopement. Specifically, on 04/04/26, Resident (R)2 was found outside on the ground, with her wheelchair on top of her, following a fall of approximately four feet from the loading dock, located in the back of the building. R2 sustained multiple abrasions to the forehead and a contusion with discoloration and bruising to the left elbow.Findings include:Review of the undated facility policy titled Elopement Risk Assessment and Management Policy revealed the purpose of the policy was to identify residents who may be at risk for elopement, implement individualized interventions to promote resident safety, and ensure compliance with resident rights and person-centered care principles. The policy stated that the facility shall assess all residents for elopement risk upon admission, with a significant change in condition, following any elopement or attempted elopement, and as otherwise clinically indicated. The policy further stated that the Elopement Risk Screening Tool serves as a screening instrument to identify residents who may be at increased risk for elopement and is intended to assist staff in determining the need for further assessment and care planning and shall not be used as the sole determinant for any specific intervention. The policy stated that WanderGuard devices and other electronic monitoring systems shall be considered one potential intervention among many available interventions. The decision to utilize a WanderGuard shall be based upon the resident's individualized assessment, history, behaviors, effectiveness of less restrictive interventions, and overall care plan. The policy also stated that not all residents identified as at risk for elopement require a WanderGuard device.Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE], with diagnoses including, but not limited to, lack of coordination, vascular dementia, repeated falls, and glaucoma.Review of R2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/26, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severe cognitive impairment. Further review of the MDS revealed that R2 had no wandering behaviors documented during the assessment period.Review of R2's Care Plan revealed documentation of the following: Under Behavior/Confusion, the care plan stated that R2 had episodes of confusion, which mainly occur at night. The care plan further documented that R2 had a history of behaviors including yelling out for help repetitively, often at night. This intervention was initiated on 01/27/22. Under Falls, the care plan documented that R2 is at risk for falls related to a history of falls, impaired mobility, impaired balance, weakness, and requiring assistance with activities of daily living (ADLs) and toileting. The care plan documented an intervention related to R2 being observed lying flat on the ground with her wheelchair on top of her following an unwitnessed breach of the exit door and unwitnessed incident. Further review of R2's care plan revealed that a WanderGuard intervention was initiated on 04/06/2026 following the elopement incident that occurred on 04/04/2026. The care plan documented that the WanderGuard was placed to alert staff to movements and reduce the risk for elopement.Review of R2's Elopement Risk Screening dated 01/20/26, revealed R2 scored a 14, indicating she was at risk for elopement. Further review of R2's Morse Fall Scale (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 - Actual harm Residents Affected - Few	Assessment revealed R2 scored a 65, indicating she was at high risk for falls.Review of R2's hospital Emergency Department notes dated 04/04/26 - 04/06/26, revealed documentation stating, Pt BIB (brought in by) EMS for unwitnessed fall from Presbyterian home at baseline mentation, of alert and oriented to person and place, L elbow pain with small bruise noted, denies complaints, C collar placed by EMS prior to arrival.Attempted interviews with R2 on 06/15/26 and 06/16/26, was not successful due to R2's cognitive impairment related to vascular dementia and baseline orientation status of alert and oriented to person only.During an interview on 06/15/26 at 3:38 PM, the Assistant Director of Nursing (ADON) revealed she was familiar with R2. The ADON stated, I think she got past the doors. The ADON stated she completed an elopement assessment and that a WanderGuard was placed on R2 following the incident. The ADON stated an agency nurse was the supervisor on duty at the time of the incident. The ADON reported that during the night of the incident, a nurse quit unexpectedly, and she came in to cover the shift afterward. According to the ADON, the agency nurse informed her that R2 had gotten out of the building and exited through the doors that led to the outside. The ADON stated R2 had a fall after exiting the doors and was found outside. The ADON stated she instructed the nurse to send R2 to the emergency room. The ADON confirmed R2 had dementia and stated, She likes to eat snacks. The ADON stated the exit doors are alarmed; however, if a resident does not have a WanderGuard and attempts to exit, the alarms will not activate. The ADON confirmed R2 did not have a WanderGuard in place at the time of the incident.During an interview on 06/15/26 at 3:53 PM, R2's Responsible Party/POA (power of attorney) stated she was informed that R2 had a fall and was found outside. She reported that R2 was transported to the hospital, where X-rays and a CT scan were completed. She stated, There were no internal brain bleeds. The doctor released her about an hour and a half later. She reported that the physician did not note any significant findings. The Responsible Party/POA stated she was notified by facility staff at approximately 9:00 PM. She stated, They told me they found her outside from the fall. Staff were looking for her because they didn't find her in her bed. The Responsible Party/POA reported that R2 had never had an incident like this before. She stated that after the incident, there was a discussion with staff, and a WanderGuard was placed on R2. Responsible Party/POA stated the facility had enough staff at the time and that no one expected this behavior from R2 because she had never exhibited it previously. She added, She's declining by the day.During an interview on 06/15/26 at 4:23 PM, the Administrator revealed that R2 wandered through the door located by the service hall, which is an automatic door. The Administrator reported this occurred after dinner and that R2 wandered outside and fell just outside the doorway. The Administrator stated R2 was sent to the hospital for evaluation and that the Assisted Living Director came to assist during the incident. The Administrator reported R2 was found near the courtyard. The Administrator stated no injuries were noted and that there were no changes to R2's medications following the event. The Administrator reported that a WanderGuard intervention was implemented that night. The Administrator stated R2 slept well afterward and that the next day was Easter. The Administrator stated the fall was unwitnessed and that a security staff member found R2.During a phone interview on 06/16/26 at 11:02 AM, Certified Nursing Assistant (CNA)1 stated she worked the 2:30 PM to 10:30 PM shift and typically cared for the same group of residents; however, she was not the assigned CNA for R2 on 04/04/26. CNA1 reported that R2's assigned CNA that day was a PRN (as needed) aide. CNA1 confirmed she last saw R2 at approximately 6:45 PM after redirecting her from the dining hall to the nurses' station. CNA1 reported that at approximately 8:00 PM, staff asked if she had seen R2 recently, and she replied that she had not. CNA1 stated she was later informed that a search for R2 had been initiated around 8:40 PM to 8:45 PM. CNA1 reported she ultimately located R2 outside on the side of the back dock/ledge in a dark area while it was raining. CNA1 stated R2 was found on the ground, sitting on her bottom in bushes and pine straw, with her back and head against the concrete and her wheelchair overturned on top of her. CNA1 reported R2's shirt was soaked, her eyes were open, and she believed R2 had been outside for some time. CNA1 reported that three staff members assisted R2 up the 3 to 4 steps and brought her inside, while (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	another staff member retrieved the wheelchair. CNA1 stated that once inside, R2 was assessed and vital signs were obtained. CNA1 reported R2 was alert and awake. Based on R2's location, CNA1 stated she was unsure which door R2 exited from and reported that all nearby doors lead to open areas where a resident could either cut through the courtyard or go the long way around the building. Based on R2's location, CNA1 stated she believed R2 attempted to go around the building, encountered a slight ledge, and fell into the bushes. CNA1 identified the kitchen door and laundry door as possible exit points and reported that a camera is positioned above one of the doors.During a walkthrough conducted on 06/16/26 at 11:19 AM, revealed staff described R2's pathway of travel from the facility through unlocked employee double doors, through a second set of double doors, and onto the loading dock area. A physical door and alarm test was conducted on 06/16/2026 at 12:36 PM with Maintenance present to facilitate the assessment. During the evaluation, two of five doors tested were not operating as intended. Upon observing the malfunctioning doors, the Maintenance Director stated, I've got to fix that.During an interview on 06/16/26 at an unspecified time, the Maintenance Director stated he has served in this role since September 2025 and was familiar with R2, the resident involved in the elopement. The Maintenance Director reported he was notified that a code for an elopement had been called and was informed which resident was missing. He stated that the security patrol staff member, who works third shift, located R2 after a short search. The Maintenance Director explained that maintenance performs daily checks on all secured doors, noting that any door requiring a PIN code is considered a secured door. He stated that for residents with WanderGuard devices, the doors will either lock or alarm when approached. He reported these checks are completed daily for both LTC and SNF units. The Maintenance Director clarified that if a resident without a WanderGuard exits through these doors, the doors will not alarm and will open when pushed. He added that some doors are automatic; however, the employee-access doors are not automatic. The Maintenance Director reported there had been no recent issues, malfunctions, or repairs involving the doors or alarms in 2026. He also stated that no staff are available to perform daily door checks on weekends. Regarding WanderGuard devices, the Maintenance Director explained that the devices contain an internal battery that sends an electronic notification to staff when the battery is low. When asked about cameras, the Maintenance Director stated that the facility has exterior cameras; however, the interview ended before additional details were provided. The Maintenance Director stated that R2 did not have a WanderGuard device in place at the time of the incident.