STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425362	A. Building B. Wing	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley River Healthcare	1137 Sam Rittenberg Blvd Charleston, SC 29407

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 review of the facility policy titled: Elopements and Wandering Residents, observation, interviews, and record reviews, the facility failed to provide adequate supervision to prevent elopement, for 1 of 3 residents reviewed for elopement. On March 22, 2022, at approximately 8:37 PM, Resident (R)1 eloped from the facility through the front doors. She had a wanderguard in place to her left ankle, in which the alarm did sound on the door. However, at the time of her exit, family members were being buzzed into the building, allowing her to have a successful elopement. R1 was found approximately 500 feet from the facility in front of the [NAME] Lodge building, and returned unharmed at approximately 8:50 PM. R1 was properly dressed in full street clothing, to include a gray shirt and gray pants, and shoes. The weather was noted to be about 70 degrees Fahrenheit. On March 24, 2022, at 3:45 PM, the Administrator was presented with an Immediate Jeopardy (IJ) template indicating IJ existed at F689 with a start date of March 22, 2022, and end date of March 23, 2022. Review of audits, testing documentation, and random staff interviews revealed the facility had identified their deficiency and had a plan in place to alleviate the immediacy prior to survey. Implementation of the plan was verified through observation, staff interviews, and record reviews. Observation verified that all door alarms were functioning successfully. Documentation review revealed staff was educated on wandering/ elopement policy and procedures and immediacy on responding to door alarms.The IJ was identified as past noncompliance. This failure constituted substandard quality of care, resulting in the completion of an extended survey. Findings include: Review of the facility's policy titled, Elopements and Wandering Residents indicated the following: 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1 was admitted to the facility on [DATE], for rehab services with the potential of long-term care following a brief hospitalization , with an anticipated return to home at discharge. Her diagnoses include, but are not limited to, alcohol dependence, dementia, malnutrition, muscle weakness, and hypertension. Review of the Admission Minimum Data Set (MDS) dated [DATE] showed R1 has a Brief Interview of Mental Status (BIMS) score of 6, indicating she is cognitively impaired. Her mood score is a 4, which indicates potential for minimal depression. Review of the Electronic Medical Record (EMR) indicated a progress note dated 3/14/22 which stated, Resident continues with exit seeking behaviors, wandering to doors without walker, pushing hard at locked doors. Increased confusion ongoing, POA (Power of Attorney) informed and in agreement. Wander guard applied to Left leg. Staff alerted. Review of the March Physician Orders in the EMR revealed an order dated 3/14/22, which states; Wanderguard monitoring: Wanderguard to left leg on at all times. Check placement every shift for elopement precautions. Review of the Medication Administration Record (MAR) for March 2022 revealed adequate documentation of wanderguard placement for each shift since application of the wanderguard. An additional progress note dated 3/16/22 indicated, discharged from therapy services as of 3/18. Patient will transfer to Long Term Care due to unable to return home and live by herself and stay alone. Review of a Wandering Risk Screen Assessment completed on 3/22/22 at 9:54 PM revealed R1 scored 11, indicating a high risk for wandering. Review of R1's care plan dated 3/14/22 with a revision date of 3/22/22 indicated elopement risk as an identified problem. The goal is R1 will not leave facility grounds unattended through next review. Interventions were to relocate R1 to the second floor, 1:1 staff for 24 hours, which resolved on 3/23/22, attempt reorientation as needed, check wanderguard placement and function every shift, complete elopement assessment as indicated, involve in activities of preference, observe whereabouts in facility when off the unit, and redirect wandering as needed. Review of the Physician Progress Notes dated 3/23/22 indicated, Resident with an acute episode of wandering yesterday evening. Eloped walking down the sidewalk and found outside the [NAME]. No signs of trauma or injury. Amnestic to the event. Wanderguard in place on patient's left ankle. Wear wanderguard at all times. Check place every shift. Encourage and redirect. Additional review of the EMR on 3/24/22 at 1:15 PM noted the following entry by Licensed Practical Nurse (LPN) 1 on 3/22/22 at 9:00 PM; I was in the middle of starting my med pass when somebody rings to get buzzed in to visit their family member. When I got to the door to open it, it kept ringing, so I tried to turn off the alarm. the alarm wouldn't not cut off. I walked around downstairs to try to find a staff member but all I saw was agency nurse. I went upstairs to ask the CNAs how I cut the alarm off and they told me, and I told them I couldn't get the alarm off and would it be possible if R1 had gotten outside because I did not see her in her room. I checked all the rooms downstairs and then I ran outside looking for her. When I got to the sidewalk, I saw the reflection of her walker all way down the street. When I finally caught up to her, she was almost passed the [NAME] Lodge. As we were walking back, three CNAs were coming down the street to help me find her. We got her back into the building safely. She isn't injured she's really confused, and she keeps saying she wants to go home. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 3/24/22 at 11:56 AM revealed R1 lying in bed, asleep. She had a wanderguard to her left ankle and her call light was in reach. Additional observation on 3/24/22 at 12:45 PM, revealed R1 sitting up on her bed. She appeared pleasant and calm. An attempt was made to interview her on 3/24/22 at 12:48 PM; however, she did not recall the incident. She stated, I have not been out of the facility. Multiple attempts were conducted on 3/24/22 to reach LPN1 via telephone for interview with no success. During an interview with the Administrator on 3/24/22 at 1:30 PM, she stated, On the night of 3/22/22, the Director of Nursing and myself received notification that R1 had gotten out of the building and was located, walking in front of the building next door. R1 was returned safely to the facility, unharmed and assessed with no injuries noted. The family and Physician were also immediately notified and R1's representative came in that night to make sure she was okay and settled into her new room. At that time, I came to the facility and along with other staff began audits, education, and implementation of moving all residents identified as elopement risks to the 2nd floor. By being on the 2nd floor, if a wanderer tries to get on the elevator to come down, the elevator is equipped with a lock that will not allow them to move it, unless staff enters the code. I feel like this is the safest to avoid restraining the residents. I am very pleased of how the staff reacted and responded, and if I had to score them, I would give them a 90% completion rate out of 100%. She also stated, We immediately began testing all exit doors and ensuring functionality of the wanderguard alarms and system. This incident was not a failure of the system, but that R1 was able to get out while other visitors were walking in. When asked if agency staff receive the same training as facility staff, the Administrator stated, Yes, they go through an orientation on their first day here and are also provided badges with all of the codes on them. An interview with CNA1 on 3/24/22 at 3:09 PM revealed the following, I was working that night when a nurse came upstairs saying she could not turn the alarm off, and she thought R1 maybe outside. I, along with another CNA came outside to help look, but when we got outside, LPN1 was already returning into the building with R1. That same night, the managers began educating us and made us take tests on elopements to show what we knew and learned. If we are identifying wanderers, we use the intercom and the code word, walker. That alerts all staff that a wanderer has possibly gotten out. The weather that night was very pleasant, it was not rainy or cold, about 70 degrees. Upon return, R1 was fully dressed and talking and laughing with us. An interview with CNA2 on 3/24/22 at 3:23 PM revealed the following, I was R1's aide that night. When I last saw her around 8 PM, she was in her room stating she had to use the restroom, so I assisted her to the restroom. That was the last time I saw her. Next thing I know, I heard the alarm going off and said, I think it's R1. A CNA trainee and I checked our hall for her, then I told the trainee to wait with the other residents, while I went outside to check outside with LPN1. By the time I got outside, LPN1 was returning with R1. R1 was in good spirits and asked us where we were going? After the incident and assessing her, R1 was moved to the second floor. When asked if she had received any training and education, CNA2 responded, Yes, they began educating and testing us that night on elopement procedures and were still training and testing staff when I left the next morning. (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 the facility plan of correction documentation showed 15-minute checks were initiated on the night of 3/22/22 as soon as R1 was returned to the facility. On 3/23/22, R1 was seen by her Physician. A urinalysis was performed and found to be negative. She was again assessed, and no injuries were found. Additional review of the facility's documentation revealed written witness statements taken on the night of 3/22/22, which coincided with the statements given during the survey. Additional review of facility presented documentation on 3/24/22 at 3:30 PM revealed the facility implemented exit door audits and testing immediately on 3/22/22 with 100% of doors and wanderguard panels functioning properly. Review of the facility's Quality Assurance Performance Improvement (QAPI) plan revealed an adhoc meeting was held on 3/23/22 to discuss the elopement with the Administrator and QAPI committee present. Education and in-services were reviewed related to Elopement, including documentation of testing staff on their knowledge. 100% audit of wanderguard assessments were completed for all residents currently residing in the building. All residents identified as elopement risks were moved to the 2nd floor and their care plans were updated to reflect any changes related to room changes, wanderguard placements and ensuring the Physician and/or Resident Representatives were notified. The facility's removal plan indicated the following actions: 1. A complete head to toe assessment was completed upon return to the facility. 2. The preliminary report was submitted to the state agency. 3. R1's care plans were reviewed. 4. Review of the latest Minimum Data Set (MDS) assessment were completed for Resident 1. 5. Incident investigation was initiated. 6. Family member was notified of the incident. 7. Attending Physician was notified of the incident. 8. Resident was monitored 1:1 for at least 72 hours. 9. Resident 1 was placed on 1:1 supervision, immediately. 10. All residents were evaluated for wandering/elopement risk. 11. Statements were obtained from residents/staff/visitors. 12. All exit doors were checked for function ability. 13. Daily quality review of staff responses to exit door alarms to be checked. Any concern will be reported to the Administrator immediately. 14. All elopement books were reviewed and updated if necessary. The elopement books are available at the front desk, all nursing stations, therapy room and kitchen area. (continued on next page)

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