STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425407	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Wellmore- Tega Cay	111 Wellmore Drive Fort Mill, SC 29708

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** 50085 Based on observations, record review, interviews, and review of facility policy, the facility failed to provide adequate supervision to prevent a successful elopement for 1 of 1 resident reviewed for accidents. Specifically, Resident (R)1 had a successful elopement from the facility on 04/08/24. During the elopement, R1 suffered lacerations to the right eyebrow and right side of scalp, scattered, scuffed, bleeding scabbed areas were also noted to R1's right lower leg. On 07/24/24 at 6:59 PM, the Administrator was notified that the failure to prevent a resident from successfully eloping from the facility constituted Immediate Jeopardy (IJ) at F689. On 07/24/24 at 6:59 PM, the survey team provided the Administrator with a copy of the CMS IJ Template and informed the facility IJ existed as of 04/08/24. The IJ was related to 42 CFR 483.25 - Quality of Care. On 07/25/24 at 6:10 PM, the facility provided an acceptable IJ Removal Plan. On 07/25/24, the survey team, validated the facility's corrective actions and removed the IJ as of 07/24/24. The facility remained out of compliance at F689 at a lower scope and severity of D. 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 last revised on March 2019 stated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Review of the undated facility policy titled SLC-WELLMORE Roam Alert Policy and Procedure documented, The Roam Alert Notification System is a Wander Management system used to monitor cognitively impaired individuals with wandering, exit-seeking, or aggressive behaviors. The Member wears a Roam Alert wrist/ankle band signaling device. When the Member is near a monitored doorway and the door is open, an alarm sounds at the door, displays on the Staff Station Computer, and alarms to the direct care staff pagers. (continued on next page)

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: generalized anxiety disorder, pneumonia, and hypertension. Review of the hospital's Physical Therapy Evaluation dated 04/03/24, revealed, patient is an [AGE] year old admitted [DATE] with history of dementia, falls, asthma, MR, and hypertension. Patient was found in her bed by memory care staff minimally responsive on day of admission. Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/11/24, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating R1 was severely cognitively impaired. Further review of the MDS revealed there were no wandering behaviors exhibited. Review of R1's Elopement Risk Tool dated 04/05/24, revealed R1 had no wandering behavior exhibited and resident is cognitively impaired and independently ambulatory. Not applicable was selected in response to the resident having previously attempted to leave a residence or other place unescorted. Elopement risk assessment score of 0 out of 9, indicating R1 was not at risk. Review of R1's Care Plan with an effective date of 04/05/24, revealed the problem, Wandering - [R1] is at risk for Wandering Behavior - [R1] is actively exit seeking. The goal revealed, Current level of mobility will be maintained within a secure environment through the next review. Interventions included but were not limited to, Assess potential physical causes for wandering and exit seeking. Provide diversional activites. Redirect [R1] behavior/activity when wandering/exit seeking is observed. Wander Guard/Roam Alert - Check Functioning, Placement, and Positioning per order. frequent rounding. monitor [R1] in facility and document attempts to exit seek out of facility. Review of R1's Physician Orders dated 04/05/24, revealed the following order, Wander guard/roam alert-check placement and positioning two times daily. Review of R1's Progress Note dated 04/06/24 at 5:18 PM revealed, Resident admitted to Wellmore skilled nursing with a diagnosis of Multifocal pneumonia, essential hypertension, asthma, GERD [a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach], generalized anxiety. Resident requires skilled nursing for assessment, medical and medication management. Resident is alert x 2 . Per daughter report. Resident lived in [memory care], used a rollator for mobility, completed her activities of daily life independently. Resident was able to stand to pivot with supervision only, continent of bladder so far. Resident noted transferring self out of bed to wheelchair without asking for assistance after she had just asked to lie down. The resident has been shown how to use call light for assist. Resident requires skilled nursing services for assessment, medical and medication management. The resident is confused and refused/spit out medication, resident was upset when redirected to where her room was. Resident has behavioral issues and wanders frequently without exit seeking throughout the night and refuses to keep oxygen on she stated, I don't need it do just fine w/o it. frequent checks of oxygen levels ongoing and stable. Will continue plan of care. Review of R1's Progress Note dated 04/07/24 at 12:50 PM revealed, Resident keeps wandering around, staff redirecting. Wander guard in place . resident taught on how to use the call bell for help. (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 R1's Progress Note dated 04/08/24 at 8:15 PM, revealed, During evening Med Pass at approximately 1755, [Licensed Practical Nurse [LPN]2] was alerted by the High 400 Rehab Hall nurse that resident had been sighted by a visitor on the sidewalk just outside the High 400 exit door. This nurse responded immediately to assist and observed [R1] sitting on the grassy area near sidewalk. Upon assessment, [R1] was alert and responsive. [R1] was not able to recall what had happened, but stated she was looking for her daughter and wanted to call her. Lacerations noted to right eyebrow and right scalp. Scattered, scuffed, bleeding scabbed areas also noted to right lower leg. Resident denied any pain and/or further injury and was able to stand with assist without difficulty. [R1] assisted back inside unit via w/c, vital signs checked and stable. One to one care provided by [Certified Nursing Assistant [CNA]1], while this nurse contacted the MD [Medical Director] who advised to send resident to ER [emergency room] for eval and treat. EMS [Emergency Medical Services] activated, and resident was transported out of facility by Medic at 7 PM. Review of R1's Physician Progress Note with a date of service of 04/09/24, documented, Patient was sent to ED last night after having an unwitnessed fall . She sustained 2 lacerations on her right scalp and near her right eyebrow . Sutures were placed and patient returned to the facility . Patient is a poor historian related to their dementia . Skin: Right lateral eyebrow with running suture in place. Right frontal scalp just above hairline with running suture in place. Ecchymosis and minimal edema of right upper eyelid . Diagnoses Laceration of right eyebrow, subsequent encounter Laceration of scalp, subsequent encounter . Review of TekCare (a system used to track wander guard alerts) report dated 04/08/24, revealed no documentation that R1's wander guard device alerted on the day of the elopement. Review of a Huddle Form dated 04/08/24, revealed R1 was fully clothed and wearing tennis shoes when R1 eloped. Facility surveillance cameras were inoperable at the time of the elopement. Unable to identify visitor that found R1. During an observation and interview on 07/24/24 at 5:11 PM, Registered Nurse (RN)1 revealed the alarm for wander guard does not sound for doors that exit into the facility's courtyards. R1 was found outside on the ground in one of the areas. The courtyard was one door down from R1's room. RN1 stated there is an iron gate that surrounds the area, accessible with a code. Observation revealed the wander guard did not alarm at the door or gate, when we allowed R2 access to the door and gate. RN1 confirmed there was no alarm sounding. During an interview on 07/24/24 at 12:37 PM, Licensed Practical Nurse (LPN)1 revealed that she was charting on her assigned hall, and was told by a visitor at approximately 5:55 PM that a resident was outside on the ground. LPN1 stated she went outside and assessed R1. LPN1 realized that R1 was not her resident, so she used the walkie talkie and called that unit's nurse, and she came immediately. LPN1 further stated R1 stayed on the ground for assessment until EMS arrived. LPN1 stated the resident was asking for a phone to call her daughter as she rendered first aid. LPN1 revealed that wander guards go off when they get to an exit door. LPN1 stated she did not hear any alarms going off on her side of the unit (high 400 hall). LPN1 concluded that R1 did not leave through her unit. (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 07/24/24 at 12:57 PM, LPN2 revealed that R1 was fast and constantly walking up and down the halls, with and without devices, she would wander around frequently. R1 would normally want a phone to call her daughter. LPN2 further stated being in other residents' room on the low 400 hall but heard LPN1 request immediate assistance on the walkie talkie. LPN2 saw R1 located on a grassy pad outside of the rehab hallway door entrance. LPN2 continued that R1 was bleeding and LPN1 had direct pressure on the injury. R1 was confused but it was not abnormal for this patient. LPN2 stated the resident was trying to call her daughter. R1 was able to stand up with assistance to a wheelchair. R1 was wheeled into her room to be cleaned. The on call MD was notified and the resident was sent to the emergency department for further treatment. LPN2 revealed that the wander guard alarm did not go off for the patient and stated that the alarm sounded when the resident re-entered the building from the incident. LPN2 concluded that wander guard checks consist of visibly seeing that the device is in place. There is no other way to check, I just ensure that I see the device. During an interview on 07/24/24 at 1:25 PM, the Director of Facilities stated, The wander guard system is on most of the doors of the facility. If anyone with a tag gets close to it, it will beep and if they go through the door or if the if the door is open it goes through the Tekton system (nurse call system) causing an alarm. The system is checked weekly by using a tag and do a run though. The Director of Facilities revealed he has a test tag that he uses each time. The nurses have scanners on the cart they are supposed to be using daily to ensure the device is functioning. The Director of Facilities stated he input the information of the patient initially and gave the device to the patient. I have not had any issues with the device. In the past it may have been issues with doors when I did rounds but nothing that has affected patient care. Those issues have been fixed in the past. There were no issues in April. I am not aware of any patient that went outside of the building, and I did not have any record of alarms that went off that day for an elopement attempt. During an interview on 07/24/24 at 1:36 PM, Certified Nursing Assistant (CNA)1 revealed that R1 wanders, so she tried to keep her around her prior to this incident. R1 was last seen sitting in a chair in her room at 5:45 PM. CNA1 stated while she was picking up dinner trays from residents rooms a family member of another resident said she saw a lady outside on the ground. By the time this information was told to CNA1, she left and went to see R1 on the ground. CNA1 further stated R1 was located close to the door of high 400 and she was bleeding. CNA1 revealed she did not hear any alarms prior to and during this event, but R1 had a wander guard on her leg. The device did not show on the screen for the nursing staff. I was picking up trays and going back and forth in the hallways and no alarm was seen or sounded. During an interview on 07/24/24 at 3:53 PM, R1's Responsible Party (RP) revealed, [R1] had bilateral pneumonia and came to them from the hospital. While in the hospital [R1] was on a Neuro floor due to her Dementia and Delirium. Upon admission I told them of my concerns about it not being a locked unit. I told them that the room being next to a courtyard is not a good decision. My mom voiced that she wanted out. She also has a history of exit seeking behavior. She eloped from a previous facility, then she was sent to memory care in Rock Hill. Prior to that she eloped from our home and drove away, a [NAME] [be on the lookout] had to be placed on her. (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 07/25/24 at 1:38 PM, the Director of Nursing (DON) revealed the staff and team are very communicative and if there is an issue we are proactive. The nursing staff can see any intervention changes on their care plans and in their system for documentation. The DON stated expectation will always be progressive, focusing on the best way to keep the residents safe, starting at admission, to ensure the safety of all patients that stay with us. The DON further stated, I was aware that the patient came from a memory care unit. I was told that patient ambulated by a rollator. Being that the patient was from a memory care unit I put a wander guard on the resident. I told her that I was on call for the weekend, and I told her if anything happens, I will contact her. During an interview on 07/25/24 at 1:59 PM, the Social Worker revealed that she heard the conversation between the Assistant Director of Nursing (ADON), DON and the RP. The Social Worker revealed that the resident was in memory care at two different facilities prior to admission to this facility. The Social Worker stated the RP said that R1 walks, and R1 does wander, however the RP did not voice that R1 has a history of exit seeking behavior, just wanders. On 07/25/24 at 6:10 PM, the facility provided an acceptable IJ Removal Plan, which included the following: An in-service held on April 10, 2024 at 7:30 AM and 2:00 PM regarding falls, elopements, and rounding. Follow up in-service was conducted on 7/24/2024 at 8:00 PM and 7/25/2024 at 7:30 AM regarding policies and procedures on elopements, roam alerts, and door alarms. Upon R1's return from hospital on April 8, 2024, R1 had 1:1 round the clock care for the remainder of stay at this facility. After the incident, social work coordinated discharge plans with previous memory care facility to evaluate resident in anticipation of returning. Resident discharged on [DATE] to her previous facility that could meet her needs in a more appropriate setting. Implemented on July 24, 2024, a new door alarm installed on SNF Rehabilitation door leading to the courtyard. Implemented on July 24, 2024, if a resident with a confirmed provider with a diagnosis of dementia, history of wandering, BIMS of less than 10, or history of elopement that are self-ambulatory will be escorted and/or accompanied while in courtyard by a staff member, or a family member. Skilled Nursing staff in service on the correction plan on July 24, 2024 at 8:00 PM and July 25, 2024 at 7:30 AM. Regroup was sent to all Skilled Nursing Facility staff on July 24, 2024, with education on elopements, roam alerts, and delayed egress maglock doors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Facilities or designee will test the functioning status of the skilled nursing rehabilitation courtyard door alarm and courtyard gate equipped with a delayed egress maglock tied to a universal transmitter that goes to TekCare weekly to prevent future events. All elopement risk screening tools in EMAR for residents at risk will be audited weekly by the DON and/or designee until 100% compliance is met. All negative findings will be reported to QAPI. All negative findings will be corrected upon discovery. Date of substantial compliance is 07/24/24.