

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Nhc Heathcare - Bluffton		STREET ADDRESS, CITY, STATE, ZIP CODE 3039 Okatie Highway Okatie, SC 29909	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, review of a police incident report, witness statements, and interviews, the facility failed to ensure that Resident (R)1 received adequate supervision to prevent a successful elopement from the facility on 06/22/25 at approximately 3:15 PM. Specifically, R1 was found by 2 Samaritans, facility staff, and law enforcement outside of the facility. Per police incident documentation, R1 was found near a wooded swamp area near the facility's parking lot. R1 was observed covered in dirt and in need of toileting care (R1's pants was saturated with urine). On 07/18/25 at 12:57 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 07/18/25 at 12:57 PM, the Administrator was notified that the failure to provide appropriate supervision for a resident, which resulted in the resident successfully eloping from the facility constituted Immediate Jeopardy at F689. On 07/18/25 at 12:57 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 06/22/25. The IJ was related to 42 CFR S483.25(d) - Free of Accident Hazards/Supervision/Devices. On 07/18/25 at 4:52 PM, the facility provided an acceptable IJ Removal Plan. On 07/18/25 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-Compliance as of 06/27/25. 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, Elopement Prevention Procedure revealed Elopement occurs when a patient wanders, walks, runs away, escapes or otherwise leave the facility grounds/perimeter unnoticed and unsupervised and and/or prior to a scheduled discharge. Review of R1's Face Sheet revealed he was admitted to the facility on [DATE], with diagnoses including but not limited to: Alzheimer's disease, urinary incontinence, history of falling, muscle weakness, and anxiety disorder. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/11/25, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicates that R1 has severe cognitive impairment. Further review of the MDS under the behavior section revealed, [R1] exhibited wandering behaviors one to three days during the look back period. Review of the functional abilities section revealed [R1] has no impairment with his upper or lower body extremities. [R1] requires substantial/maximal assistance with toileting hygiene and can walk independently from 10 - 150 feet, [R1] does not require a wheelchair. Review of R1's Elopement assessment dated [DATE], revealed the resident is at risk for elopement, continue current plan of care [R1] is on the memory care unit. Review of an Officer Report for Incident reported on 06/22/25 at 3:58 PM and occurred on 06/22/25 between 3:58 PM and 4:36 PM, revealed, On 06/22/25 at approximately 3:58 PM I received a call for service regarding a missing person located at the facility, when I arrived on scene, I discovered the following information. Observations leading up to the scene: a good Samaritan white male and a nurse were assisting an older gentleman [R1] from the wooded swamp area into the parking lot. [R1] was covered in dirt and had urinated his pants. According to dispatch [R1] had escaped/eloped the facility and was missing for a period of time. When I arrived on scene, I spoke with [R1] who was being escorted away from the swamp behind the facility. I asked [R1] how he was doing, he barely was able to speak but while stuttering and mumbling he was able to say he was okay and tried to ask how I was doing, [R1] suffers from dementia. A second good Samaritan was able to provide [R1] with a wheelchair and assist in getting him back into the facility. On the scene I met with [R1's] Resident Representative (RR) who visits [R1] two to three times a week on a normal basis. [R1's] RR stated that [R1] was seriously injured at least five times in the last six months. [R1's] RR stated that she arrived at the facility at approximately 3:15 PM and was advised that [R1] was missing from the facility. [R1's] RR stated that [R1] has dementia and has suffered from approximately five head injuries within the last six months. [R1's] RR stated that these head injuries have cause [R1] to not be able to think on his own or recall memories and only repeats words back to the speaker. [R1] RR stated that each one of instances were not explained to her by nursing staff and documented it as an unwitnessed fall. A phone interview on 07/15/25 at 12:08 PM, with R1's RR revealed that the resident was successfully able to elope from the facility on 06/22/25 around 2:30 PM or 3:00 PM. RR stated that she came to visit the resident on 06/22/25 and was unable to locate him in his room or other resident areas. RR stated that she questioned staff and they were unaware of where the resident was as</p>		