STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425053	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH-WALTERBORO	**401 WITSELL STREET WALTERBORO, SC 29488**

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 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to ensure the Level I Pre-Admission Screening and Resident Review (PASARR) assessment was updated to reflect the change in mental status and failed to refer one (1) of one (1) residents reviewed for PASARR requirements (Resident #32) for a PASARR Level II assessment following new [DIAGNOSES REDACTED].#32 revealed he/she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 7/17/19 a [DIAGNOSES REDACTED]. A Level I PASARR was completed 4/11/2019. At that time, the Level I indicated Resident #32 had no mental illness and there was no need for referral for specialized services. An updated Level I PASARR with Resident #32's new [DIAGNOSES REDACTED]. Review of the most recent Minimum Data Set (MDS), a 5-day assessment dated [DATE] after a readmission from the hospital on [DATE], confirmed the [DIAGNOSES REDACTED]. Further review of the MDS assessment revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he/she was cognitively intact and capable of making his/her own decisions. Review of the care plan developed on 4/7/2020 documented the potential for complications and adverse reaction related to use of [MEDICAL CONDITION]/anti-psychotic medication due to the [DIAGNOSES REDACTED]. A goal dated 9/26/2020 was to show no complications or adverse reactions from use of medications. Interventions included medication as ordered, monitor for adverse reactions to medications and report to physician, monitor for increase behaviors, lethargy, changes in mentation, vital sign changes and changes in respirations, decreased output, changes in sleep patterns and any other issues and report the changes to the physician. A pharmacy consult was recommended and completed monthly for a possible gradual dose reduction (GDR) as needed. Observation of Resident #32 on 8/10/2020 at 9:30 a.m. revealed he/she was still in bed. He/She stated he/she liked to stay in bed most of the day. He/She stated he/she got up sometimes, but his/her preference was to stay in bed. He/She was awake and alert and able to make his/her needs known. A second observation on 8/11/2020 at 4:00 p.m. revealed Resident #32 was up in a wheelchair at the bedside. He/She stated it was time for him/her to get in bed as he/she was tired after getting back from [MEDICAL TREATMENT]. On 8/12/2020 at 10:30 a.m., an interview with the Social Services Director (SSD) confirmed the Level 1 PASARR was completed prior to the resident's admission to the facility. He/she stated the Level 1 PASARR had not been updated to reflect the new [DIAGNOSES REDACTED]. He/she stated had the Level I PASARR been updated, it would have triggered a referral for a Level II PASARR for evaluation of services. The Level II referral for possible services was not completed as required.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to develop and/or implement comprehensive care plans for three (3) of 23 sampled residents triggered for investigations (Resident #29, Resident #83, Resident #91). The facility failed to complete weekly skin assessments as directed in the care plan for Resident #29 who had two (2) pressure ulcers. Restorative services were not implement in accordance with Resident #83's care plan. Falls interventions including the use of Dycem and use of a functioning bed alarm were not implemented for Resident #91 in accordance with the care plan. The findings include: 1. On 8/11/2020 at 10:15 a.m., during a tour of the coronavirus (COVID)-19 unit, the Unit Manager for Hall One (1) was interviewed and stated Resident #29 had wounds on his/her left buttocks and the sacral area. The Unit Manager for Hall One (1) stated the resident had recently acquired them while he/she was ill with COVID-19 and had lost some weight. The Unit Manager for Hall One (1) also noted the resident received Hospice services and his/her weight loss was expected as his/her condition continued to decline. Review of the medical record for Resident #29 revealed he/she was originally admitted to the facility on [DATE] with a recent readmission on 3/2/2020 after a hospital stay. [DIAGNOSES REDACTED]. Review of the most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #29 did not have any pressure ulcers when the assessment was completed. A care plan was initiated on 5/5/2020 for skin breakdown was updated on 7/31/2020 with pressure areas on the left buttocks and sacral area identified. The goal was for the pressure areas to heal without complications by the target date of 9/26/2020. Interventions included treatment as ordered, float heels as indicated, pressure reduction mattress, prompt incontinence and catheter care, skin assessment per protocol and as needed, wheelchair cushion, and turn and position frequently. A Stage II pressure ulcer on the sacrum was identified on 7/6/2020 and noted on the Wound Management Detail Report, measuring 1centimeter (cm) X (by) 1 cm and without depth. The sacral pressure ulcer was reassessed by the Wound Care RN on 7/8/2020 and 7/15/2020. There were no changes in the assessment of either of the wounds. There was no documentation of a wound description including measurements or the current condition of the wound since 7/15/2020 (28 days prior). Documentation in the medical record revealed a pressure ulcer to his/her left buttocks identified on 7/13/2020 by The Wound Care Registered Nurse (RN) and re-assessed by the Wound Care RN on 7/15/2020 with documentation on the Wound Management Detail Report. The wound was identified as a Stage II wound measuring 0.5 cm X 0.5 cm without depth. There was no documentation of a wound description including measurements or the current condition of the wounds since 7/15/2020 (28 days prior). Review of the Physician's Progress Note dated 7/20/2020 revealed he/she was aware of the pressure ulcers and had documented their presence in his/her progress notes. Review of the Treatment Administration Record (TAR) for July 2020 and August 2020 confirmed the daily treatment was being completed as ordered by the Licensed Practical Nurse (LPN) daily. Review of the Nursing Progress Notes dated 7/1/202 through 8/12/2020, revealed documentation the treatment was being completed; however, there was no description of the wounds. Interview with the Wound Care RN on 8/11/2020 at 11:45 a.m. revealed he/she completed wound measurements weekly. He/she said he/she has not seen Resident #29's wounds since 7/15/2020. He/she also stated he/she did not go on the COVID unit (which was where Resident #29 resided) and was not sure who was responsible for assessing the wounds. He/she stated the licensed practical nurses (LPNs) who worked the COVID Unit on a daily basis could not do the assessments, it must be completed by an RN. Interview with the Director of Nursing (DON) on 8/11/2020 at 12:30 p.m. confirmed the wounds for Resident #29 had not been assessed by an RN since 7/15/2020 which was 28 days ago. He/she stated the Wound Care RN did not go onto the COVID unit to do treatments or assessments and the nurses working on that unit who completed the daily treatments were all LPNs and they could not complete the weekly skin assessments. He/she stated either the Wound Care RN or herself should have assessed the wounds weekly and documented in the medical record the status of the wound with measurements at that time. He/she stated he/she had not assigned an RN to complete weekly wound assessments on the COVID Unit and he/she had not completed them him/herself. Observation on 8/12/2020 at 11:00 a.m. of Resident #29's wound to his/her left buttock revealed a very small open area with a scant amount of serosanguinous drainage on the old dressing. The Hall 1 LPN stated the area had improved

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.

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and he/she hoped it would be healed soon. The area on the sacrum was observed as no longer open. A follow up interview with the DON on 8/12/2020 at 2:00 p.m. revealed an assessment by an RN of Resident #29's wound has not been completed to document the current status of the wound. On 8/12/2020 at 3:00 p.m. the DON presented a Wound Management Information Sheet dated 8/12/2020 at 2:54 p.m. documenting the current status of the wound on the left buttocks as 0.5cm X 0.5cm X 0.1cm-Stage II-with light serosanguineous drainage. This documentation also noted the area to the sacrum was healed but was nonblanchable. This assessment was completed by the DON. He/she stated it had not been completed earlier so he/she just completed it. Review of facility protocol Wound Observation and Assessment Documentation dated January 2015 and approved in January 2020 noted, At least every 7 days a comprehensive nursing assessment is completed by a registered nurse that includes a review of the current plan of care, current wound status (based on assessment and review of all documentation), and the patient/resident's response to the treatment plan. The facility did not follow the plan of care for Resident #29; the facility failed to complete weekly wound assessments with documentation in the medical record in accordance with the care plan. 2. Resident #83 was admitted to the facility on [DATE]; [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set ((MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of zero (0) indicating severe cognitive impairment. The resident required limited assistance with bed mobility, required extensive assistance with eating, toileting and hygiene, and the resident was not transferred from the bed. The resident had limitation in range of motion (ROM) of the lower extremities bilaterally and did not have limitation in ROM of the upper extremities. The MDS also documented the resident did not receive therapy or restorative services. Review of the revised care plan dated 7/27/2020 revealed the resident was to be placed in the restorative nursing program for active range of motion to bilateral upper extremities for shoulder flexion, elbow flexion/extension, wrist flexion/extension, 15 repetitions, five (5) sets daily. Observation on 8/13/2020 at 11:29 a.m. revealed the resident lying in bed on his/her back. Further observation revealed the resident had bilateral amputation of the legs above the knees. Interview with the Restorative Aide on 8/12/2020 at 11:00 a.m. revealed Resident #83 was not on a restorative program. Interview with the Director of Nursing (DON) on 8/12/2020 at 11:41 a.m. revealed he/she never received the plan for restorative services from the therapy department. Interview with Minimum Data Set (MDS) Coordinator #2 on 8/13/2020 at 11:17 a.m. revealed the DON developed the restorative care plans and therapy may develop some. Interview with the DON on 8/13/2020 at 11:27 a.m. revealed after checking the care plan on the electronic record, therapy wrote the care plan for Resident #82's restorative services. The facility failed to provide a policy, upon request, for care plans. The facility failed to implement the plan of care for restorative services for this dependent resident. 3. Resident #91 was admitted to the facility on [DATE]; [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] documented a BIMS score of three (3) indicating severe cognitive impairment. The resident required extensive assistance of one (1) staff with bed mobility, required set-up assistance with transfers, and required total assistance with toileting and personal hygiene. The resident was independent with locomotion. The resident was steady with moving from a seated to standing position and surface to surface transfers, was not steady but able to stabilize without staff assistance with walking and turning around and the testing of moving on and off the toilet did not occur. The MDS further documented the resident had no falls since the last assessment and utilized a wheelchair (w/c) and a bed alarm daily. Review of the fall care plan revised 5/5/2020 documented the following interventions: Dycem (non-slip mat) to w/c, floor pad to bedside, bed/chair alarm as ordered, and ensure alarms were in place and in good working condition. Observation on 8/10/2020 at 11:34 a.m. revealed the resident was sitting up in bed. The bed was positioned next to the wall on the right side, the quarter rail raised on the left side, a floor mat on the floor on the left side of the bed and the bed alarm present but not in the on position. Observation on 8/10/2020 at 11:44 a.m. revealed the resident ambulated down the hall and sat in a chair at the dining room table. The bed alarm was on but not sounding. Observation on 8/11/2020 at 10:45 a.m. revealed the resident lying in bed on his/her back. Further observation revealed the bed alarm cord was not attached to the bed alarm control box. Observation on 8/13/2020 at 11:29 a.m. revealed the facility had not placed the Dycem in the resident's w/c. Interview with Licensed Practical Nurse (LPN) #4 on 8/13/2020 at 11:33 a.m. revealed the nurses should check one (1) time per shift to ensure the fall prevention interventions were in place. Interview with Certified Nurse Aide (CNA) #5 on 8/13/2020 at 11:45 a.m. revealed the interventions needed for each resident were listed on the computer. Upon asking, CNA #5 could not find the location of the fall interventions on the computer. Interview with Unit Manager (UM) #1 on 8/13/2020 at 11:55 a.m. revealed the nurses should communicate to the CNAs what interventions the resident required. The facility failed to implement the care plan by providing the Dycem, the bed alarm and failed to ensure the bed alarm was working as planned.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to revise the care plan for one (1) of 23 sampled residents triggered for investigations to include the use of the floor mat. (Resident #73). The findings include: Resident #73 was admitted to the facility on [DATE]; [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four (4) indicating severe cognitive impairment. The MDS also documented the resident required limited assistance of one (1) staff member with bed mobility, transfers and ambulation. The resident required extensive assistance of one (1) staff for toilet use and personal hygiene. The resident was not steady but able to stabilize without assistance with moving from a seated to standing position, walking, turning around, moving on and off the toilet and surface to surface transfers. The resident had no impairment with range of motion and utilized a wheelchair. The MDS revealed the resident had two (2) or more falls since the last assessment and utilized a wander/elopement alarm, floor mat alarm and bed alarm daily. Review of the physician's orders [REDACTED]. Review of the care plan for falls updated 7/24/2020 did not include the intervention for the floor mat. Review of the Fall Risk assessment dated [DATE] revealed the resident was at high risk for falls. Observation on 8/11/2020 at 10:54 a.m. revealed the resident was lying in bed. The floor mat was not present. Observation on 8/13/2020 at 11:32 a.m. revealed the resident lying in bed without the floor mat present. Interview with Minimum Data Set (MDS) Coordinator #2 on 8/13/2020 at 11:17 a.m. revealed no one person was responsible for making sure the care plans were revised. Interview with Licensed Practical Nurse (LPN) #4 on 8/13/2020 at 11:33 a.m. revealed the resident should not have a fall mat since he/she was ambulatory. Interview with CNA #5 on 8/13/2020 at 11:45 a.m. revealed the interventions needed for each resident were listed on the computer. Upon asking, CNA #5 could not find Resident #73's fall interventions on the computer. Interview with Unit Manager (UM) #1 on 8/13/2020 at 11:55 a.m. revealed the nurse should communicate to the CNAs what interventions the resident required. The CNAs were responsible for putting the interventions in place and the nurses were to check to make sure the CNAs provided the interventions. Interview with Director of Nursing (DON), and Corporate Nurse #1 and #2 on 8/13/2020 at 12:15 p.m. revealed if changes were made during the risk meetings, the DON or MDS staff were responsible for revising the care plan. If changes to the care plan occurred after the risk meeting, the nurses were responsible for revising the care plan. The facility failed to provide, upon request, a policy for care plans. The facility failed to revise the care plan for the use of the floor mat in accordance with physician's orders [REDACTED].
F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and staff interview, the facility failed to provide basic life support including cardiopulmonary resuscitation (CPR) to a resident whose legal representative had elected full code designation. The facility did not follow physician's orders [REDACTED].#245) triggered for investigations after the resident was found unresponsive. Closed record review revealed Resident #245 had a full code status and the failure to follow physician's orders [REDACTED]. The resident expired in the facility without CPR being provided or 911 called. The facility immediately implemented corrective actions and removed the immediacy of the noncompliance by [DATE]. The findings include: Review of the facility's Advance Directive policy revised on [DATE], revealed residents have the right to decide their medical care.

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F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) Advanced Directives executed in accordance with state law shall be honored by the healthcare center. Review of the facility's Do Not Resuscitate (DNR) policy, revised on [DATE], revealed the facility recognized the resident's desire and right to withhold cardiopulmonary resuscitation and other life-prolonging measures through the use of a Do Not Resuscitate (DNR) order. Unless an order to withhold life-sustaining treatment was entered on the resident's medical record, life-sustaining treatment will be performed on all residents when it is medically justified. Review of Resident #245's closed record revealed an admitted [DATE]; the resident expired in the facility on [DATE]. The resident was admitted with [DIAGNOSES REDACTED]. The resident had not implemented an Advance Directive. However, review of physician's orders [REDACTED]. Review of Resident #245's admitting History and Physical (H&P) dated [DATE] revealed the legal representative was provided options regarding the resident being a full code or DNR. The H&P revealed the legal representative desired for Resident #245 to be a full code. Review of the admitting physician's orders [REDACTED].#245's code status was designated Full Code. Further review of the computerized Face Sheet denoted [DATE] the resident as a Full Code. Resident #245 was in the facility less than 72 hours. Therefore, the Admission Minimum Data Set (MDS) was not completed. The baseline care plan revealed the resident was a full code. Review of Resident #245's Medication Administration Record [REDACTED]. Further review of the investigation report revealed at 10:50 p.m. Certified Nursing Assistant (CNA) #6 provided the resident personal care. Review of the facility's Event Timeline report revealed on [DATE] at 12:00 a.m. CNA #7 completed shift rounds. The Timeline revealed Resident #245 was provided incontinent care. Further review of the Timeline revealed on [DATE] at 1:00 a.m. an outside Lab Technician (Tech) entered Resident #245's room to perform blood (lab) draw. The Lab Tech notified RN #3 the resident was unresponsive. The Timeline revealed RN #3 performed a sternal rub, checked the resident's pulse and reviewed the resident's medical record to confirm code status. The investigation timeline revealed RN #3 thought the clinical record revealed DNR status. The facility investigated the incident regarding Resident #245 immediately. RN #3 was suspended, not allowed to return to work and was then terminated. Phone interview with RN #3 on [DATE] at 7:40 p.m. revealed she/he was employed by the facility for over two (2) years. The RN revealed the facility process to determine a resident's code status was to check the computer. She/he stated the code status would be highlighted on the Face Sheet. She/he further stated the facility had a DNR list that was located on the side of the crash cart. This list informed staff if a resident was designated DNR. She/he stated if a resident's name was not on the DNR list, staff were to assume the resident was a full code. The nurse recalled on [DATE] it was a busy night. She/he stated Resident #245 was a new admit and she/he was not familiar with the resident's care needs. The RN revealed administering medications to the resident around 9:30 p.m. She/he recalled that Resident #245 was very ill. She/he recalled seeing CNA #5 around 11:30 p.m. providing Resident #245 care. RN #3 recalled around 1:00 a.m. being at the nurses' desk when the Lab Tech informed her the resident appeared to be unresponsive. She/he stated she/he immediately went to assess Resident #245. Upon her/his assessment, the resident was cyanotic (bluish color) around the lips, fingertips and the body slightly stiff. She/he further stated, she/he attempted to turn up the resident's oxygen, assessed for pulse (no pulse) and performed a sternal rub. The RN recalled attempting to access the computer system to verify code status; however, the computer system would not open due to possible updates. She/he stated she/he looked at the resident's admitting orders but did not see a Full Code status. The nurse concluded by stating in her/his professional opinion the resident had been deceased for approximately 45minutes to one (1) hour, and that she/he did her/his best. Interview on [DATE] at 12:33 p.m. with LPN Unit Manager (UM) Hall 2 revealed being employed at the facility for eight (8) years. She/he revealed being the admitting nurse for Resident #245. She/he indicated when a resident was admitted from the hospital, the discharge orders served as the admitting orders for the nursing home. She/he further explained the facility's Physician had the ability to review and sign the computerized orders. The LPN stated without signed documentation and verification, everyone was assumed to be a Full Code. She/he further revealed the facility's system to identify a resident's code status was the computer Face Sheet. However, if the computer system was not working, each unit's crash cart had a list of residents who were identified as DNR. Interview on [DATE] at approximately 9:40 a.m. with the Administrator revealed no computer or system updates where noted during Resident #245's incident on [DATE] and she/he provided documented evidence. The Administrator revealed the facility immediately started and investigation to Resident #245's event. The facility utilized a Self-Imposed Immediate Jeopardy checklist (dated [DATE]). The Administrator revealed the facility's staff were trained to look in a resident's chart and Social Service staff provided and an updated DNR list on the side of every cash cart. The Administrator revealed, immediately after Resident #245's incident, all staff were in-serviced on code status. In addition, the code status of all residents was reviewed for accuracy. The staff CPR records were also reviewed to ensure CPR certifications were up to date. The Allegation of Compliance for removal of the immediate jeopardy was presented to the survey team on [DATE] and was accepted by the State Agency on [DATE]. The immediate jeopardy started on [DATE] and was removed on [DATE] (the date the facility fully implemented their Allegation of Compliance). Implementation of the Allegation of Compliance was verified during the survey. Observations of Hallway 2, 3, and 4 crash carts was conducted on [DATE] between 1:15 p.m. and 1:30 p.m. An up to date DNR list was posted on the side of each crash cart. Review of a sample of staff personnel records revealed no expired CPR certifications. Review of the CPR in-service training sign in sheet revealed the last staff training was conducted on [DATE]. Multidisciplinary staff members were interviewed. All staff stated they had attended in-services and that the topics included: Code Status, to include all admissions are designated full code until the Physician signs the DNR. Re-education was provided on Code Blue, and when/how to perform CPR. In addition, the facility in-serviced staff on DNR and Advance Directive policies. Administration were notified every time a resident was found unresponsive.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to provide restorative services as planned for one (1) of two (2) sampled residents reviewed for restorative services. (Resident #83). The findings include: Resident #83 was admitted to the facility on [DATE]; [DIAGNOSES REDACTED]. The resident required limited assistance with bed mobility, required extensive assistance with eating, toileting and hygiene, and the resident was not transferred from the bed. The resident had limitation in range of motion (ROM) of the lower extremities bilaterally and did not have limitation in ROM of the upper extremities. The MDS also documented the resident did not receive therapy or restorative services. Review of the Care Area Assessments (CAA) for the 7/24/2020 annual MDS revealed the CAA for Activities of Daily Living did not trigger. Review of revised care plan dated 7/27/2020 revealed the problem, Resident requires active range of motion to bilateral upper extremities daily, with the start date of 6/26/2020. The interventions included: place resident in restorative nursing program, active ROM to bilateral upper extremities for shoulder flexion, elbow flexion/extension, wrist flexion/extension, 15 repetitions, five (5) sets daily. The frequency was once a day between 7:00 a.m. and 11:00 p.m. Review of the Occupational Therapy (OT) Discharge Summary revealed the resident received OT services from 5/1/2020 to 6/26/2020. With the discharge plan, the resident was referred to the restorative nursing program. Observation on 8/13/2020 at 11:29 a.m. revealed the resident lying in bed on his/her back with the head of bed elevated approximately 75 degrees. Further observation revealed the resident had bilateral amputation of the legs above the knees. Interview with Certified Nurse Aide (CNA) #3 on 8/12/2020 at 10:34 a.m. revealed the CNAs did not complete restorative services at the facility. The facility had a Restorative Aide (RA) that completed the restorative services. Interview with the RA on 8/12/2020 at 11:00 a.m. revealed the therapy department developed the restorative program and gave the plan to the Director of Nursing (DON). The DON then gave the restorative plan to the RA. Every Friday the DON and the RA discussed all the residents on the restorative program. The RA further stated Resident #83 had never been on a restorative program. Interview with the DON on 8/12/2020 at 11:41 a.m. revealed he/she never received the plan for restorative services from therapy. The DON further stated therapy had developed the care plan for restorative services. The facility failed to provide a policy regarding restorative services upon request. The facility failed to provide restorative services for Resident #83 as planned.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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**

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Based on observation, interview, record review and review of the facility's policy, the facility failed to provide adequate supervision and assistive devices to four (4) of 23 sampled residents (Resident #22, Resident #55, Resident #73, Resident #91) triggered for investigations to prevent accidents. The facility failed to prevent two residents, who were known to wander, from eloping (Resident #22 and Resident #55). These two unsupervised residents exited the facility through a delayed egress door, ambulated approximately 58 feet across a driveway, opened the door of an unlocked vehicle, and sat down in the car. The facility failed to implement interventions including bed alarms, chair alarms, fall mats, and application of Dycem (non-skid material) to prevent falls for two residents (Resident #73 and Resident #91). The findings include: 1. The facility's Lippincott Elopement Precaution policy, revised 8/17/18, revealed an elopement was defined by the National Institute for Elopement Prevention and Resolution as a situation in which, a cognitively, physically, mentally, emotionally or chemically-impaired resident wanders away, escapes or otherwise leaves a caregiving facility or environment unsupervised unnoticed, or prior to a schedule discharge. The compared mental capacity may be related to [MEDICAL CONDITION] or moderate to late-stage dementia. Review of the clinical record for Resident #22 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of Resident #22's clinical recorded revealed the Physician and family agreed on 8/6/2020 to place the resident on Hospice. Resident #22's comprehensive Admission Minimum Data Set ((MDS) dated [DATE] revealed the resident's cognition was severely impaired with a Brief Interview Mental Status (BIMS) score of two (2). The resident was assessed to wander one (1) to three (3) days per week. The wandering placed the resident in a significant risk of getting into dangerous places. Resident #22 was assessed to require supervision of one staff with bed mobility, walking in and out of the room, and with locomotion on and off unit. The resident's balance was unsteady but he/she was able to stabilize without staff assistance. The facility assessed the resident to have no limitation with range of motion. The resident was assessed to have decreased visual acuity (no glasses). The Behavior Care Assessment Area (CAA) dated 12/2/19 identified the resident's wandering as an immediate threat to self. Review of the 11/26/19 Elopement Risk Assessment revealed Resident #22 scored 11, which indicated the resident was at high risk for elopement. The intervention identified on the assessment was to initiate the use of a Wander-guard. Nevertheless, the Wander-guard was not ordered until 12/4/19, which was 3 days after an elopement occurred. Review of the Physician's initial History and Physical dated 11/27/19 revealed the resident was walking and wandering around the facility. Review of Resident's #22's initial behavioral care plan dated 11/29/19 revealed the resident wandered into other residents' rooms and took their belongings; was found sleeping in another resident's bed; and continued exit seeking. The care plan approaches were: redirect resident to not enter other residents' rooms without permission and to not exit the building. Review of Resident #22's Event Report dated 12/1/19 at 5:30 p.m. revealed the resident was found sitting outside hall 2 exit door in an employee's vehicle. The resident sustained [REDACTED]. The report revealed the facility observed the resident make verbal statements about leaving and the resident wandered with no rational purpose and attempted to open doors. The facility's immediate intervention was to a apply Wander-guard, which based on the 11/26/19 Elopement Risk Assessment, should have been applied on 11/26/19. Observation on 8/10/2020 at 9:10 a.m. of the entrance into the facility through Door two (2) revealed the door was locked and a keypad code was needed to enter or exit the facility through the door. Continued observation of the Door 2 area revealed the nurses' desk area was directly visible to the delayed egress Door two (2) that Resident #22 exited from on 12/1/19. Observation during the initial tour on 8/10/2020 at 9:47 a.m. revealed Resident #22's bed was low, against the wall, call light in reach and fall mat to the right of bed. The resident responded to verbal stimuli by opening her/his eyes. Observation at 12:45 p.m. revealed Certified Nursing Assistant (CNA) #3 in the room cueing the resident to eat lunch. The resident only took sips of liquids. Observation on 8/11/2020 at 10:23 a.m. revealed CNA #3 assisting Resident #22 with a family video call. The resident was groomed and wearing weather appropriate clothing. Phone interview on 8/10/2020 at 6:20 p.m. with Resident #22's legal representative revealed prior to coronavirus (COVID), the legal representative was visiting the resident at least three (3) times a week. The resident's spouse visited daily ([AGE] years of marriage). The legal representative verbalized Resident #22 needed long term care because the resident's spouse was unable to provide safe care due to increase wandering and increased care needs. The representative described Resident #22 as a fireball. The resident was able to ambulate without assistance and had poor vision. The legal representative recalled being notified of the 12/1/19 elopement event. The representative questioned Resident #22's ability to hold the delayed egress door for 15 seconds to open it because he/she was legally blind. The representative concluded that Resident #22 had experienced a decline in condition and was not the same person who entered the facility in November 2019. 2. Review of the clinical record for Resident #55 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #55's Comprehensive Significant Change MDS dated [DATE] revealed the resident's cognition was severely impaired with a BIMS score of three (3). The resident was assessed to have no wandering behaviors. The resident required extensive assistance of one (1) with bed mobility, transfer, movement on and off the unit, toilet use, and personal hygiene. The resident's movement from seated to standing position, on/off the toilet and transfer between bed to wheelchair (w/c) was not steady and required staff assistance for balance stabilization. The resident's visual acuity was impaired. Resident #55 was assessed to have had one (1) fall without injury. The Behavioral CAA dated 7/18/19, identified Resident #55's observable characteristics as confusion, disorientation, forgetfulness and having a decreased ability to make him/herself-understood. The cognitive analysis revealed the resident had dementia with behavior and required staff assistance with daily functions. The resident's dementia was advanced; he/she tended to have sundowning behavior in the evening and at bedtime. The resident could be aggressive when redirected. Review of the most recent Quarterly MDS dated [DATE] (prior to the elopement) revealed the resident's BIMS score was three (3). The resident was assessed with [REDACTED]. The resident required extensive assistance of one (1) staff with bed mobility, dressing, toilet use, personal hygiene and bathing. The resident's balance was unsteady but he/she was able to balance without staff assistance. The resident was able to move from a seated to standing position, walking, turning around, as well as moving on and off toilet. The resident had no limitations with range of motion. Review of Resident #55's most recent Elopement assessment dated [DATE] revealed the resident was at high risk for elopement. The intervention was to continue use of Wander-guard. Review of Resident #55's Event Report dated 12/3/19 at 8:37 a.m. regarding the 12/1/19 elopement, revealed that the resident was found outside hall 2 exit door sitting in an employee's vehicle. The resident sustained [REDACTED]. She/he had also expressed statements of wanting to leave the facility. The facility assessed Resident #55's confusion and dementia as a possible contributing factors to the elopement. The facility intervention was to continue the resident's Wander-guard. Observation during initial tour on 8/10/2020 at 10:12 a.m. revealed the resident was lying in a low bed and the call light was in reach. The resident's eyes open and he/she verbalized his/her first name. The resident was wearing a wander-guard on his/her left wrist. Observation at 2:35 p.m. on the same date revealed the resident was in his/her room, up in the w/c wearing weather appropriate clothing. Interview on 8/11/2020 at 12:33 p.m. with LPN Unit Manager (UM) Hall 2 revealed he/she had been employed by the facility for eight (8) years. The UM stated on 12/1/19, the day the two (2) residents exited the facility, he/she was not working and wasn't in the UM position. He/she revealed he/she was familiar with Resident #22 and Resident #55. The UM stated if staff were in a resident's room providing care it was difficult to hear the door alarm. The UM revealed no additional training was provided to staff after the 12/1/19 elopement. Interview on 8/11/2020 at 12:53 p.m. with the Environmental Director revealed the function of the delayed egress door was to allow exit in an emergency. He/she described when someone engaged the exit bar for 15 seconds the alarm would sound, then the door would unlock. During the interview the Environmental Director measured the distance from the sofa (where the residents normally sat), across the driveway to the first car in the parking lot. The Director stated the distance was 57 feet. He/she stated the delayed egress door would continue to sound an alarm until staff input the bypass code. Interview on 8/12/2020 at 1:55 p.m. with the Director of Nursing (DON) revealed when an elopement assessment was completed and a resident scored 11 or higher the immediate intervention was to apply a Wander-guard. He/she revealed being aware of the 12/1/19 event. The DON stated additional training was provided but was unable to provide documentation of training. Phone Interview on 8/13/2020 at 12:40 p.m. with the Unit 2 LPN revealed being the nurse on duty for Resident #22 and Resident #55 on 12/1/19 when the elopement occurred. The LPN stated the two residents usually ate their dinner and then sat in the common area on the sofa. He/she recalled the event of 12/1/19 and revealed being at the end of the hallway providing care to another resident. The LPN stated when a resident's door was shut, staff were unable to hear the egress door alarm. He/she stated a staff member from another unit informed him/her that the egress door was alarming. The LPN stated he/she and CNA #1 went to investigate why the alarm was sounding. During the observation, they noted Resident #22 and Resident #55 were sitting in a staff member's vehicle. Unit 2 LPN did not recall having any training after the 12/1/19 elopement incident occurred. Phone Interview on 8/13/2020 at 1:00 p.m. with CNA #1 revealed he/she was employed by the facility for

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	425053	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH-WALTERBORO	401 WITSELL STREET WALTERBORO, SC 29488

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) over [AGE] years. He/she recalled caring for Resident #22 and Resident #55 often and indicated the residents required supervision. He/she revealed most of the time the residents stayed in the common area on the sofa. However, the evening the residents exited the facility, he/she recalled providing care for another resident and was unable to hear the egress door alarm. A staff member came from another unit and informed them the egress door was alarming. He/she stated the unit LPN and he/she went to investigate why the alarm was sounding. The CNA #1 recalled as she/he was looking around outside, she/he observed the residents in a vehicle. The CNA stated that the residents were able to enter the vehicle due to broken door locks. The CNA stated both residents had time to leave the facility, cross the drive way, get into the vehicle, fasten seatbelts and pull back the cover to the sunroof. He/she concluded by verbalizing it was a blessing Resident #22 and Resident #55 got into the vehicle because they could have gotten to the busy street. The CNA #1 did not recall additional training occurring after the 12/1/19 elopement event. Interview on 8/11/2020 at 9:45 a.m. with the Administrator revealed an elopement was defined as a situation when a resident left the facility grounds. The residents that exited the facility on 12/1/19 never got off the facility grounds. An additional interview was conducted on 8/13/2020 at 1:31 p.m. with the Administrator and Senior Nurse Consultant and revealed that based on the facility's Lippincott Elopement policy the two (2) residents were cognitively impaired and left the facility unsupervised the incident should have been defined as an elopement. The Administrator provided documentation of the 2019 Annual Skills Fair dated August 17-21 for CNAs and nurses. The Annual Skills Fair training included, but was not limited to, topics of residents' rights, abuse and neglect, dementia care, wandering and elopement. However, no addition training was documented after the 12/1/19 elopement. Furthermore, no new interventions were implemented after the incident on 12/1/19 even though staff could not hear the alarm when in residents' rooms. 3. Resident #73 was admitted to the facility on [DATE]; [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four (4) indicating severe cognitive impairment. The resident had the behavior of wandering four to six (4-6) days of the seven (7) day observation period. The MDS also documented the resident required limited assistance of one (1) staff member with bed mobility, transfers and ambulation. The resident required extensive assistance of one (1) staff for toilet use and personal hygiene. The resident was not steady but able to stabilize without assistance with moving from a seated to standing position, walking, turning around, moving on and off the toilet and surface to surface transfers. The resident had no impairment with range of motion and utilized a wheelchair. The MDS revealed the resident had two (2) or more falls since the last assessment and utilized a wander/elopement alarm, floor mat alarm and bed alarm daily. Review of the Care Area Assessment (CAA) dated 10/22/19 for falls revealed the resident had physical and cognition deficits, received antidepressant medications daily and was assisted with activities of daily living by staff. Review of the care plan for falls updated 7/24/2020 listed the following interventions: adjust toilet seat height for safety, therapy as ordered, quarter siderails for enabling increased movement, assist for toileting and transfers as needed, cue for safety awareness, keep environment safe, non-skid shoes/gripper socks, place call light within reach and bed/chair alarm as ordered. Review of the physician's orders [REDACTED]. Review of the Fall Risk Assessments dated 6/20/19, 2/15/2020, 5/2/2020 and 5/20/2020 assessed the resident as a high fall risk. Observation on 8/10/2020 at 12:29 p.m. revealed the resident ambulating down the hall by pushing the wheelchair (w/c) backwards, holding onto the seat of the w/c. No chair alarm was present. Observation on 8/11/2020 at 10:54 a.m. revealed the resident lying in bed with his/her eyes closed. The left side of the bed was against the wall. Further observation revealed no floor mat present. Observation on 8/11/2020 at 12:37 p.m. revealed the resident walking in the room without staff assistance. The bed alarm was present on the bed but not sounding. Observation on 8/12/2020 at 10:15 am revealed the resident sitting in a w/c outside the conference room. Further observation revealed no chair alarm was present. Observation on 8/12/2020 at 2:17 p.m. revealed the resident lying in bed with his/her alarm not hooked to the alarm box, the cord was not visible. The Certified Nurse Aide (CNA) found the cord tucked under the mattress and hooked it to the control box. The CNA at that time stated the resident could unhook the alarm. Observation on 8/13/2020 at 11:32 a.m. revealed the resident lying in bed; no floor mat or bed alarm were present. Interview with CNA #4 on 8/12/2020 at 2:19 p.m. revealed the resident sometimes removed the alarm. He/she stated staff used the alarm because the resident got up at night to go to the bathroom. CNA #4 also stated the resident did not have an alarm for the w/c. Interview with Licensed Practical Nurse (LPN) #4 on 8/13/2020 at 11:33 a.m. revealed the bed alarm came up missing just recently. LPN #4 stated the resident should also have an alarm for the w/c. He/she further stated he/she did not know about the use of a floor mat but the resident moved and some things got left behind. LPN #4 stated the nurses should check one (1) time per shift to ensure the fall prevention interventions were in place. LPN #4 stated at approximately 11:45 a.m. the resident should not have a fall mat since he/she was ambulatory. Interview with CNA #5 on 8/13/2020 at 11:45 a.m. revealed the interventions needed for each resident were listed on the computer. Upon asking, CNA #5 could not find Resident #73's fall interventions on the computer. Interview with Unit Manager (UM) #1 on 8/13/2020 at 11:55 a.m. revealed the nurses were responsible for communicating the residents' needs. UM #1 stated the nurse should communicate to the CNAs what interventions the resident required. The CNAs were responsible for putting the interventions in place and the nurses checked to make sure the CNAs provided the interventions. UM #1 also stated the nurses documented checking the interventions on the Treatment Administration Records (TARs). Review of the TARs for June, July and August 2020 revealed an entry for floor mats to the bedside and to check placement every shift. Further review of the TARs revealed the nurses initialed two times a day that the floor mats were in place. Interview with Director of Nursing (DON) and Corporate Nurse #1 and #2 on 8/13/2020 at 12:15 p.m. revealed the Fall Program consisted of a weekly Risk Meeting where they talked about the falls that occurred in the last week. The meeting consisted of the DON, Social Worker, MDS staff, Dietary Manager and the Unit Managers. If changes were made to the fall interventions, the DON or MDS staff were responsible for revising the care plan. The facility failed to provide, upon request, a policy for the prevention of falls. The facility failed to provide the bed and chair alarm and fall mat as planned for this resident with a history of falls. 4. Resident #91 was admitted to the facility on [DATE]; [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] documented a BIMS score of three (3) indicating severe cognitive impairment. The MDS documented the resident displayed verbal behaviors and rejection of care one to three (1-3) days during the seven (7) day observation period. The resident required extensive assistance of one (1) staff with bed mobility, required set-up assistance with transfers, and required total assistance with toileting and personal hygiene. The resident was independent with locomotion. The resident was steady with moving from a seated to standing position and surface to surface transfers, was not steady but able to stabilize without staff assistance with walking and turning around and the testing of moving on and off the toilet did not occur. The MDS further documented the resident had no falls since the last assessment and utilized a wheelchair (w/c) and a bed alarm daily. Review of the fall care plan revised 5/5/2020 documented interventions in pertinent part: Dycem (non-slip mat) to w/c, floor pad to bedside, bed/chair alarm as ordered and ensure that alarms were in place and in good working condition. Review of the nursing progress notes revealed the resident had eight (8) falls from 2/23/19 to 8/12/2020. The falls occurred on 2/23/19, 4/6/19, 4/30/19, 5/4/19, 5/9/19, 10/28/19 and 4/6/2020 with no major injury sustained. Review of the Fall Risk Assessments completed since 4/30/19 revealed the facility assessed the resident as a high risk for falls. Observation on 8/10/2020 at 11:34 a.m. revealed the resident was sitting up in bed. The bed was positioned next to the wall on the right side, the quarter rail was raised on the left side, a floor mat was on the floor on the left side of the bed and the bed alarm was present but not in the on position. Observation on 8/10/2020 at 11:44 a.m. revealed the resident ambulated down the hall and sat in a chair at the table. The bed alarm was on but not sounding. Observation on 8/11/2020 at 10:45 a.m. revealed the resident lying in bed on his/her back. Further observation revealed the bed alarm cord was not attached to the bed alarm control box. Observation on 8/13/2020 at 11:29 a.m. revealed the facility had not placed the Dycem in the resident's w/c. Interview with Licensed Practical Nurse (LPN) #4 on 8/13/2020 at 11:33 a.m. revealed the nurses should check one (1) time per shift to ensure the fall interventions were in place. Interview with CNA #5 on 8/13/2020 at 11:45 a.m. revealed the interventions needed for each resident were listed on the computer. Upon asking, CNA #5 could not find the location of the fall interventions on the computer. Interview with Unit Manager (UM) #1 on 8/13/2020 at 11:55 a.m. revealed the nurses were responsible for communicating the resident's needs. The CNAs were responsible for putting the interventions in place and the nurses checked to make sure the CNAs provided the interventions. UM #1 stated the nurse should communicate to the CNAs what interventions the resident required. The nurses documented checking the interventions on the Treatment Administration Records (TARs). UM #1 stated he/she would get Dycem to place in the w/c. He/she further stated he/she did not know Dycem was supposed to be used. Interview with Director of Nursing (DON), and Corporate Nurse #1 and #2 on 8/13/2020 at 12:15 p.m. revealed the Fall

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) Program consisted of a weekly Risk Meeting where they talked about the falls that occurred in the last week. The meeting consisted of the DON, Social Worker, MDS staff, dietary manager and the unit managers. If changes were made to the fall interventions the DON or MDS staff were responsible for revising the care plan. Review of the TAR for June, July, and August 2020 listed only the bed alarm, but not the w/c alarm, Dycem or floor mats as planned. The facility failed to provide, upon request, a policy for the prevention of falls. The facility failed to provide the Dycem and bed alarm as planned and failed to ensure the bed alarm was working.