STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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** 43313 Based on observation, interview, record review, and facility policy, the facility neglected to provide adequate supervision to prevent successful elopement for 1 of 3 residents reviewed Resident (R) 1. This failure placed R1 at risk for serious harm, injury, or death. Resident (R)1 had a successful elopement on 04/02/22 at approximately 3:30 AM and was found by an agency staff member, 1.3 miles away from the facility on North [NAME] Smart Boulevard in front of the Piggly Wiggly store. R1 was returned to the facility at approximately 5:34 AM. R1 obtained a skin tear to his right great toe. R1 was wearing a white tee shirt and blue sweatpants and no shoes, and the outside temperature was around 54 degrees Fahrenheit. On 4/5/22 at 12:40 PM, an Immediate Jeopardy (IJ) template was provided to the Administrator, notifying IJ existed at F600 due to the facility's neglect to adequately monitor R1, who has wandering behaviors, with an effective date of 04/02/22. On 04/05/22 at approximately 4:40 PM the facility provided an acceptable IJ Removal Plan related to F600. The IJ was lowered to a scope and severity of D. The facility's removal plan for F600 included: 1) Clinical Leadership will ensure that appropriate interventions are in place for each resident by reviewing physician orders and updating care plans to reflect wandering/elopement risk. 2) Administrator initiated education on exit seeking/elopement policy with all-staff inserviced. 3) Regular elopement drills will be held weekly on all shifts to reduce the risk of elopement. 4) [NAME] Kontrols to go to the facility to evaluate all other exit doors in facility that do not have alarm enunciator and to install enunciators as soon as possible. 5) Additional staff person will be added to the 11-7 shift to continuously walk the halls observing all exit doors and residents with exit-seeking behaviors until the enunciators have been successfully installed on each exit door. Implementation of the removal plan was verified through observations, staff interviews, and record reviews. Observation verified that all doors were functioning successfully with the wanderguards being used in the facility. Documentation review revealed that staff were educated with demonstration check offs on the use of wanderguards, immediacy on responding to door alarms, and following the elopement policy and procedures. These trainings were conducted on 04/04/22. Findings include: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Review of the facility's policy titled Abuse/Neglect Policy and Procedure last revised May 2000, revealed that it is the policy of the facility that abuse/neglect whether physical or verbal will not be tolerated. This includes the resident, employee, family members, visitor or resident to resident. Review of the Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 01/13/22, revealed the facility admitted R1 to the facility on [DATE]. R1 was not cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 00 out of 15. R1's pertinent diagnosis includes unspecified dementia without behavioral disturbances. During the investigation on 04/05/22 at 1:10 PM, the Director of Nursing (DON) reported being aware of what door R1 exited and a tour was conducted of the facility with the DON. During the tour of 04/05/22 at 1:13 PM, the DON demonstrated the use of the door and held the bar down 15 seconds and it alarmed. The sound was not as loud as the other doors in the facility. The DON reported this door is not equipped with a sensor for the wanderguard, due to the low volume of the alarm, staff could not hear it alarming. During the investigation on 04/05/22 at 1:15 PM, the Maintenance Supervisor reported he checks the alarm on the door weekly and reported he does not have any paperwork to support this. He further reported that the facility requested a quote to update the alarm and this too, he did not have any paperwork to support. Record review of R1's care plan with a creation date of 1/19/22 revealed he requires assistance with activities of daily living, has a diagnosis of dementia, history of right hip fracture, alcohol dependence, frequent falls and malnutrition. He experiences weakness and has a poor sense of safety. He has a history of wandering and exit seeking. It was updated on 4/5/22 to include his recent elopement on 4/2/22. Review of the monthly orders dated April 2022 revealed a wanderguard was added to R1's Physician orders as of 4/5/22. During an interview on 04/05/22 at 9:30 AM, the Administrator stated she received a call from staff on 04/02/22 at 3:40 AM reporting that R1 was not in the facility and was last seen between 3:15 AM - 3:30 AM, when he was put in bed with a tee shirt and wearing a brief. When staff started rounds at 04:24 AM, R1 was not in his room. Staff began to look for R1 in rooms and then went outside and this is when they heard the back service door alarm going off and reports the alarm was not heard prior to going outside to look for R1, as that alarm is not very loud. The door is equipped with a 15-minute egress alarm and R1 knows if he pushes on it, it will open. The Administrator reported that R1 was not on 1:1 and is normally very accommodating, but at nights he does wander. R1 is ordered to have a wander guard and the Administrator reported that he was wearing it, but the door that he left out of does not have a sensor for the wander guard on it. R1 was wearing a white tee shirt and blue sweatpants and no shoes, and the outside temperature was around 54 degrees Fahrenheit. A staff member was driving around the area by the local Piggly Wiggly store which is 1.3 miles away from the facility. The store is on a two-lane highway and staff saw R1 and asked him to get in her car and she drove R1 back to the facility. When R1 was assessed by the nurse he was found to have skin tear to his right great toe and no other injuries. (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 on 04/05/22 at 09:40 AM, the Director of Nursing (DON) stated that he was not on duty during R1's elopement. He reported R1 was found that Monday morning. He reports that R1 can answer questions and stays in his room during the day, but during second and third shift, R1 reports he must go to work, and he tries everything he can to get out of the building. R1 has successfully gotten off his wing, but this is the first time he has gotten out of the facility. The DON reported that R1 does have a wanderguard on and to his knowledge, he was wearing it when he left the facility. On 04/05/22 at 12:10 PM, attempts were made made to contact the agency nurse Licensed Practical Nurse (LPN) 1 with no success. On 04/05/22 at 12:12 PM, Registered Nurse (RN)1 stated on 04/02/22 she got a call from LPN 1 stating that one of the residents cannot be located and she did not know what to do. RN1 stated she asked LPN1 if the Administrator and the police were contacted and the LPN said no. RN1 stated she advised LPN1 to contact the Administrator and police. RN1 stated she was provided the name of the resident that was missing, and since she does not live very far from the facility, she got in her car to drive around to look for R1. RN1 reported she saw R1 walking on the sidewalk so she had to turn the car around and went to ask him if he could get in her car and he did. RN 1 stated that she works at the facility and knows the residents. RN1 reported he looked confused but complied and got in the car. She reported she found him around 5:00 AM - 5:15 AM and he was wearing blue sweatpants and a white shirt and no shoes. She was not able to recall the outside temperature but reported it was not cold. RN1 reported that R1 had a scratch to his right foot but was otherwise ok. RN1 reported she got R1 back to the facility, the nurse assessed him for injuries, and the Administrator showed up and she left. RN1 reported that R1 is a major elopement risk due to the facility not having a dementia unit and he was able to get out this morning. On 04/05/22 at 12:27 PM, Certified Nursing Assistant (CNA)1 reported on 04/02/22 R1 was up until 1:00 AM and they last placed him in bed after 2:00 AM when they turned the lights off and went back to check on him at 4:00 AM and he was missing. CNA1 reported that they all started to look for him in rooms then they started looking outside and still could not find him. CNA1 reported everyone started to panic and she called the facility's prior DON and told her. The previous DON was called due to CNA1 not having anyone else phone number and everyone there was agency staff. CNA1 stated the previous DON asked her if we had called the Administrator and the police? CNA1 reported the double doors were closed and did not recall hearing an alarm. CNA1 reported R1 was found walking but did not know location or distance or the outside temperature. CNA1 reported R1 was brought back to the facility and was checked out by the nurse. On 04/05/22 at 12:20 PM, CNA2 reported on 04/02/22 R1 had been trying to get out of the facility during second and third shift and he does this a lot. She reported that at 3:30 AM, R1 was taken to the bathroom and was put in bed. At 4:24 AM, she and other staff started rounds and did not find R1 in his room, so they looked for him on Units A and B. CNA2 stated she looked out Unit B's door that was closed by housekeeping and the alarm was going off. She reported that the nurse went out for break at 4:10 AM and at that time, there was no alarm sounding. The nurse told her she was going on break and would be sitting in her car. CNA2 reported that R1 was not seen leaving the facility and this was the first time he got out of the facility but had previously got off his unit. CNA2 reported she called her boss and she got in her car and went driving around and found him. (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	On 04/05/22 at 1:38 PM, R1 was observed in bed wearing a tee shirt and blue sweatpants. An interview with R1 revealed he had been in the facility for 1 month and he had a house, but came here so he could help keep others. R1 stated his son is in the process of getting things lined up for him to go home. R1 reported he is treated well, getting medications on time and is good. When R1 was asked if he had ever left the facility to go to work or home, he reported that he has never tried to leave and did not know what I was talking about. R1 was asked if he has a device on his ankle and he pulled down socks of both feet and no wander guard was in place. On 04/05/22 at 2:00 PM, an interview with the DON confirmed R1 did not have a wanderguard in place and one was then added. On 04/05/22 at 4:18 PM, an interview with the brother for R1 reported that R1 was taken home by another brother for a visit on 3/30/22 and per conversation with his brother, R1 did not want to return to the facility, but was told he had to return.

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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** 43313 Based on observations, interviews, record reviews, and review of the facility's policy titled, Exit Seeking/Elopement, the facility failed to provide adequate supervision for 1 of 1 resident reviewed for accidents related to wandering. Resident (R)1 had a successful elopement on 4/2/22 at approximately 3:30 AM and was found by a facility agency staff member, 1.3 miles away from the facility on North [NAME] Smart Boulevard, in front of the Piggly Wiggly store. R1 was returned to the facility at approximately 5:34 AM. R1 obtained a skin tear to his right great toe. R1 was wearing a white tee shirt and blue sweatpants and no shoes, and the outside temperature was around 54 degrees Fahrenheit. On 4/5/22 at 12:40 PM, an Immediate Jeopardy (IJ) template was provided to the Administrator, notifying her IJ existed at F689 due to the facility's failure to adequately monitor R1, who has wandering behaviors, with an effective date of 4/2/22. On 4/5/22 at approximately 4:40 PM, the facility provided an acceptable IJ Removal Plan related to F689. The IJ was lowered to a scope and severity of D. Additionally, the failure constituted substandard quality of care, warranting the completion of an extended survey. The facility's removal plan for F689 included: 1) Clinical Leadership will ensure that appropriate interventions are in place for each resident by reviewing physician orders and updating care plans to reflect wandering/elopement risk. 2) Administrator initiated education on exit seeking/elopement policy with all-staff inserviced. 3) Ongoing education will be provided by Clinical Leadership for all new hires during orientation. 4) Regular elopement drills will be held weekly on all shifts to reduce the risk of elopement. 5) [NAME] Controls to go to the facility to evaluate all other exit doors in facility that do not have alarm enunciator and to install enunciators as soon as possible. 6) Additional staff person will be added to the 11-7 shift to continuously walk the halls observing all exit doors and residents with exit-seeking behaviors until the enunciators have been successfully installed on each exit door. Implementation of the removal plan was verified through observations, staff interviews, and record reviews. Observation verified that all doors were functioning successfully with the wanderguards being used in the facility. Documentation review revealed that staff was educated with demonstration check offs on the use of wanderguards, immediacy on responding to door alarms, and following the elopement policy and procedures. These trainings were conducted on 04/04/22. Findings include: R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to: unspecified dementia without behavioral disturbances and alcohol dependency. Review of the Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 01/13/22 revealed, R1 was not cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score 00 out of 15. R1 requires assistance from one staff member for some Activities of Daily Living (ADLs). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility submitted a 24 hour report via facsimile to the State Agency on 04/02/22 indicating that around 4:24 AM on 04/02/22, staff started their rounds and noted that R1 was not in his room. Staff immediately began searching the facility and could not locate R1. An agency staff member saw R1 down the street, in front of the Piggly Wiggly, and asked R1 to get into her car to go home. R1 got into the car and was back at the facility at approximately 5:34 AM on 04/02/22. R1 was assessed and a skin tear was noted to exist under R1's right great toe and voiced complaint of slight lower back discomfort. R1's family and physician were left voice messages by the nurse. A record review of R1's progress note dated 4/2/22 states; At approximately 04:45 AM staff could not locate R1. All staff in the building alerted and all rooms were searched. Resident was not located in the facility. Administrator was made aware and 911 called. R1 was found by an agency staff member walking on the sidewalk on N [NAME] Smart Boulevard, in front of the Piggly Wiggly store. Resident was returned back to the facility by agency staff. Record review of R1's care plan with a creation date of 1/19/22 revealed he requires assistance with activities of daily living, has a diagnosis of dementia, history of right hip fracture, alcohol dependence, frequent falls and malnutrition. He experiences weakness and has a poor sense of safety. He has a history of wandering and exit seeking. It was updated on 4/5/22 to include his recent elopement on 4/2/22. Review of the monthly orders dated April 2022 revealed a wanderguard was added to R1's Physician orders as of 4/5/22. During the investigation on 04/05/22 at 1:10 PM, the Director of Nursing (DON) reported being aware of what door R1 exited and a tour was conducted of the facility with the DON. During the tour of 04/05/22 at 1:13 PM, the DON demonstrated the use of the door and held the bar down 15 seconds and it alarmed. The sound was not as loud as the other doors in the facility. The DON reported this door is not equipped with a sensor for the wanderguard, due to the low volume of the alarm, staff could not hear it alarming. During the investigation on 04/05/22 at 1:15 PM, the Maintenance Supervisor reported he checks the alarm on the door weekly and reported he does not have any paperwork to support this. He further reported that the facility requested a quote to update the alarm and this too, he did not have any paperwork to support. Review of the facility's policy Exit Seeking/Elopement Policy and Procedure, without date, revealed the facility is to provide a course of action by the staff in the event a resident has displaced exit seeking behaviors or leaves the premises without notifying staff or their intention 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	During an interview on 04/05/22 at 9:30 AM, the Administrator stated she received a call from staff on 04/02/22 at 3:40 AM reporting that R1 was not in the facility and was last seen between 3:15 AM - 3:30 AM, when he was put in bed with a tee shirt and wearing a brief. When staff started rounds at 4:24 AM, R1 was not in his room. Staff began to look for R1 in rooms and then went outside and this is when they heard the back service door alarm going off and reports the alarm was not heard prior to going outside to look for R1, as that alarm is not very loud. The door is equipped with a 15-minute egress alarm and R1 knows if he pushes on it, it will open. The Administrator reported that R1 was not on 1:1 and is normally very accommodating, but at nights he does wander. R1 is ordered to have a wander guard and the Administrator reported that he was wearing it, but the door that he left out of does not have a sensor for the wander guard on it. R1 was wearing a white tee shirt and blue sweatpants and no shoes, and the outside temperature was around 54 degrees Fahrenheit. A staff member was driving around the area by the local Piggly Wiggly store which is 1.3 miles away from the facility. The store is on a two-lane highway and staff saw R1 and asked him to get in her car and she drove R1 back to the facility. When R1 was assessed by the nurse he was found to have skin tear to his right great toe and no other injuries. During an interview on 04/05/22 at 9:40 AM, the Director of Nursing (DON) stated that he was not on duty during R1's elopement. He reported R1 was found that Monday morning. He reports that R1 can answer questions and stays in his room during the day, but during second and third shift, R1 reports he must go to work, and he tries everything he can to get out of the building. R1 has successfully gotten off his wing, but this is the first time he has gotten out of the facility. The DON reported that R1 does have a wanderguard on and to his knowledge, he was wearing it when he left the facility. On 04/05/22 at 12:10 PM, attempts were made made to contact the agency nurse Licensed Practical Nurse (LPN) 1 with no success. On 04/05/22 at 12:12 PM, Registered Nurse (RN)1 stated on 04/02/22 she got a call from LPN 1 stating that one of the residents cannot be located and she did not know what to do. RN1 stated she asked LPN1 if the Administrator and the police were contacted and the LPN said no. RN1 stated she advised LPN1 to contact the Administrator and police. RN1 stated she was provided the name of the resident that was missing, and since she does not live very far from the facility, she got in her car to drive around to look for R1. RN1 reported she saw R1 walking on the sidewalk so she had to turn the car around and went to ask him if he could get in her car and he did. RN 1 stated that she works at the facility and knows the residents. RN1 reported he looked confused but complied and got in the car. She reported she found him around 5:00 AM - 5:15 AM and he was wearing blue sweatpants and a white shirt and no shoes. She was not able to recall the outside temperature but reported it was not cold. RN1 reported that R1 had a scratch to his right foot but was otherwise ok. RN1 reported she got R1 back to the facility, the nurse assessed him for injuries, and the Administrator showed up and she left. RN1 reported that R1 is a major elopement risk due to the facility not having a dementia unit and he was able to get out this morning. (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	On 04/05/22 at 12:27 PM, Certified Nursing Assistant (CNA)1 reported on 04/02/22 R1 was up until 1:00 AM and they last placed him in bed after 2:00 AM when they turned the lights off and went back to check on him at 4:00 AM and he was missing. CNA1 reported that they all started to look for him in rooms then they started looking outside and still could not find him. CNA1 reported everyone started to panic and she called the facility's prior DON and told her. The previous DON was called due to CNA1 not having anyone else phone number and everyone there was agency staff. CNA1 stated the previous DON asked her if we had called the Administrator and the police? CNA1 reported the double doors were closed and did not recall hearing an alarm. CNA1 reported R1 was found walking but did not know location or distance or the outside temperature. CNA1 reported R1 was brought back to the facility and was checked out by the nurse. On 04/05/22 at 12:20 PM, CNA2 reported on 04/02/22 R1 had been trying to get out of the facility during second and third shift and he does this a lot. She reported that at 3:30 AM, R1 was taken to the bathroom and was put in bed. At 4:24 AM, she and other staff started rounds and did not find R1 in his room, so they looked for him on Units A and B. CNA2 stated she looked out Unit B's door that was closed by housekeeping and the alarm was going off. She reported that the nurse went out for break at 4:10 AM and at that time, there was no alarm sounding. The nurse told her she was going on break and would be sitting in her car. CNA2 reported that R1 was not seen leaving the facility and this was the first time he got out of the facility but had previously got off his unit. CNA2 reported she called her boss and she got in her car and went driving around and found him. On 04/05/22 at 1:38 PM, R1 was observed in bed wearing a tee shirt and blue sweatpants. An interview with R1 revealed he had been in the facility for 1 month and he had a house, but came here so he could help keep others. R1 stated his son is in the process of getting things lined up for him to go home. R1 reported he is treated well, getting medications on time and is good. When R1 was asked if he had ever left the facility to go to work or home, he reported that he has never tried to leave and did not know what I was talking about. R1 was asked if he has a device on his ankle and he pulled down socks of both feet and no wander guard was in place. On 04/05/22 at 2:00 PM, an interview with the DON confirmed R1 did not have a wanderguard in place and one was then added. On 04/05/22 at 4:18 PM, an interview with the brother for R1 reported that R1 was taken home by another brother for a visit on 3/30/22 and per conversation with his brother, R1 did not want to return to the facility, but was told he had to return.