

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Woodruff Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835</p> <p>Based on review of the facility policy, observation, record review, and interview, the facility failed to ensure hand hygiene was followed during an observation of wound care for Resident (R)49, for 1 of 1 resident reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>Review of the facility policy dated 11/03/2023 and titled, Hand Hygiene recorded under the policy, According to the World Health Organization, hand hygiene is performed at minimum, at the following times. Before a clean procedure, after exposure to body fluids, after touching the residents surroundings including equipment and devices.</p> <p>Record review of R49's medical record revealed he was admitted to the facility on [DATE] with diagnoses that included but not limited to stenosis of carotid artery, diabetes mellitus with neuropathy, hypothyroid, hypertension, and pressure ulcer to the right heel.</p> <p>On 10/18/24 at 10:43 AM, an observation of a dressing change for R49 revealed the following: R49 consented to the observation. Registered Nurse (RN)2 prepared the overbed table and placed a barrier down before placing the supplies for the dressing change. Observed on the overbed table were normal saline, gauze, skin prep and 2 dressings pre dated and initialed. RN2 had the treatment order printed. RN2 donned a gown and washed her hands and donned gloves. She then closed the blinds. She removed R49's bunny boots to his bilateral feet. R49 was lying in bed. RN2 removed the sock and dressing from R49's left foot, dated 10/16/24. Using the same gloves, she cleaned the wound with normal saline. She then removed her gloves, sanitized her hands, and applied skin prep around the outer wound. Afterward, she applied the dressing and gathered all supplies and discarded them in the trash.</p> <p>On 10/18/24 at 10:52 AM, an interview with the RN2 revealed, When touching the dirty, I should have removed the gloves. I was kind of nervous.</p> <p>On 10/18/24 at 4:38 PM, an interview with the Director of Nurses (DON) revealed, For a dressing change, after removing the soiled dressing, glove removal, then hand hygiene.</p> <p>On 10/18/24 at 11:07 AM, an interview with the Infection Prevention Nurse revealed, For a dressing change, gather supplies, provide a clean field, sanitize hands until dry. Then don gloves, remove old dressing, then remove gloves, re-sanitize and apply new gloves.</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48835</p> <p>Based on review of the facility policy, observation, record review, and interviews, the facility failed to ensure the medication error rate was less than 5%. The medication error rate was 28%.</p> <p>Findings include:</p> <p>Review of the facility policy dated 02/2004 and titled, Administration of Medications revealed under the policy, The following Ten Rights of Medication Administration Practice should be confirmed prior to administration: Right time.</p> <p>On 10/16/24 at 12:22 PM, an observation of Licensed Practical Nurse (LPN)2 during medication administration revealed the following; LPN1 drew the following medications for Resident (R)80;</p> <p>Vitamin B 12, 2 tablets of stock medication</p> <p>Vitamin B Complex 1 tablet of stock medication</p> <p>Levofloxin 500 milligram (mg)- 1 tablet</p> <p>Gabapentin 800 mg- 1 tablet</p> <p>Azithromycin 500 mg- 1 tablet</p> <p>Sertraline 50 mg- 1 tablet</p> <p>Ethambutol 400 mg- 2 tablets and</p> <p>Biktarvy 50/200/25 1 tablet po QAM 1 tab</p> <p>An interview with LPN2 on 10/16/24 at 12:23 PM revealed, These are his morning medications. He wasn't feeling well earlier and asked if I could come back later.</p> <p>Record review of R80's medication orders revealed Vitamin B12 was ordered at 0800, Levofloxin 500 mg was ordered for 0800, Gabapentin was ordered every 8 hours, and was to be given at 0900, Azithromycin 500 mg was ordered at 0800, Sertraline 50 mg was ordered at 0800, Ethambutol 400 mg was ordered at 0800 and Biktarvy 50/200/25 was ordered at 0800.</p> <p>An interview with LPN2 on 10/16/24 at 4:20 PM revealed, I spoke to the supervisor, I told her what was going on. She didn't advise me to get an order from the doctor or anything.</p> <p>An interview on 10/16/24 at 4:29 PM with Registered Nurse (RN)4 revealed The protocol is to call the doctor and explain what was going on. Ask if we can give the medication at a later time. I can't recall a nurse telling me this AM that a resident did not take their meds. I did not call the Nurse Practitioner (NP).</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Director of Nurses (DON) on 10/17/24 at 2:21 PM revealed, If the resident wasn't feeling well that day, we could put it down as refused, medication not given. If it became routine, the nurse practioner or Physician would be called to get an order. The nurse would have called the provider prior to giving the medication, to request to give at a later time. The DON observed R80's Medication Administration Record (MAR). She said, The Gabapentin was signed as given at 2:00 PM, as well. It is not ok to give the Gabapentin as a nursing judgement that close to when the resident just received the other.</p> <p>On 10/18/24 at 10:00 AM, the DON stated, I printed the actual time stamp of the medication given yesterday. The Medication Admin Audit Report revealed the actual times the nurse administered the medication to R80 on 10/16/24. The DON verified all those medications were given late and there was not an order to give them at that time.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49918</p> <p>Based on observations, interviews and facility policy, the facility failed to ensure medications and biologicals were kept sterile and not expired in 2 out of 2 Medication and Treatment carts.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Storage of Medication revealed that medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal (Refer to Section 5- disposal of Medications, Syringes and needles), and reordered from the pharmacy (Refer to Section 3.2 - Ordering and Receiving Non-Controlled medications), if a current order exists.</p> <p>An observation on 10/16/24 at 09:43 AM (Unit 1 Treatment Cart) revealed 2 HydroferBlue Hydrofera Blue Ready-Transfer Antibacterial Foam Dressing Ref #HBRT2525 Lot#001505-1. Expired as of 05/01/24.</p> <p>An observation on 10/16/24 at 09:43 AM (Unit 1 Treatment Cart) revealed HydroferBlue Hydrofera Blue Ready-Transfer Antibacterial Foam Dressing Lot#001506-2. Expired as of 07/01/24.</p> <p>An observation on 10/16/24 at 09:43 AM (Unit 1 Treatment Cart) revealed Xeroform Occlusive Gauze Patch 4 x 4 (10.2cm x 10.2cm), Ref#8884433500, expires 2025 Lot#4011304 cut into and partially open x 2.</p> <p>An observation on 10/16/24 at 09:43 AM (Unit 1 Treatment Cart) revealed Kerlix Bandage Roll 4-1/2 x 4-1/8 yd (11.4cm x 3.7m) Ref#6715 Lot # 24E059462 Expired 2029 04 30 Manufacturer COVIDIEN, item open.</p> <p>An observation on 10/16/24 at 09:43 AM (Unit 1 Treatment Cart) revealed 10-Sage M-Care Meatal Cleansing cloths Fragrance free 2 wash cloths 5.5 in x 8 in Manufacturer [NAME] Lot# 92639. Expired as of 10/15/24.</p> <p>During an interview on 10/16/24 at 09:57 AM, the Director of Nursing (DON) stated, The nurses are responsible for checking for expired items every shift.</p> <p>During an interview on 10/16/24 at 10:09 AM, Registered Nurse (RN)3 stated, We do not have a set schedule, but we usually go through. When we have time, we review it and organize and remove items at that time. She stated, We do the dressing changes. The wound care nurse does the dressing changes.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 10/16/24 at 03:45 PM (Unit 2 Treatment Cart) revealed 2- Triamcinolone 0.1% in Eucerin 1:1 cream CMP Lot # 240815-003. Expired as of 09/14/24.</p> <p>An observation on 10/16/24 at 03:45 PM (Unit 2 Treatment Cart) revealed opened Algiste M (10x10) 4in x 4 in manufacturer [NAME] & Nephew Lot (10)2049 Ref 59480200.</p> <p>During an interview on 10/16/24 at 03:47 PM, Licensed Practical Nurse (LPN)1 stated treatment carts are checked twice a week by the Lead Nurse or Supervisor on Monday & Friday.</p> <p>An observation on 10/17/24 at 09:36 AM (Unit 2 Medication Storage Room) revealed Airborne Lot =AEC 491, Expired 09/24 Tablet chewable House Supply x 4.</p> <p>During an interview on 10/17/24 at 09:36 AM, RN2 stated, We review the medications once we get something in and going over inventory. Everyone in general should check for expiration dates no specific day is this completed.</p> <p>An observation on 10/17/24 at 10:22 AM (Unit 1 Medication Storage Room) revealed Airborne Lot # ADY983 Expired 09/24 Tablet chewable House Supply x 3.</p> <p>During an interview on 10/17/24 at 09:38 AM, RN3 stated, I took all of the expired medications out earlier. There is no one assigned to go through the cabinets.</p> <p>During an interview on 10/17/24 at 10:47 AM, the DON stated, The Cream stays in the medication storage room until pharmacy comes and pick up expired medications. To fix that I ordered bins to eliminate any confusion of it sitting on the counter. Narcotics come to the DON and get locked in a lock box behind my desk. For off duty hours when I am not here the narcotics are kept in the medication cart and given to me when I am here to keep it locked up to go to pharmacy. Pharmacy sometimes comes twice a day to pick up. It depends on our needs.</p> <p>During an interview on 10/17/24 at 10:52 AM, DON stated, The nurse on the unit check for expirations when they need to restock. The Supervisor and Unit managers check for expirations on Mondays and Fridays every week. We will reeducate on how the treatment cart should be. We will do the same with the medication rooms.'</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49818</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure foods that were stored in the freezer, refrigerators, and dry food storage were appropriately sealed, labeled, dated with a use by date, and/or discarded after the manufacturer's expiration date. This deficient practice had the potential to affect all residents who received food items from the kitchen.</p> <p>Findings include:</p> <p>Review of the facility's policy dated ,d+[DATE] and titled, Food and Supply Storage, revealed associates shall ensure that food safety and sanitation guidelines are maintained during storage of food and supply items.</p> <p>Procedure:</p> <p>1. Dry Food Storage items shall be stored by associates using the following guidelines:</p> <p>e. Discard food and supplies items for which the expiration date has expired.</p> <p>2. Refrigerated items shall be stored by associates using the following guidelines:</p> <p>I .Label and date container with name and product and expiration date.</p> <p>3. Freezer items shall be stored by associates using the following guidelines:</p> <p>b. Store buld materials in National Sanitation Foundation approved containers that hae tight fitting lids. Label with product name and expiration date.</p> <p>During an initial tour of the kitchen on [DATE] at 09:30 AM revealed</p> <p>Dry Food storage</p> <p>18 - 2 ,d+[DATE] ounce (oz) boxes Barnum's Animal Crackers with manufacturer's use by date of [DATE]</p> <p>Walk in Freezer</p> <p>2 - 32 oz containers Blueberries open/not sealed and not dated with an open date or an expiration date</p> <p>Walk in Cooler</p> <p>1 - 5 pound (lb) bag parmesan cheese open and not dated with an open date or an expiration date</p> <p>1 - 32 oz carton Thick & Easy open with no open date</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 4:23 PM, the Dietary Manager (DM) revealed that staff complete deep investigations of the food items on Mondays and Thursdays, when orders come in to make sure that expired items are removed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48835</p> <p>Based on review of the facility policy, observation, and interview, the facility failed to follow infection control practices to sanitize multi use medical equipment, and failed to perform hand hygiene during medication observation.</p> <p>Findings include:</p> <p>Review of the facility policy dated 05/2025 and titled, Hand Hygiene stated under the policy, Hand hygiene is performed after removing gloves and or other personal protective equipment.</p> <p>During a medication observation on 10/16/2024 at 08:18 AM, Registered Nurse (RN)3 opened the medication cart to obtain a pulse oximeter. She brought it into the room and used it to check the oxygen concentration of a resident's finger. After she completed giving the medication and performing hand hygiene, she then placed the pulse oximeter on the medication cart, then picked it up and placed it into the medication cart.</p> <p>On 10/16/2024 at 8:30 AM, an interview with RN3 revealed, I should have cleaned the pulse oximeter. We are taught to clean medical equipment when used for all residents.</p> <p>During a medication observation on 10/16/2024 at 8:36 AM with Licensed Practical Nurse (LPN)2, she was observed to apply gloves to pull all of her medications. After all of the medications were retrieved from the medication cart, she removed the gloves before entering the room to give the medication. She did not sanitize or wash her hands after she removed the gloves.</p> <p>On 10/16/2024 at 8:45 AM, an interview with LPN2 revealed, I wore gloves because I was taught not to touch the pills. She confirmed she should have sanitized after removing her gloves.</p> <p>An interview with the Director of Nurses (DON) on 10/17/2024 at 4:38 PM. She stated, With medication passes, nurses are to sanitize hands between each resident. After glove removal, perform hand hygiene. The pulse oximeter must be cleaned first before placing back into a med cart after a nurse uses it on a patient.</p>		