

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  425407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2025
NAME OF PROVIDER OR SUPPLIER  The Lodge at Wellmore- Tega Cay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Actual harm</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49918</p> <p>Based on review of facility policy, record review, and interview, the facility failed to prevent an avoidable accident, when Resident (R)1 fell out of the bed while receiving care for 1 of 1 resident. Resulting in R1 suffering fractures to the lower left leg.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Falls and Fall Risk, Managing copyright date 2001 MED-PASS, Inc., documented, Based on previous evaluations and current data the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Fall Risk Factors 2. Resident conditions that may contribute to the risk of falls include: . c. delirium and other cognitive impairment . l. functional impairments .</p> <p>Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including but not limited to: dementia advanced and history of fall at home.</p> <p>Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/28/24, revealed a Brief Interview for Mental Status (BIMS) score of 1 out of 15, indicating R1 was severely cognitively impaired.</p> <p>Review of R1's Care Plan with a start date of 02/27/23 documented, [R1] at risk for falls related to generalized weakness, dementia. Further review of the Care Plan revealed interventions directing staff to: Fall mats by bed for [R1's] safety, keep areas free of obstructions to reduce the risk of falls or injury during transfer, footwear will fit properly and have non-skid soles, position R1 in the center of the bed and assess frequently for safe position, and keep bed low while in bed.</p> <p>Review of R1's Physician Orders dated 11/29/22, revealed, Fall Mat two times daily.</p> <p>Review of R1's Physician Orders dated 01/28/25, revealed, Weight Bearing status: Non weight bearing-do not transfer until weight bearing status clears.</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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(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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's Progress Note dated 12/28/24 at 7:19 PM, revealed, . fall was reported from night shift nurse and lower left leg was swollen. Resident expressed pain when touched or leg was moved. VIA hospice was notified, and x-ray and pain meds were given. Xray showed fractures on lower left leg. Family and Hospice was notified of Xray results. Hospice and family made decision to send resident out to [local hospital] @ 1700/ resident was placed on Leave of absence until final notice.</p> <p>Review of R1's Progress Note dated 12/29/24 at 5:44 AM, revealed, Patient returned to the facility at 04:15, splint in place on LLE repeat x-ray in two weeks. Pt. resting in bed with bed in lowest position with mats for safety. Will notify hospice.</p> <p>During an interview on 02/20/25 at 2:53 PM, Licensed Practical Nurse (LPN)1 stated, I came to work at 7 AM. I received report and she told me that the Certified Nursing Assistant (CNA) was changing her and he was reaching for some supplies and she fell out of the bed. I was told her leg was swollen and she was complaining of pain. Daily we reiterate prevention for falls.</p> <p>During an interview on 02/20/25 at 3:27 PM, CNA1 stated, I was the CNA from 7P-7A. She was sitting on the side of the bed. I placed her back in bed. Around 6AM, [R1] was one of the last people for me to change that morning. I raised the bed to the appropriate height to place the brief under her. She has Dementia. I reach to go grab a chux and she started falling to the other side of the bed. I attempted to grab her, but she still fell . I am sorry that happened. I met with the Director of Nursing (DON), and [Registered Nurse (RN)1] informed me if a resident is confused to get help with performing Activities of Daily Living (ADLs). If I am unable to get assistance from another CNA, I need to call for the nurse or the CNA that works the other side of the building. Going forward I need to make sure we have two people assist with [R1] and any other resident that has dementia. Administration told me to have the bed low and not too high. When I roll the resident over make sure they have enough room in the bed so if they try to get out of the bed, I can reach them before that. Again, this was my fault, I am sorry that this happened. [R1] was sent to the emergency room . She is on Hospice. We called the Medical Director, too. The nurse came and did an assessment.</p> <p>During an interview on 02/20/25 at 3:37 PM, LPN2 stated, I remember it was evening shift going into day shift. I was with another resident two rooms over. [CNA1] came and told me [R1] fell . I went in to do an assessment. Her baseline is not oriented. We did a neuro assessment. She wasn't expressing any pain. I touched her head. We did a head-to-toe assessment. She grimaced around her ankle area when I touched it. It had discoloration and it wasn't straight. It was obviously painful. I called the on-call Hospice and told the nurse what happened. She was debating on what they were going to do. I tried to administer liquid Tylenol, but [R1] was not taking any oral medications. Hospice nurse came to assess and decided to send her out. The swelling started more so imaging was needed.</p> <p>During an interview on 02/20/25 at 3:48 PM, the Director of Nursing (DON) stated, We immediately investigated the situation. We had an in-service with the staff. We disciplined the employee. We felt it was some precautions that could have happened. We gave him a progressive disciplinary action. He wasn't suspended .</p>		