

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Sprenger Health Care of Port Royal		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 Richmond Avenue Port Royal, SC 29935	
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 a review of facility policy, resident records, and interviews, the facility failed to provide adequate supervision to prevent Resident (R)1 from eloping. Specifically, R1 had a successful elopement from the facility on 11/22/25. This failure to adequately supervise has the potential to cause serious injury or death to residents. On 11/25/25 at 6:57 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template informing the facility IJ existed as of 11/22/25. The IJ was related to 42 CFR 483.25 - Quality of Care. On 11/25/25 at 8:32 PM, the facility provided an acceptable IJ Removal Plan, indicating compliance as of 11/24/25. On 11/25/25 at 9:00 PM, the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. It was determined the facility had put forth good faith attempts to identify and correct their own deficiencies as of 11/24/25. The IJ was identified at Past-Noncompliance. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F689, constituting substandard quality of care. Review of the facility's policy titled, Person/Elopement, with a last revision date of 01/2022 revealed, To provide means by which to identify a resident who may be at risk to exit the facility unescorted, and to alert staff to the presence of these residents near facility exits through the use of engineering controls. For the purpose of this policy, an elopement will be identified as an unauthorized exit from the facility involving a resident whose cognitive status and safety awareness are impaired. 1. Nursing staff will assess a resident for risk for elopement on admission, or readmission. Social service and/or designee will reassess quarterly to coincide with the MDS and PRN. 2. Based on assessment, interdisciplinary team will develop and implement a comprehensive plan of care for risk of elopement. The care plan will be reviewed at a minimum quarterly and updated, as appropriate. Review of R1's face sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, alcohol dependence, protein-calorie malnutrition, nausea with vomiting, alcohol use with withdrawal delirium, anxiety disorder, depression, liver disease, and spinal stenosis. Review of R1's 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/17/25 revealed R1 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating moderate cognitive impairment. Additionally, R1 had not exhibited any wandering behaviors, and no alarms or restraints were being used. Review of R1's Elopement Risk Assessment on 11/11/25 at 3:29 PM indicated R1 was disoriented to time, non-ambulatory, and not at risk for elopement due to being unable to elope at that time. Review of R1's Elopement Risk Assessment on 11/22/25 at 8:26 AM, after the elopement, revealed R1 was at high risk for elopement. Review of R1's Secured Unit/Willow Lane Screen on 11/22/25 at 11:09 AM after the elopement revealed R1 wanders or would wander out of the facility and would not be able to find his way back. Additionally, R1 was able to ambulate or was mobile in wheelchair. Review of R1's Care Plan revealed R1 had potential for impaired adjustment in new environment and with unfamiliar staff with a start date of 11/12/25. Approaches included assessing his interests and strengths and encouraging activity participation. On 11/24/25 after the elopement, the problem, Potential for Injury/ R1 is an Identified wanderer confusion, Desire to go home, was added. Approaches included knowing his whereabouts, attempting to divert, determining his pattern to wandering, reporting episodes, and having exit door alarms on. Additionally, R1 was to have a WanderGuard on at all times. Review of the progress note by Registered Nurse (RN)2 on 11/22/2025 at 12:45 PM (late entry) revealed, Pt sitting at the resident dining room this am, with no complaints. Vital signs taken, no behaviors observed at this time. Pt left dining area and search initiated, Manager on duty notified. Pt was found across the street at in the driveway of the store. Immediate intervention for safety after pt wandered off facility property, wander guard placed and pt re roomed to memory care room [ROOM NUMBER]. On call and family daughter notified. Review of the weather for 11/22/25 at 07:55 AM revealed the temperature outdoors was 65 degrees Fahrenheit in Port Royal, South Carolina. During an observation on 11/25/25 at approximately 12:00 PM, the road immediately outside the facility was a 2-lane road with a speed limit of 15 mph. The back of Dollar General faces the facility to the left. During an interview with the Maintenance Director on 11/25/25 at 2:10 PM revealed, I came in at 08:00 AM because I was the scheduled manager on duty. On those days, I have to come in for four hours. Usually when I first come in, I do my rounds. That day, I was starting my rounds, and I was told they were looking for R1. He typically sits in the 100/200 lounge, which they call the Ice Cream Parlor. He sits in a wheelchair. By the time I got to the front door, the Certified Nursing Assistant (CNA) was wheeling him back from Dollar</p>		