STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425179	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodruff Manor	1114 East Georgia Road Woodruff, SC 29388

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, and interviews, the facility failed to ensure that Resident (R)1 was free from being administered another resident's medication, for 1 of 1 resident reviewed.Findings include:Review of the facility's policy titled Administration of Medications Plan dated 07/2025 revealed the following: 7b. The following Ten Rights of Medication Administration practice should be Right patient Right drug Right route Right time Right dose Right documentation Right action (appropriate reason) Right form Right response Right to refuseReview of R1's Face Sheet revealed admission to the facility on [DATE] with diagnoses including, but not limited to, aftercare following joint replacement surgery, presence of left artificial hip joint, cerebral infarction, and pulmonary hypertension. Review of R1's Quaterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/26/25 revealed R1 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating he was cognitively intact.Review of R1's Care Plan with a revision date of 08/16/25 revealed R1 is at risk of adverse effects of antianxiety medication. A goal indicated R1 will show a decrease in anxiety/agitation over the next 90 days and will not experience adverse effects from medication through the next review date. Further review of the care plan listed interventions directing staff to monitor for adverse effects of antianxiety medications: insomnia, irritability, dizziness, headache, confusion, drowsiness, light-headedness, sedation, difficulty speaking, hypotension, chest pain, increased or decreased appetite, and redirect from the source of anxiety/agitation as able.Review of R1's Medication Administration Record (MAR) revealed R1 is allergic to statins.Review of R1's Progress Note dated 06/17/25 revealed R1's nighttime medication was administered by Licensed Practical Nurse (LPN)1. At 20:45 it was discovered that R1 received donepezil 10 mg, buspirone 10 mg, namenda 10 mg, and lipitor 40 mg by mouth. Upon review of signing the medications out, LPN1 realized the medications were administered to the wrong patient. During an interview on 09/02/25 at 12:27 PM, R1's Resident Representative (RP) stated, They called me as soon as it happened. The medication must not have been very strong, because she was fine. She told me she was fine.During an interview on 09/02/25 at 12:45 PM, Registered Nurse (RN)1 stated, [LPN1] informed me she made a medication error. I asked her who and which medication. I then went to assess the resident. I took a set of vital signs (VS). I had [LPN1] monitor the resident and call the on-call physician to let them know. The resident is allergic to Lipitor. I called the pharmacy to see the type of reaction that would occur if she received the medication. I looked in the system to see what the reactions were. The systems showed if there was any adverse reaction, [R1] would experience muscle pains. I called the Director of Nursing (DON) and RP. [R1's] VS were stable, and he was not experiencing any shortness of breath. The DON came into the facility. I watched the DON conduct a medication pass, a medication administration quiz, and review patient rights education. I made frequent rounds on [R1]. [LPN1] was shaken up by the incident.During an interview on 09/02/25 at 1:33 PM, R1 stated, I remember taking the wrong medications. I haven't had any problems with those pills.During an interview on 09/02/25 at 1:43 PM, Nurse Practitioner (NP) stated, I do remember that, and I remember telling them to call the pharmacy. I am a palliative nurse practitioner. So, when someone calls us we rely on what they say. I instructed them to call the practitioner.During an interview on 09/02/25 at 1:50 PM, the Pharmacist stated, We run 24 hours. No one mentioned this incident to me as the pharmacist director until today. This incident was probably called into our main office. All of the pharmacists who were working at that time and shift are no longer with us.During an interview on 09/02/25 at 3:15 PM, LPN1 stated, It was a total mix-up. I looked at Point Click Care (electronic medical record system) and told myself I was going to look at [R1]. I pulled the medications and popped them out of the container. When I went in the room, we started talking. I usually give the other resident her medications first, but I didn't. I ended up giving [R2's] medication to [R1]. When I went back to PCC, I realized I didn't. I reported the incident. I contacted my supervisor. We went through her allergies. She has a statin allergy. We immediately called the NP. The allergy she had to statins was muscle cramps. I monitored her all night. It was a big mix-up. We did education. We went over the six rights of education. The nurse supervisor watched me pull medications to make sure I was pulling medications correctly.During an interview on 09/02/25 at 2:03 PM, the DON stated, They called me when it happened. The supervisor called me and reported that the resident received the wrong medication. They had already called the provider and the pharmacist and were instructed on what to do and the signs and symptoms to look for. I conducted one-on-one education with [LPN1]. During an interview on 09/02/25 at 2:09 PM, the Administrator stated, We knew it was a medication error