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	02/14/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to ensure 1 (Resident (R)10) of 2 residents reviewed for respiratory care was assessed and a care plan was developed for self-management of supplemental oxygen therapy. Findings included:A facility policy titled, Oxygen Services, effective 07/25, revealed, For a resident receiving oxygen therapy, the resident's record must reflect ongoing assessment of the resident's respiratory status, response to oxygen therapy and include, at a minimum, the resident's care plan should identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: When to administer, such as continuous or intermittent and/or when to discontinue.An admission Record revealed the facility admitted R10 on 11/12/24. The admission Record identified the resident had a medical history that included diagnoses of respiratory failure, unspecified with hypoxia; pneumonia; chronic obstructive pulmonary disease (COPD); chronic combined systolic and diastolic heart failure; end-stage renal disease; dependence on dialysis; atrial fibrillation; cognitive communication deficit; and diabetes mellitus.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/25, revealed R10 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS revealed the resident received oxygen therapy while a resident of the facility.R10's physician Order Summary Report for active orders as of 02/10/26 revealed an order started 11/12/24 for oxygen at 2 liters via nasal cannula every shift related to COPD.An observation on 02/10/26 at 3:14 PM revealed R10 was not present in the room, and the nasal cannula tubing for supplemental oxygen was hanging from the side of the bed.During an interview on 02/10/26 at 11:14 AM, R10 stated they (the resident) determined when they used supplement oxygen. The resident stated they removed their nasal cannula in the morning and reapplied it at approximately 8:00 PM. Per R10, the resident also turned the oxygen machine off in the morning and turned it back on at night by pressing the power button.R10's Care Plan Report, included a focus area revised 09/13/24, that indicated the resident was at risk for altered respiratory status/difficulty breathing related to chronic hypoxemia, respiratory failure, and COPD. Interventions directed staff to apply oxygen as ordered, 2 liters via nasal cannula (revised 12/20/25). The Care Plan Report did not address the resident self-managing their supplemental oxygen therapy.During an interview on 02/12/26 at 9:20 AM, Licensed Practical Nurse (LPN)4 stated that it was staff's responsibility to manage R10's oxygen therapy, including application and removal. LPN4 stated that the resident was forgetful at times, and that staff could not rely on the resident to manage their supplemental oxygen independently.During an interview on 02/11/26 at 10:32 AM, the Social Services Director (SSD) stated that residents were not permitted to independently manage medications unless it was specifically ordered, and the resident was assessed. The SSD stated that R10 had not been assessed for self-managing supplemental oxygen. The SSD also revealed that the interdisciplinary team had not discussed the resident removing their supplemental oxygen, and a care plan had not been developed to reflect independent oxygen management.During an interview on 02/14/26 at 5:54 PM, the Assistant Director of Nursing (ADON) revealed R10 removed their oxygen based on the resident's comfort and believed the resident could manage their supplemental oxygen. She stated the resident knew how to turn the oxygen machine on and off and the ADON could not (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	control what the resident chose to do. Per the ADON, R10 had not been formally evaluated and did not have a care plan for independent oxygen management.During an interview on 02/14/26 at 12:04 PM, the Administrator stated that if a resident was alert and oriented enough to remove their supplemental oxygen, the facility could not prevent the resident from doing so. The Administrator stated that staff were expected to check whether oxygen was in use as ordered, and if oxygen was not in use, staff should remind the resident and attempt to reapply oxygen. The Administrator stated certified nurse aides (CNAs) were expected to notify a nurse if the resident removed their nasal cannula or if oxygen was not being worn. Per the Administrator, nursing staff were responsible for reapplying oxygen, managing oxygen therapy, and documenting as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure medical records were complete and accurate for 2 (Resident (R)3 and R56) of 2 residents reviewed for pressure ulcers/injuries.Findings included: A facility policy titled, Documentation of Resident Care, dated 01/2026, revealed, The Skilled Nursing Facility shall document the care given to the resident utilizing and efficient and standardized method. The policy further revealed under the Procedure section, 2. Required Licensed Nursing documentation includes but is not limited to i. Surgical or wound site condition and care, s. Observations, t. Clinical Assessment, w. Skin Inspection. A facility policy titled, Pressure Ulcers, dated 09/2025, revealed, Procedure: All residents are assessed on admission and weekly for an entire body audit review which includes all body surface areas. The policy further revealed, The skin body audit contains clear documentation of all existing wounds and any areas that may have previous deep tissue injury. The policy also revealed, Documentation: At any time during the resident's stay on the Skilled unit a pressure related wound is recognized, a wound LDA [Lines, Drains, and Airways] is created which includes: Date of onset, site and location, size (location, size (length and width), depth, exudates, odor, wound bed, tunneling, undermining, surrounding skin color, surrounding tissue and wound edges, any cultures sent, response to treatment, provider and family notification, and pain. Dressing changes are documented in the electronic health record. Nursing progress notes are utilized for additional documentation. 1. An admission Record revealed the facility admitted R3 on 10/19/2017. According to the admission Record, the resident had a medical history that included diagnoses of anorexia, protein-calorie malnutrition, muscle weakness, and vitamin D deficiency. A comprehensive Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2025, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was at risk for developing pressure ulcers but did not have ulcers at the time of the assessment. R3's Care Plan Report included a focus area revised 01/27/2026, that indicated the resident had impaired skin integrity, which included a Stage 2 (partial-thickness skin loss) pressure injury to the coccyx. Interventions directed staff to complete weekly body audits (initiated 08/18/2024); provide wound care as ordered; and document the wound, healing, and signs of infection and alert the provider of negative findings (revised 01/16/2026). R3's physician Order Recap Report for the timeframe from 02/01/2026 to 02/28/2026 contained an order started on 01/01/2026 and discontinued on 01/11/2026 to clean the wound with wound cleanser, pat the area dry, apply a xeroform (a germ prevention non-stick dressing used for wound healing) dressing, and cover the area with a foam bordered dressing daily and as needed. The Order Summary Report also revealed an active order dated 01/11/2026 to clean the wound with wound cleanser, pat the area dry, apply a Hydrofera Blue (an antibacterial foam dressing that promotes healing by removing germs from the wound) dressing, and cover the area with a foam bordered dressing every other day and as needed. R3's January 2026 Treatment Administration Record revealed staff documented that wound care was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided daily from 01/02/2026 to 01/11/2026 and was provided every other day from 01/13/2026 to 01/31/2026. R3's February 2026 Treatment Administration Record revealed staff documented that wound care was provided every other day from 02/01/2026 to 02/10/2026. R3's electronic medical record (EMR) was reviewed for the timeframe from 12/31/2026 through 02/06/2026. R3's EMR revealed there was no documentation containing weekly measurements or weekly descriptions of the resident's wound. R3's Skin Only Evaluation, dated 01/03/2026, indicated R3 had a pressure ulcer on the sacrum. R3's Skin Only Evaluation, dated 01/04/2026, 01/18/2026, and 02/01/2026, revealed Licensed Practical Nurse (LPN)2 documented that R3's skin was intact (no wounds), and the resident had no skin issues. R3's Skin Only Evaluation, dated 01/11/2026, 01/25/2026, 01/31/2026, and 02/07/2026, revealed LPN3 documented that R3 had no skin issues. During an interview and concurrent review of the Skin Only Evaluations on 02/13/26 at 6:18 AM, LPN2 stated that R3 had a wound on their sacrum that was not intact. The LPN stated that the wound care nurse assessed and documented regarding the resident's wound; however, the wound care nurse's notes were not in the resident's medical record. LPN2 that she documented that the skin was intact because the rest of the resident's skin (excluding the sacral wound) was intact. An attempt to interview LPN3 by telephone was made on 02/13/26 at 10:39 AM; however, LPN3 did not answer the call or return the call by the end of the survey. During an interview on 02/12/26 at 7:03 PM, Registered Nurse (RN)1 stated that she reviewed wounds in the facility weekly and sent the information on a wound report via electronic mail (e-mail) to the Director of Nursing (DON), the MDS nurse, the Assistant Director of Nursing (ADON), the dietician, and the Administrator (ADM). RN1 stated there was not a wound report form in the facility's electronic medical records (EMR); subsequently, she completed summaries weekly. RN1 stated the floor nurses conducted a skin assessment weekly, and wounds could be notated on that form. RN1 stated if a floor nurse needed information regarding the history of the wound, they had to ask someone in management because the information was not in the resident's medical record. During an interview on 02/13/26 at 2:29 PM, the DON stated RN1 obtained wound measurements and assessed the appearance of wounds weekly and expected RN1 to document all wound care notes in the resident's EMR. The DON provided e-mails which revealed that wound assessments were completed weekly. The DON stated that she was not previously aware that RN1 was not charting in residents' EMRs. The DON stated she was also not aware the floor nurses were documenting that Resident #3's skin was intact when the resident had a wound. The DON stated she spoke with the floor nurses, and they were confused. The DON stated that for some reason the floor nurses thought they should only document whether there were any new skin issues. During an interview on 02/14/26 at 10:04 AM, the Administrator stated that he expected all wound care notes to be in the resident's medical record and to be completed correctly. The Administrator stated that the DON or their designee was responsible for monitoring wound care documentation. 2. An admission Record revealed the facility admitted R56 on 01/25/24. According to the admission Record, R56 had a medical history that included diagnoses of cerebral aneurysm, non-ruptured; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia with other behavioral disturbance; anxiety disorders; muscle weakness; difficulty walking; other lack of coordination; and unspecified psychosis not due to a substance or known physiological condition. A significant change of condition MDS, with an ARD of 01/06/26, revealed that R56 had severe impairment in cognitive skills for daily decision making and had short-term and long-term memory problems per a staff assessment for mental status (SAMS). The MDS also revealed that R56 had impairments on one side of their upper extremities and both sides of the lower extremities and utilized a wheelchair for mobility. An activity Progress Note, dated 01/12/26 at 11:04 AM, revealed that R56 was alert to self and confused, had physical decline and weight loss, and spent most of the time in bed. A health status Progress Note, dated 01/17/26 at 6:17 PM, revealed that a certified nurse aide (CNA) alerted the nurse of heel breakdown and a pink area to R56's buttocks. There was no documented evidence that staff assessed the breakdown/areas. A skin only Progress Note, dated 01/20/26 at 12:36 PM, for R56 revealed that areas were noted to the resident's heels and treatment was in place. The note did not address the measurements or an assessment of the area to the heels and buttocks. An electronic mail (e-mail) with a subject line of Wounds, dated 01/22/26 at 10:28 AM, sent by Registered Nurse (RN)1 to the Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrator, and other staff members, revealed RN1 assessed R56's heels and the resident had a left heel deep tissue injury (DTI), which measured 3 centimeters (cm) by (x) 2 cm and was purple/red. Per the email, there was a new treatment for skin prep and a foam dressing every three days and as needed. The email revealed the resident was also wearing Prevalon boots and the heels were being floated when in bed. An e-mail with a subject line of Wound Report, dated 01/27/26 at 6:01 PM, sent by RN1, to the DON, ADON, Administrator, and other staff members revealed the RN assessed R56's heels. The email revealed that the resident had a left heel DTI, which measured 3 cm x 2 cm and was purple/red. R56's Care Plan Report revealed a focus area initiated on 01/27/26, that indicated the resident had a pressure ulcer and was at risk for a non-healing/infection. Interventions directed staff monitor/document/report as needed any changes in skin status (appearance, color, wound healing, signs/symptoms of infection, wound size, and stage), and weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue, and exudate. A skin only Progress Note, dated 01/28/26, and 02/10/26 revealed that there were no current skin issues but indicated the treatment to the heels continued. An e-mail with a subject line of Wounds, dated 02/04/26 at 1:35 PM, sent by RN1 to the DON, ADON, Administrator, and other staff members revealed the RN assessed R56's left heel DTI, which measured 7 cm x 4 cm and was purple. Per the email, staff would continue treating the area with skin prep and a foam dressing. An e-mail with a subject line of Wounds 02/11/2026, dated 02/10/26 at 12:30 PM, sent by RN1 to the DON, ADON, Administrator, and other staff members revealed the DTI to R56's left heel continued to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measure 7 cm x 4 cm and was purple. The email also revealed that the area continued to be treated with skin prep and a foam dressing. An Order Summary Report, with orders effective as of 02/13/26, revealed an order dated 02/04/26 to apply skin prep to the left heel and apply a Mepilex foam dressing (a comfortable foam dressing used to absorb wound draining and minimize pain) every three days and as needed until healed. During an observation on 02/13/26 at 3:10 PM, the ADON provided wound care to R56's left heel. During an interview on 02/14/26 at 9:57 AM, the ADON, who was also the Infection Preventionist (IP) stated that she tracked wounds from an infection control standpoint. The ADON stated that RN1 assessed all wounds and documented and sent them a weekly report. The ADON stated that she had never looked in the EMR to see whether wound measurements were documented. Per the ADON, she had seen the nurses' documentation and measurements in the EMR but never investigated to make sure RN1's assessments were documented. During an interview on 02/14/26 at 10:11 AM, the DON stated that the resident's medical record should include the type of wound, a description and measurements, and the current treatment. She stated that R56's wound documentation should be in the resident's medical record. The DON further stated if they needed any changes to treatment, and if the resident went out of the facility to the wound center, all that information should be documented in the progress notes in the EMR. She stated that she became aware while the survey team was onsite that wound assessments were not documented in residents' EMRs. Per the DON, they received a weekly wound report, and they reviewed the report weekly in their Safe and Soundmeeting; however, she did not go back and verify the information was documented in the EMR. The DON stated that RN1 was a certified wound nurse. According to the DON, the facility used a different EMR before converting to the current EMR in August 2024. The DON stated RN1's wound reports were detailed, and she thought the RN was documenting wound assessments in the EMR. During an interview on 02/14/26 at 10:58 AM, the Administrator stated he expected wound assessments and treatments to be documented in residents' medical records. He stated the facility had not identified that documentation of wound summaries was an issue or concern prior to the survey.