STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425296	A. Building B. Wing	04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- North Augusta	1200 Talisman Drive North Augusta, SC 29841

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42338 Based on record review and interviews, the facility failed to prevent neglect to a Resident (R)9, diagnosed with Vascular Dementia and history of wandering. R9 had a successful elopement from the facility on 08/28/22 around 1:55 PM. R9 was noticed wandering outside of the building unsupervised by an employee. Once noticed, the employee attempted to get R9's attention, but he ran into a wooded area adjacent to the facility after being called. R9 was found by the police after receiving a call from a neighbor stating R9 was in their back yard, approximately 0.2 miles away from facility. R9 was dressed in pajamas and the weather was undocumented. On 04/10/23 at 4:08 PM, an Immediate Jeopardy (IJ) template was provided to the facility's Administrator, notifying them that an IJ existed at F600 with an effective date of 08/28/22. On 04/10/23 at 6:25 PM, the facility provided an acceptable IJ Removal Plan indicating they identified their own deficient practice and implemented a plan prior to the start of the survey. Verification of the removal plan confirmed the facility put forth good faith attempts and implemented a plan to remove the immediacy to include training, drills, and in-services, effective 09/16/22. Implementation of the removal plan for F600 includes daily checks for functionality of wander guard bracelets will be conducted by assigned nurses and/or designee and findings documented in the resident's electronic medical record. Functionality will be checked using the tag/device checker for activation and/or taking resident to door and listening for alarm sound and door locking. The Director of Health Services (DHS) and Administrator initiated education on 08/29/22 and Clinical Care Coordinator completed education on 08/29/22. All newly hired nursing staff will receive education in orientation. A mock elopement drill was performed to ensure compliance on 09/16/22 with in-service provided at that time. The facility will continue to complete elopement risk assessments upon admission, quarterly, annually and with significant change to identify high risk wanderers per policy, with appropriate interventions added as needed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's door alarm device daily testing will be reviewed by Administrator and/or DHS for 2 weeks, then weekly for 4 weeks, then monthly for 3 months with results presented during monthly Quality Assurance Performance Improvement (QAPI) committee meeting with appropriate corrective actions as indicated. Per policy, door alarms will continue to be checked daily by Maintenance Director/ Designee (Manager on Duty) and wander guards will be checked for placement and functionality by assigned nurse(s), recorded in resident (s) electronic health record. Ongoing audits will be determined on findings and corrective actions needed. Audit tools will be reviewed by the Administrator and/or DHS weekly and results will be presented during the monthly QAPI committee meeting monthly for 3 months and/or until substantial compliance. Findings Include: A review of the facility's face sheet revealed R9 was admitted to the facility on [DATE] with diagnoses including,but not limited to: anxiety, vascular dementia, depressive disorder, wandering disease, chronic obstructive pulmonary disease, and heart failure. Review of a Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/07/22 indicated R9 had a Brief Interview of Mental Status (BIMS) score of 1, indicating severe cognitive impairment. An Elopement Risk assessment dated [DATE] revealed R9 scored a 10, which indicates that he was moderate risk for elopement. Interventions included 3-day monitoring, 4 weeks behavior management program to determine appropriate interventions after 3-day evaluation, and/or quarterly assessments. If significant wandering persists, follow recommendations for High Risk, which is 3-day monitoring, weekly behavioral management and applying a wander guard. Review of R9's Care Plan dated 07/12/22 and updated on 08/22/22 revealed R9 is at risk for elopement related to poor memory, wandering and looking for exits. Interventions were: Use of Wander guard to alert patient and staff of attempts to exit facility unattended. Additional review of the care plan dated 08/22/22 and titled Behavior Symptoms indicated R9 was care planned for taking other residents and staff belongings and cutting off wander guard. Interventions put into place were to: Assess resident for placement in a specially designed therapeutic unit and obtain a psych consult/psychosocial therapy. Review of a Social Services Director (SSD) progress note dated 08/22/22 at 1:32 PM revealed, SSD was informed that R9 did not have his wander guard on. SSD went to R9's room and found a pair of scissors. SSD attempted to notify R9 Responsible Party but was unable to reach. Veterans Administration was notified via e-mail about behaviors Review of a nurse's progress note dated 08/28/22 at 4:00 PM revealed,R9 observed walking across parking lot towards wooded area, staff unable to stop him and he proceeded further into the woods and unable to be reached. Alert North [NAME] Police Station and active search began. Resident was found safe by police in neighboring yard. Physical exam by Director of Health Services and Resident to be sent to Veterans Administration Medical Center (VAMC). Review of nurse's progress note dated 08/28/22 at 4:11 PM revealed, R9 transported by ambulance to (VAMC) for evaluation and treatment as ordered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Administrator on 03/14/23 at 2:45 PM revealed, On 08/28/22 around 1:55 PM, CNA1 who was working as the receptionist this day, followed resident R9 out the front door into the parking lot as he was walking out of the door stating that he was leaving. Licensed Practical Nurse (LPN)1 noticed R9 walking across the parking lot and tried to assist CNA1 in re-directing. R9 began walking towards the woods and became combative and aggressive towards them, and staff are unable to hold residents. CNA1 called the Administrator while LPN1 called 911. The Administrator further stated, LPN1 stated the police instructed her not to follow R9 in the woods because if they had to use their dogs to track R9's scent, that would cause interference, therefore, R9 proceeded into the woods alone. Police arrived at 2:04 PM and began a search for R9 in the wooded area. At 3:00 PM, dispatch received a call-in reference to a male suspect in a nearby neighborhood. Officers responded to that location and R9 was escorted back to the facility. R9 was assessed for injuries was sent to the Veteran Affairs (VA) hospital. An interview with LPN1 on 04/10/23 at 12:38 PM revealed, On 08/28/22, as she was taking a smoke break, she noticed R9 walking from the side of the building. LPN1 stated that she called his name, and he started running towards the woods. LPN1 stated that she called for the receptionist for help. LPN1 stated she called the Administrator and she and other staff from facility came to assist, but R9 ran into the woods. LPN1 further stated, She cannot recall the time, but she remembers that R9 was wearing plaid pajamas and he had his backpack. She also added the weather was not too hot because she was sitting in her car. During an interview with CNA1 on 04/10/23 at 12:47 PM, she revealed she was working as the receptionist this day and LPN1 was taking her smoke break. LPN1 ran into the facility and stated that a resident had gone into the woods. CNA1 stated that she called the Administrator and 911. Police told them not to go into the woods because they did not want the dogs to pick up everyone's scent. About 3:00 PM, a neighbor called police saying an unidentified male was in their back yard. R9 returned to facility at 3:15 PM. Review of the police report revealed R9 was alert and verbally responsive with mild anxiety noted. A moderate amount of perspiration was noted to the face and arms. Clothes moist. Small open area to top of right earlobe. Small scratch to right forearm. R9 discharged from the facility to Veterans Administration Medical Center via ambulance. Family notified.

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(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** 42338 Based on record review, interviews, and the review of the facility's policy, the facility failed to provide adequate supervision to a Resident (R)9, diagnosed with Vascular Dementia and history of wandering. R9 had a successful elopement from the facility on 08/28/22 around 1:55 PM. R9 was noticed wandering outside of the building unsupervised by an employee. Once noticed, the employee attempted to get R9's attention, but he ran into a wooded area adjacent to the facility after being called. R9 was found by the police after receiving a call from a neighbor stating R9 was in their back yard, approximately 0.2 miles away from facility. R9 was dressed in pajamas and the weather was undocumented. On 04/10/23 at 4:08 PM, an Immediate Jeopardy (IJ) template was provided to the facility's Administrator, notifying them that an IJ existed at F689 with an effective date of 08/28/22. On 04/10/23 at 6:25 PM, the facility provided an acceptable IJ Removal Plan indicating they identified their own deficient practice and implemented a plan prior to the start of the survey. Verification of the removal plan confirmed the facility put forth good faith attempts and implemented a plan to remove the immediacy to include training, drills, and in-services, effective 09/16/22. Implementation of the removal plan for F689 includes daily checks for functionality of wander guard bracelets will be conducted by assigned nurses and/or designee and findings documented in the resident's electronic medical record. Functionality will be checked using the tag/device checker for activation and/or taking resident to door and listening for alarm sound and door locking. The Director of Health Services (DHS) and Administrator initiated education on 08/29/22 and Clinical Care Coordinator completed education on 08/29/22. All newly hired nursing staff will receive education in orientation. A mock elopement drill was performed to ensure compliance on 09/16/22 with in-service provided at that time. The facility will continue to complete elopement risk assessments upon admission, quarterly, annually and with significant change to identify high risk wanderers per policy, with appropriate interventions added as needed. The facility's door alarm device daily testing will be reviewed by Administrator and/or DHS for 2 weeks, then weekly for 4 weeks, then monthly for 3 months with results presented during monthly Quality Assurance Performance Improvement (QAPI) committee meeting with appropriate corrective actions as indicated. Per policy, door alarms will continue to be checked daily by Maintenance Director/ Designee (Manager on Duty) and wander guards will be checked for placement and functionality by assigned nurse(s), recorded in resident (s) electronic health record. Ongoing audits will be determined on findings and corrective actions needed. Audit tools will be reviewed by the Administrator and/or DHS weekly and results will be presented during the monthly QAPI committee meeting monthly for 3 months and/or until substantial compliance. Findings Include: Review of the facility's undated policy titled, Relias Training: Section 1-Safe Supports for Someone at Risk for Elopement, revealed an elopement occurs when a person supported leaves the premises of a residential care setting without authorization or the necessary supervision to do so. (continued on next page)

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(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	A review of the facility's face sheet revealed R9 was admitted to the facility on [DATE] with diagnoses including,but not limited to: anxiety, vascular dementia, depressive disorder, wandering disease, chronic obstructive pulmonary disease, and heart failure. Review of a Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/07/22 indicated R9 had a Brief Interview of Mental Status (BIMS) score of 1, indicating severe cognitive impairment. An Elopement Risk assessment dated [DATE] revealed R9 scored a 10, which indicates that he was moderate risk for elopement. Interventions included 3-day monitoring, 4 weeks behavior management program to determine appropriate interventions after 3-day evaluation, and/or quarterly assessments. If significant wandering persists, follow recommendations for High Risk, which is 3-day monitoring, weekly behavioral management and applying a wander guard. Review of R9's Care Plan dated 07/12/22 and updated on 08/22/22 revealed R9 is at risk for elopement related to poor memory, wandering and looking for exits. Interventions were: Use of Wander guard to alert patient and staff of attempts to exit facility unattended. Additional review of the care plan dated 08/22/22 and titled Behavior Symptoms indicated R9 was care planned for taking other residents and staff belongings and cutting off wander guard. Interventions put into place were to: Assess resident for placement in a specially designed therapeutic unit and obtain a psych consult/psychosocial therapy. Review of a Social Services Director (SSD) progress note dated 08/22/22 at 1:32 PM revealed, SSD was informed that R9 did not have his wander guard on. SSD went to R9's room and found a pair of scissors. SSD attempted to notify R9 Responsible Party but was unable to reach. Veterans Administration was notified via e-mail about behaviors Review of a nurse's progress note dated 08/28/22 at 4:00 PM revealed,R9 observed walking across parking lot towards wooded area, staff unable to stop him and he proceeded further into the woods and unable to be reached. Alert North [NAME] Police Station and active search began. Resident was found safe by police in neighboring yard. Physical exam by Director of Health Services and Resident to be sent to Veterans Administration Medical Center (VAMC). Review of nurse's progress note dated 08/28/22 at 4:11 PM revealed, R9 transported by ambulance to (VAMC) for evaluation and treatment as ordered. During an interview with the Administrator on 03/14/23 at 2:45 PM revealed, On 08/28/22 around 1:55 PM, CNA1 who was working as the receptionist this day, followed resident R9 out the front door into the parking lot as he was walking out of the door stating that he was leaving. Licensed Practical Nurse (LPN)1 noticed R9 walking across the parking lot and tried to assist CNA1 in re-directing. R9 began walking towards the woods and became combative and aggressive towards them, and staff are unable to hold residents. CNA1 called the Administrator while LPN1 called 911. The Administrator further stated, LPN1 stated the police instructed her not to follow R9 in the woods because if they had to use their dogs to track R9's scent, that would cause interference, therefore, R9 proceeded into the woods alone. Police arrived at 2:04 PM and began a search for R9 in the wooded area. At 3:00 PM, dispatch received a call-in reference to a male suspect in a nearby neighborhood. Officers responded to that location and R9 was escorted back to the facility. R9 was assessed for injuries was sent to the Veteran Affairs (VA) hospital. (continued on next page)

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(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	An interview with LPN1 on 04/10/23 at 12:38 PM revealed, On 08/28/22, as she was taking a smoke break, she noticed R9 walking from the side of the building. LPN1 stated that she called his name, and he started running towards the woods. LPN1 stated that she called for the receptionist for help. LPN1 stated she called the Administrator and she and other staff from facility came to assist, but R9 ran into the woods. LPN1 further stated, She cannot recall the time, but she remembers that R9 was wearing plaid pajamas and he had his backpack. She also added the weather was not too hot because she was sitting in her car. During an interview with CNA1 on 04/10/23 at 12:47 PM, she revealed she was working as the receptionist this day and LPN1 was taking her smoke break. LPN1 ran into the facility and stated that a resident had gone into the woods. CNA1 stated that she called the Administrator and 911. Police told them not to go into the woods because they did not want the dogs to pick up everyone's scent. About 3:00 PM, a neighbor called police saying an unidentified male was in their back yard. R9 returned to facility at 3:15 PM. Review of the police report revealed R9 was alert and verbally responsive with mild anxiety noted. A moderate amount of perspiration was noted to the face and arms. Clothes moist. Small open area to top of right earlobe. Small scratch to right forearm. R9 discharged from the facility to Veterans Administration Medical Center via ambulance. Family notified.