STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425289	A. Building B. Wing	06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve Healthcare and Rehabilitation	1800 Eagle Landing Blvd Charleston, SC 29410

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** 37781 Based on record reviews, staff interviews, and review of the facility policy, the facility failed to provide adequate supervision for 1 of 3 residents reviewed for accidents related to wandering. Resident (R)1 had a successful elopement on June 15, 2022, between 10:30 PM and 10:55 PM. Failure to establish, maintain and implement written policies and procedures regarding supervision places an individual's health and safety at risk for serious injury, harm, impairment, or death. On June 15, 2022, at approximately 10:30 PM, R1 was last seen on the 300 Unit attempting to exit the side door. Her wanderguard, located on her left ankle set the alarm off. As staff was responding, Certified Nursing Assistant (CNA)1 redirected R1 away from the door and down the hall. After staff successfully disarmed the alarm door at the 300 Unit, another alarm was heard sounding. It was then noted that the 400 Unit exit door was sounding. On June 15, 2022, at approximately 10:55 PM, R1 was found outside the facility, in approximately 300 feet from the facility, in a bushy/leafy area. When found, there was a small stick on her forehead, but she had no open injuries, or identified pain. The weather was noted to be dry and cool. On June 20, 2022, at 3:18 PM, the survey team provided the Administrator with a copy of the Centers for Medicare and Medicaid Services (CMS) Immediate Jeopardy (IJ) Template, notifying the facility IJ existed at F689 due to the facility's failure to adequately monitor R1, who had a diagnosis of Dementia with an effective date of June 15, 2022. On June 20, 2022, at 5:00 PM, the facility provided an acceptable IJ Removal Plan related to F689. The immediacy of the IJ was removed as of June 16, 2022. Further review of the facility's implemented plan showed substantial evidence that the facility took all necessary actions to remove the immediacy prior to the start of the survey, warranting the IJ to be justified as Past noncompliance with a confirmed compliance date of June 16, 2022. This was confirmed via observations, random staff interviews and review of audits and education. Additionally, the failure constituted substandard quality of care, warranting the completion of an extended survey on June 20, 2022. Findings include: (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 the facility's undated policy titled, Elopements and Wandering Residents, revealed, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .The facility is equipped with door locks/alarms to help avoid elopements. 4d. Adequate supervision will be provided to help prevent accidents or elopements . R1 was admitted to the facility on [DATE], with diagnoses including, but not limited to dementia with behaviors, major depressive disorder, anxiety, hypertension, and palliative care related to dementia. Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of March 9, 2022, indicated she has a Brief Interview of Mental Status (BIMS) score of 99, indicating she is severely cognitively impaired. Review of R1's most recert quarterly MDS with an ARD of April 28, 2022, indicated a BIMS score of 0 with cognitive skills coded as severely impaired. Her activities of daily living for locomotion for on and off the unit was coded as supervision only, indicating she could ambulate on her own. R1 was not coded for the use of assistive devices. Review of R1's medical records revealed R1 was assessed via a telehealth visit on June 16, 2022, at 1:33 AM. Summary of findings indicate: 87 y/o F with h/o dementia with behavior disturbance, major depressive disorder, anxiety disorder, HTN, and HLD, made successful egress out a side door of facility this evening, while another door was alarming. She has a wander guard, but it only triggers an alarm in proximity to the front door of the building. She managed to get to some nearby woods and was ultimately found on her back by a dumpster. She sustained a slight abrasion to her forehead, but no other injuries found on nursing assessment. She was seen on video and did not appear in any acute distress. She was unable to articulate what happened. She is not on antiplatelet or anticoagulation therapy. Further review of the progress notes indicates on June 16, 2022, at 1:49 AM, R1 was immediately placed on 1:1 supervision and daughter was notified of the incident. On June 16, 2022, R1 was moved to a room closer to the nurses' station for increased monitoring. R1 was noted to have adjusted well to the move. As of a progress note dated June 18, 2022, R1 continued to have stable vitals and neuro checks remained at R1's baseline. Review of R1's Wandering/Elopement Risk assessment dated [DATE], indicated a wandering risk score of 14, indicative of high risk for wandering. The assessment codes R1's mobility as ambulates with one assist or independent. It also codes a diagnosis of Alzheimer's disease. In the section for history of wandering, it codes R1 as a known wanderer/hx(history) of wandering. An additional Wandering/Elopement Risk Assessment, completed on June 16, 2022, indicated a wandering risk score of 11, indicative of at risk for wandering. The assessment codes R1 as oriented to person, mood/behavior-combative, severely agitated, exhibits/expresses fear and/or anxiety, having wandering behaviors, able to ambulate or move about the facility without the use of an assistive device, cognitively impaired with poor decision-making skills and history of wandering/elopement from a previous location. (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 care plan with an initiation date of June 28, 2019, and revision date of November 17, 2021, indicated a focus: R1 wanders throughout the facility. Ambulates while carry baby doll at times socializing with staff and others. Goals are for R1 to remain safe within environment through the review date and R1 will not leave the center unattended. Interventions are to accompany to meals and scheduled activities, alert bracelet on left ankle, calmly redirect to an appropriate area, check alert bracelet placement every shift and functioning every day, close observation, educate family/visitors to advise staff when leaving patient following visit, encourage socialization with others and provide recreational programming, and engage in activities/tasks to keep occupied Interventions added on June 16, 2022 indicate, line of sight with 30 minute documentation and request family provide familiar objects from home. R1 is also care planned with an initiation date of January 14, 2019, with a focus area of: Use of wanderguard for safety related to cognitive deficit. Goal is patient will have no ill effects of wanderguard such as skin irritation and or distress with use of wanderguard over the next review. Interventions are to assist patient to ambulate/reposition, wanderguard/alert bracelet per physician's order, report change in skin integrity, and provide observation of residents where about at all times. Interventions added with an initiation date of June 15, 2022, are assure resident's picture is in elopement book with updated information, body audit completed once when outside, lumbar x-ray completed, room change to be closer to nurses' station for clear proximity observation and staff education on elopement policy. Review of R1's Physician Orders revealed an order for a secure alert bracelet to be applied to the left leg. Check functioning and placement each shift. Review of R1's Treatment Adminstration Record (TAR) revealed documentation of checks completed as ordered. Additional review of the medical record revealed a Radiology Report dated June 16, 2022, which revealed no fracture or subluxation seen, as a result of the incident. During an interview with the Director of Nursing (DON) on June 20, 2022, at 1:22 PM, she stated she received a phone call on June 15, 2022, and 10:55 PM from a staff member indicating they could not find R1. She stated she lives 25 minutes from the facility, so she immediately was in route to the facility. Around 11 PM on June 15, 2022, she received another telephone call stating R1 had been found outside the facility, having exited the back door of Unit 400. She stated upon her arrival to the facility at approximately 11:20 PM on June 15, 2022, she immediately assessed R1 and found no injuries. She then began gathering statements from all staff on the units, observed the area R1 was found, re-interviewed R1, who did not recall the incident and immediately began in-servicing all staff that was in the building. During an additional interview and facility tour with the DON on June 20, 2022, at 1:40 PM, she showed the surveyors where R1 had been found outside of the facility, in the back of the building, approximately 300 feet from the facility, in a bushy/leafy area. She stated the back parking lot is lit but was unsure if the lights reached that far back. In addition, the DON stated she was unable to determine if R1 had fallen or if she had gotten tired and laid down in the bushes. When found, she had a stick on her forehead, but there were no open injuries. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview with CNA1 on June 20, 2022, at 1:46 PM, she stated, I heard the alarm and ran out of my resident's room and asked where is R1. R1 was walking towards me, so I tried to attempt to get her to bed. R1 became combative and refusing to go to bed. R1 then walked away from me, so I went back to assist another staff member in turning the alarm off. We were yelling out door codes until we finally got the alarm to stop. Once we got the door to stop alarming, I then heard another alarm going off. I immediately thought, Oh no, that's R1 again. I proceeded down to the 400 Unit and saw staff looking, so I came back and told the Nurse. He then called a Code Purple, and I saw two other CNAs heading out the 400 Unit door to look for her. Finally, someone said they had found her out back in the bushes, and when I looked, it was her pink sweatsuit that she had on. During a telephone interview with CNA2 on June 20, 2022, at 2:20 PM, she stated, I work 11p-7a. I arrived to work around 10:50 PM on June 15, 2022, and when I got to the door, everyone was looking and saying R1 was missing. I immediately threw down my stuff at the door and started checking the parking lot. It was dark and I didn't see or hear R1. I headed back towards the facility to get my car keys so that I could drive and check the subdivision behind the building. By the time I made it back to the parking lot to my car, I heard someone say they'd found her. When I looked, staff was walking her down the hall. She had on a pink sweatsuit and was still appearing to be combative and trying to get away from them, which is her usual behavior. When asked if there had been any training or in-services related to elopement, CNA2 stated the facility had recently done training prior to this incident and immediately the night of the incident as well. During a telephone interview with Licensed Practical Nurse (LPN)1 on June 20, 2022 at 2:22 PM, she stated, Around 10 PM, she noticed that the door to the Magnolia Unit was closed. She then saw an elderly lady walking in the hall by herself. She stated she walked towards R1 and introduced herself, offered her hand and led R1 back to the Magnolia Unit until she came across LPN2. LPN1 stated she asked LPN2 if she was missing a resident, and she replied, yes. About 20 minutes later, Registered Nurse (RN)1 came running through the building and she asked him what was wrong. He replied, R1 was missing. A few minutes later, R1 was found and brought back into the building. When asked if there had been any staffing education, LPN1 replied, Yes, we were immediately in-serviced that night. Multiple attempts were made to contact LPN2 via telephone, with no success. A written statement from RN1 taken on the night of the elopement revealed the following: I had walked to the end of the 300 hallway to encourage R1 away from the door. She had tripped the alarm. After she turned and started walking away, I started to close the door and shut the alarm off. I tried the code **** multiple times, but it wasn't working. I turned around to ask CNA1 if she knew another code. She told me to try ****. That code worked to shut the alarm off. At this time, I could hear another alarm so I headed back to the nurses station to discover the 400 hallway alarm going off. So I went to that door and the other nurse and CNAs were outside and they didn't see her so I told one to stay outside and the others check rooms and bathrooms. I then called a code purple. I explained to staff that it was R1 and she was wearing a pink sweatsuit. After searching, the CNAs called me and had found R1 in the back of the parking lot near the rear of the building. She was brought back into the facility by the CNAs and myself. On this day, I was the nurse on the Magnolia 400 hallway. Multiple attempts were made to contact RN1, with no success. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A written statement from CNA3, dated June 16, 2022 revealed, I was headed out of the building to take the trash to the dumpster and a Code Purple was called about 10:55 PM. A nurse then directed myself, and two other CNAs to go check outside to the back of the facility. As we were walking in the back of the facility, we began yelling out resident's name. As we were yelling, we heard a voice and continued to follow the voice, that led to the edge of the woods. Resident was laying on the ground on her back with a small stick on her forehead, looking at us. Immediately notified RN1 to come out to assess her before moving the resident. The nurse arrived and assessed the resident and the resident was taken back into the facility. Multiple attempts were made to contact CNA3, with no success. During a telephone interview with R1's daughter, her Responsible Party (RP), on June 20, 2022 at 3:15 PM, she stated she is aware of her mother's wandering behaviors. She stated this is not the first time her mother had gotten out of the building, but it has been a few years since she last got out. The RP stated the facility was previously providing a sitter, however, since the new company has taken over the building, they were no longer providing that service. She stated approximately two weeks ago, she paid for her own personal private sitters to come into the building to sit with her mother. She stated her mother has began wandering around the facility more since the onset of COVID, however, because her mother is familiar with the staff and facility, she does not want to move her to another unit or facility with a memory care unit. She stated R1 is also receiving Hospice services, and this is another reason why she does not wish to move her mother somewhere else, however, she does feel her mother will get out of the building again, because she is determined and enjoys walking around, although it is aimlessly. During an interview with the Administrator on June 20, 2022 at 3:45 PM, he stated, he was unaware of the facility previously providing sitters, as the facility recently became under new management. He stated this was something he would look into, however, he feels on the night of the incident, staff immediately implemented the elopement plan as soon as R1 was noted to not be in the building. Additional review of the facility's plan of compliance revealed a 100% audit completed of all residents in the building. There were 12 residents identified as having a risk of elopement. All residents were re-assessed and care plans were updated as necessary. A 100% audit of door alarm functioning was completed, beginning on June 15, 2022 and was ongoing at the time of the survey. 1:1 documentation was reviewed with a start date of June 15, 2022, immediately after the return of R1 to the facility. The facility's removal plan included the following: 1. Resident was found within 6 minutes and returned to the facility safely. Family and Physician were notified. 1:1 staff was implemented on 6/15/22. Body audit was conducted immediately. X-ray was completed with no positive results. The resident was relocated to a room in closer proximity to the nurses' station. Re-education of staff began immediately. Met with family and IDT to discuss interventions. The care plan for resident was updated 6/16/2022. Placement and function of wanderguard bracelet confirmed on 6/15/22 by the Director of Nursing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Residents currently in the facility with a BIMS score of 10 or less were assessed by 6/16/2022 using the elopement evaluation. There were no newly identified residents at risk for elopement. The Wander/Elopement Risk book was reviewed by the Director of Nursing on 6/16/22 to ensure all residents that were assessed as at risk for wandering/elopement were identified in the book. The book was found to be accurate and up to date. 3. The Administrator checked 100% of the facility doors on 6/15/22 and found all doors and alarms functioning correctly. Staff education on procedures for managing residents at risk for wandering and elopement started on 6/15/22 and was completed with staff by 6/16/22. 120Db alarms were installed on all doors exiting the care area. 4. 3 Exit seeking behavior drills will be conducted weekly for 4 weeks across various shifts then 2 times per week for 4 weeks then weekly for 4 weeks or until substantial compliance is continuously received. Facility doors will be checked by the Maintenance Director (Manager on Duty on the weekends) daily for 4 weeks then 3 times per week for 4 weeks then weekly for 4 weeks to ensure all doors within the facility lock/release and alarm appropriately. 5. Administrator will review the results of all audits in QAPI monthly x 3 months or until substantial compliance is achieved. Allegation of Compliance- 6/16/22