STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425085	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH-ORANGEBURG	**755 WHITMAN STREET SE ORANGEBURG, SC 29115**

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 -** Actual harm **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** Based on observation, interview, and record review, the facility failed to provide adequate supervision and assistance to prevent accidents as evidenced by the elopement of Resident #1 for 1 of 3 residents reviewed for elopement. The findings include; Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The facility submitted a reportable to the State Agency on 5/7/2020 indicating Resident #1 had walked out of the facility, fell , scraped face and lip and was sent to the emergency room for evaluation. Review of the hospital's discharge paperwork on 5/13/2020 indicated Resident #1 had a discharge [DIAGNOSES REDACTED]. S/he was discharged back to the facility with prescriptions for Nasal Spray and [MEDICATION NAME] ointment. On 5/13/2020 at approximately 12:30 PM, during an interview with the Director of Nursing, s/he showed the area where the resident had exited the building and stated that due to the resident being a new admit, they were placed on a quarantined unit because of the recent COVID-19 outbreak. The DON agreed that the alarm did sound, but due to the plastic enclosing the hall, the staff were unable to hear the alarm. Review of the Resident's Minimum Data Set (MDS) from Admission indicated a Brief Interview of Mental Status (BIMS) score of 12 indicating minimal cognitive deficiencies. Review of the Fall Risk assessment completed on 4/28/2020 indicated the Resident scored a 14 and a high risk for falls due to unsteady gait. Review of the Baseline Care Plan dated 4/29/2020 showed Resident #1 was care planned for falls related to weakness requiring interventions to include; education on call light use, assisting with toileting and transfers as needed, and keeping the environment safe. Observations of the Resident on 5/13/2020 showed minor healing injuries to the face, pleasant manner and mood and placement at the nurse's station with a mask on.

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

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.