

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Bennettsville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 15-401 Bypass, West Bennettsville, SC 29512	

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)
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835</p> <p>Based on review of facility policy, record review, and interview, the facility failed to develop a care plan for 2 of 3 residents, Resident (R)1, R2. Specifically, there were no care plan giving staff instructions on providing care to R1 and R2. R1 was sent to the local hospital concerning wounds and R2 developed maggots in a wound.</p> <p>On 3/12/24 at 4:35 PM, the Administrator and Director of Nursing (DON) were notified that the failure to develop a comprehensive care plan for R2 regarding wound care of the left foot constituted IJ at F656.</p> <p>On 03/13/24 at approximately 4:55 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 08/04/23. The IJ was related to 42 CFR 483.21 - Comprehensive Resident Centered Care Plan.</p> <p>On 3/13/24 at approximately 4:45 PM, the facility provided an acceptable IJ Removal Plan for F656. On 3/14/24 at 11:00 AM the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F656 at a lower scope and severity of D.</p> <p>Findings include:</p> <p>Review of the facility policy dated 05/05/23 titled Care Plan Process, Person Centered-Care revealed, Policy: The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident . Procedures: 3.develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs . 11. The person-centered care plan includes: A. Date B. Problem C. Resident goals for admission and desired outcomes . E. Interventions, discipline specific services, and frequency .</p> <p>Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to: second degree burn left foot, Stage 4 Chronic Kidney Disease, unstageable pressure ulcers on the left and right feet that developed into stage 4 pressure ulcers, and a stage 4 pressure ulcer on the left buttock/sacrum area. Further review of the Face Sheet reveled R1 was discharged to the hospital on 03/01/24.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/23 revealed R2 had a Brief Interview of Mental Status score of 5 out of 15, indicating R1 was severely cognitively impaired. Further review of the MDS revealed under section M, 1 unstageable and a foot wound (burn), resident had 2 unstageable DTI's at the time the MDS assessment was completed.</p> <p>Review of R1's Physician Orders revealed the following active orders, Air mattress to bed for pressure reduction. Clean area to left buttock with dwc apply santyl cover with calcium alginate and secure with optifoam dressing once daily and prn until resolved. Geo mattress to bed for pressure reduction. Pressure reduction cushion to chair when out of bed. Elevate/Float Heels while in bed. Apply betadine to right heel pad with gauze and wrap with kerlix once daily. Apply skin prep to area to left inner ankle once daily. Apply skin prep to top of left foot once daily for protection. Elevate/Float Heels while in bed.</p> <p>Review of R1's Baseline Care Plan dated 12/06/23 and edited on 12/14/23, revealed the Baseline Care Plan wasn't complete and R1's wounds/ulcers were not addressed.</p> <p>Review of R1's Care Plan dated 12/28/23, revealed, Problem: Pressure Ulcer Risk for Injury r/t abnormalities of mobility. Further review of the care plan revealed, no care plan or interventions for providing care/treatment to any of R1's wounds/ulcers.</p> <p>Review of R1's Progress Note dated 03/01/24 at 5:29 PM, documented, Resident's family in house at bedside states resident's wound has a foul smelling odor, and request resident be sent to ER for further evaluation. Resident sent to [local hospital] per family request.</p> <p>Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE], with diagnoses including but not limited to: amputation of great toe.</p> <p>Review of R2's Admission MDS with an ARD of 07/26/23 revealed R2's BIMS score of 15 out 15 indicating R2 was cognitively intact. Further review of the MDS under section M revealed, 2 unstagable DTI PU upon admission.</p> <p>Review of R2's Physician Orders dated 08/04/23, revealed the following order, Clean surgical site to left great toe with DWC apply non adherent dressing pad with gauze wrap loosely with kerlix and then apply ace wrap once daily and PRN. Clean surgical site to right great toe with DWC apply non adherent dressing cover with bordered gauze daily and PRN.</p> <p>Review of R2's Care Plan revealed no care plan to provide care/services, for R2's amputation.</p> <p>Review of R2's Progress Notes revealed R2 was discharged on [DATE] to the doctor's office and was directly admitted to the hospital. R2 did not return to the facility.</p> <p>Review of R2's Progress Notes dated 08/22/23 at 2:51 PM revealed, Resident return from [local orthorpedic] md states wound care nurse to address both l/r great toe amputation sites needs heels protectors l heel. wound care nurse made aware bilateral heels floated. copy of consultation given to wound nurse.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of R2's Progress Notes dated 09/11/23 at 10:30 AM revealed, Nurse went in room to do drsg changes. started on left foot when i took the drsg off maggots was on resident wound bed. odor noted vs 97. 9 57 128/60 r 18 spoke with [physician] states to get resident to [NAME] ortho asap drsg placed on left foot and bhrc transport took resident to [NAME] ortho .</p> <p>During an interview on 03/12/24 at 12:30 PM, the Minimum Data Set (MDS) Nurse stated, Our system turned over on 06/01/23 when we were bought by a new company. We had to manually input all of our care plans and they hired other nurses to help. They completed them remotely, but we got delayed. There were multiple residents that discharged before we had a change to get to the care plans. I never had a chance to see [R2]. I didn't go back to see who didn't have a care plan because I just haven't had the time. We hired another person here part time, but she quit.</p> <p>During an interview on 03/12/24 at 3:00 PM, the Administrator stated, I knew MDS was still catching up on the care plans. The computers changed last year on June 1, we were taken over by a new company. I didn't realize [R2] was affected by that turnover process and didn't have the care plans in place.</p> <p>During an interview on 03/13/24 at 11:45 AM, MDS Nurse revealed, [R1] had 3 stage 4 pressure ulcers when I completed his Discharge Minimum Data Set (MDS) on 03/01/24. I didn't know he had those wounds. He had a stage 4 on each heel and a stage 4 on his left buttock/sacrum. Two of those he acquired here. I reviewed his care plan and he does not have a care plan addressing any of those pressure ulcers. The MDS Nurse further stated, The wounds were not communicated to me. I went to the Administrator and told her I wasn't getting the information on the wounds. Since then, we now discuss all new wounds and healed wounds in the morning meeting.</p> <p>During an interview on 03/13/24 at 12:20 PM, the Wound Nurse stated, [R1] had 3 stage 4 pressure ulcers, to his sacral area and both heels. When he first admitted , he had a burn to his left foot and a dry area on the back of his left foot. Then when returned after the fall with fracture, he had an unstageable to his left foot. He then acquired new pressure ulcers on the right heel and left buttock that developed into stage 4 pressure ulcers. We had wound care see him and his family knew about the wounds. I do not complete the care plans for wounds, so I don't know why he didn't have care plans on those areas.</p> <p>During an interview on 03/13/24 at 12:32 PM, the Director of Nurses (DON) stated, [R1] should have care plans addressing each of his wounds. I do not see a care plan for them, only a risk for pressure ulcer care plan. We discuss them now every morning in the morning meeting after reviewing all the notes from the previous day or from the weekend, it was hit or miss before, but now it's daily.</p> <p>On 03/13/24 at approximately 4:45 PM, the facility presented a removal plan, which included the following:</p> <p>Resident 1 and Resident 2 identified no longer resides in the facility.</p> <p>A audit was completed to validate comprehensive care plans have been developed and implemented on residents with wounds by the Director of Nursing and Nurse Assessment Coordinator on 3/13/24.</p> <p>Care plans for the identified residents with wounds were updated on 3/13/24 by the Nurse Assessment Coordinator.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Administrator will reeducate the Interdisciplinary Team (IDT) on comprehensive care plan on 3/13/24 to include: Updating or developing comprehensive care plans when the resident the resident's clinical status or change in condition dictates the need. Development of comprehensive care plans no more than 21 days after admission.</p> <p>Any member of the Interdisciplinary Team not receiving this reeducation on 3/13/24 will receive prior to their next scheduled shift.</p> <p>The Director of Nursing will review comprehensive care plans for residents with wounds weekly to validate accuracy and completion.</p> <p>The Director of Nursing will review comprehensive care plans weekly following the Minimum Data Set quarterly assessments to validate completion and accuracy.</p> <p>The Medical Director was notified of the Immediate Jeopardy on 3/13/24.</p> <p>An Ad Hoc Quality Assurance and Performance Improvement Meeting was held on 3/13/24.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835</p> <p>Based on review of the facility policy, record review, and interview, the facility failed to ensure wound care was completed on days when Resident (R)2 went out to dialysis, subsequently R2 developed maggots in the wound of her left foot, for 1 of 2 residents reviewed for foot care.</p> <p>On 3/12/24 at 4:35 PM, the Administrator and the Director of Nursing (DON) were notified that the failure to follow physicians orders to ensure wound care was completed on days when Resident (R)2 went out to dialysis, constituted Immediate Jeopardy (IJ) at F687. Furthermore, the Administrator and DON were notified that the failure to develop a comprehensive care plan for R2 regarding wound care of the left foot constituted IJ at F656.</p> <p>On 3/12/24 at approximately 4:45 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 08/04/23. The IJ was related to 42 CFR 483.25 - Quality of Care.</p> <p>On 3/13/24 at approximately 11:59 AM, the facility provided an acceptable IJ Removal Plan for F687. On 03/13/24 at 1:00 PM, the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F687 at a lower scope and severity of D.</p> <p>An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F687 constituting substandard quality of care.</p> <p>Findings include:</p> <p>Review of the facility policy revised on 05/05/23, titled Physician Orders, states, Procedures: 3. Upon admission, the facility has physician orders for the resident's immediate care to include but not limited to: C. Routine Care orders to maintain or improve the resident's functional abilities .</p> <p>Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE], with diagnoses including but not limited to: amputation of great toe.</p> <p>Review of R2's Care Plan revealed no care plan related to care/treatment of R2's amputation.</p> <p>Review of R2's Wound Note dated 07/20/23, documented, Resident with surgical wound to right great toe from amputation.</p> <p>Resident stated amputation was performed approximately a month ago and she has not f/u with MD who performed operation. Facility will reach out to [physician] for f/u. Sutures are still intact with 10 visible sutures. There is an area that has some seropurulent drainage present with small open area measuring 0.8x0.2cm. Area cleaned with calcium alg. with silver applied to open area. MD and RR aware.</p> <p>Review of R2's Progress Notes dated 09/11/23, revealed, Maggots was on [R2] wound bed, odor noted.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of R2's Progress Notes dated 09/11/23, revealed R2 was discharged to the doctor's office and was directly admitted to the hospital. R2 did not return to the facility.</p> <p>Review of R2's Physician Order dated 08/04/23, revealed an order to clean surgical site to left great toe with Dermal Wound Care (DWC) apply non adherent dressing pad with gauze, wrap loosely with kerlix and then apply ace wrap once daily and as needed (PRN).</p> <p>Review of R2's Treatment Administration Record (TAR) revealed missing signatures for the following days, 08/09/23, 08/18/23 and 08/30/23, indicating the treatment was not completed as R2 was at dialysis or not available.</p> <p>During an interview on 03/12/24 at 12:13 PM, the Director of Nurses (DON) stated, [signatures on the TAR] indicate that the nurse did not complete the dressing changes for [R2], but she has PRN orders so the nurses should have completed the dressing changes sometime later and would have given a report to the on-coming nurses that the dressings needed to be changed. [R2] received dialysis on Monday, Wednesday and Friday. The DON further stated, [R2] had maggots in her wound. We have never had maggots in a wound before, nor have we since seen maggots. She was sent to the doctor and then went to the hospital. She did not return.</p> <p>During an interview on 03/12/24 at 1:43 PM, Licensed Practical Nurse (LPN)1 stated, The odor was very foul, so I removed the dressing on [R2] left foot to look. I saw little white insects, I thought my eyes were deceiving me. They were falling out of her wound. I went and got my Administrator. She came immediately and said they were maggots, but they were tiny. It scared me, I had never seen them before. We cleaned the wound and called her doctor. [R2] was sent to her orthopedic physician and from there, he admitted her to the hospital.</p> <p>During an interview on 03/12/24 at 12:13 PM, the Administrator confirmed there were maggots in R2's left foot wound. The Administrator stated, [LPN1] came to me early that morning and told me to come see the wound. I saw the maggots in her wound. We cleaned it really well and applied the dressing. [LPN1] called her orthopedic doctor and she was sent out that day. He direct admitted her to the hospital.</p> <p>During an interview on 03/12/24 at 1:57 PM, the Wound Nurse stated, I have never seen maggots in a wound. I was not here that day they found them, I had requested that day off.</p> <p>On 03/12/24 at approximately 7:30 PM, the facility submitted a removal plan, which included the following:</p> <p>License Nurses that were working on 9/11/23 at the time maggots were found, were educated and on how maggots form, and that it takes 5-7 days for them to appear after a fly has lit on would and laid eggs. they were able to visualize what the maggots look like when they first hatch. This education was completed by the administrator.</p> <p>License Nurses staff completed ordered treatments for all other wounds in the facility on this date, September 11, 2023, and there were no other maggots present.</p> <p>Resident identified no longer resides in the facility, and has not since 09/11/23.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Residents with wound care orders have the potential to be affected by the alleged deficit practice. An audit of residents with wound care orders will be completed by the Director of Nursing on 3/12/24 validating treatments are completed as ordered. There were no missing treatments identified.</p> <p>Licensed Nurses will be reeducated by the Director of Nursing on 3/12/24 on following physician orders including:</p> <ul style="list-style-type: none"> - Wound care orders - When a resident is out of the facility and wound care is not completed as ordered, it should be completed upon the residents return - Documentation will reflect explanation to why wound care was not completed at time ordered and when it is completed upon residents return <p>Any licensed nurse not receiving this education by this date will received prior to their next scheduled shift. This will be presented in New Hire orientation.</p> <p>Director of Nursing will validate daily in clinical morning meeting treatment for wound care is completed as ordered. Areas of concern will be addressed upon discovery.</p> <p>Medical Director was notified of this Immediate Jeopardy on 3/12/24.</p> <p>An Ad Hoc QAPI will be held on 3/12/24.</p> <p>AOC 3/12/24</p>