STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425310	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hollow of Sumter Rehabilitation Center	1761 Pinewood Road Sumter, SC 29154

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42338 Based on record review, interviews, and review of facility policy, the facility failed to provide treatment and services to prevent and/or heal Resident (R)6's pressure ulcers for 1 of 1 resident. This failure resulted in R6 acquiring multiple pressure ulcers. On [DATE] at 4:30 PM, the Administrator was provided a copy of the CMS Immediate Jeopardy Template and informed that the failure to provide treatment and services to prevent or heal multiple pressure ulcers for R6 constitued IJ at F686 with an effective date of [DATE]. On [DATE] at 6:18 PM, the facility provided an acceptable IJ Removal Plan. On [DATE], the survey team validated the facility's corrective actions and removed the IJ as of [DATE]. The facility remained out of compliance at F686 at a lower scope and severity of D. An Extended Survey was conducted in conjunction with the Complaint Survey for non-compliance at F686, constituting substandard quality of care. Findings include: Review of the undated facility policy titled Skin and Wound Management revealed, Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). Treatment/Management 1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing abd debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. Monitoring 1. During resident visits, the physician will evaluate and document the progress of wound healthing . 2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the undated facility policy titled Repositioning revealed, The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs . to prevent skin breakdown, promote circulation and provide pressure relief for residents. General Guidelines 1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. 3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. 5. Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing. Interventions 3. Residents who are in bed should be on at least an every two hour (q2 hour) repositioning schedule. 6. If ineffective, the turning and repositioning frequency will be increased. Review of R6's Face Sheet revealed R6 was admitted to facility on [DATE], with diagnoses of but not limited to: vascular Dementia, diverticulosis, Chronic Obstructive Pulmonary Disease and hyperlipidemia. Further review of R6's Face Sheet revealed R6 was receiving hospice care and expired on [DATE]. Review of R6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 3 out of 15 indicating R6 had severe cognitive impairment. Review of R6's Care Plan revealed, Skin: Resident is at risk for skin breakdown & PU r/t frequent incontinence, hemiplegia post CVA, & cognitive impairment . Interventions for this Care Plan revealed, Assess and record changes in skin status. Report pertinent changes to physician, Administer/monitor effectiveness of/response to preventive treatments as ordered, encourage patient to turn and reposition in bed and limit time up in Geri-chair, Heel protectors BID when in bed, minimize pressure over bony prominence, monitor lab results as ordered and report abnormal results to physician, provide diet as ordered and monitor nutrition status and dietary needs. Further review of R6's Care Plan revealed the following Focus, [R6] requires extensive to total assistance with ADLs [activities of daily living] . [R6] is incontinent of B&B [bowel and bladder] . Review of R6's Physician Orders revealed, Monitor function and setting of air mattress. Used as prevention and protection d/t [due to] being bed bound and non ambulatory start date [DATE]. Apply heal boots to bilateral feet for protection of skin breakdown start date ,d+[DATE]. unstageable wound left elbow: cleanse with Dakin's 0.125% apply TAO [triple antibiotic ointment] and border gauze dressing daily start date [DATE]. Unstageable wound to back: cleanse with Dakin's 0.125% apply TAO, abd pad daily start date [DATE]. Unstageable sacral wound Cleanse with Dakin's 0.125%, apply Dakin's 0.125% damp gauze to wound bed, cover with abd pad daily start date [DATE]. Skin prep to right heel q [every shift] shift start date [DATE]. Review of R6's Skin assessment dated [DATE], revealed, Skin warm & dry, skin color within normal limits, mucous membranes moist, turgor normal. No current skin issues noted at this time. Review of R6's Skin assessment dated [DATE], revealed, Skin warm & dry, skin color within normal limits, mucous membranes moist, turgor normal. No current skin issues noted at this time. Review of R6's Skin assessment dated [DATE] revealed, Skin warm and dry, skin color within normal limits, mucous membranes moist, turgor normal. Resident has current skin issues. The skin issues were listed as follows: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Skin Issue: Deep tissue injury. Skin issue location: right lateral ankle including 1st toe Length: 11.8 Width: 1.7 Wound bed: Epithelial. Wound odor: No. Tunneling: No. Undermining: No. Tissue: Painful. Tissue: Firm. 2. Skin Issue: Deep tissue injury. Skin issue location: sacrum Length: 6 Width: 9 Depth: 0.1 Wound bed: Necrotic. Peri wound condition: Fragile. Wound odor: No. Tunneling: No. Undermining: No. Tissue: Firm. Tissue: Warm. 3. Skin Issue: Deep tissue injury. Skin issue location: right hip Length: 0.8 Width: 0.4 Depth: 0.1 Wound bed: Epithelial. Wound odor: No. Tunneling: No. Undermining: No. Skin Issue: Deep tissue injury. Skin issue location: right ischium Length: 5 Width: 6 4. Skin Issue: Deep tissue injury. Skin issue location: right upper back Length: 17 Width: 17 Dressing saturation: None. Wound odor: No. Tunneling: No. Undermining: No. Tissue: Painful. Tissue: Firm. Tissue: Warm. 5. Skin Issue: Deep tissue injury. Skin issue location: right ankle Length: 2 Width: 2 Wound bed: Granulation. Wound exudates: None. Wound odor: No. Tunneling: No. Undermining: No. Tissue: Mushy. Tissue: Warm. 6. Skin Issue: Deep tissue injury. Skin issue location: left first toe Length: 0.6 Width: 2.8 Wound odor: No. Tunneling: No. Undermining: No. Tissue: Painful. Tissue: Firm. Tissue: Warm. 7. Skin Issue: Deep tissue injury. Skin issue location: left buttock Length: 1.8 Width: 3.9 Depth: 0.1 Wound bed: Necrotic. Wound odor: No. Tunneling: No. Undermining: No No other documentation on skin assessments to review after [DATE]. Review of R6's Progress Note dated [DATE], revealed, Resident has new skin break down on back, sacrum, buttocks, ankles and feet . Review of R6's Medication Administration Record (MAR) dated [DATE] revealed, Triple Antibiotic External Ointment . Apply to left foot ulcer topically one time a day . was not completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of R6's Treatment Administration Record (TAR), indicated that no treatment to wounds were being done as ordered by the physician. During an interview on [DATE] at 3:35 PM, the Director of Nursing (DON) revealed that when a resident is receiving hospice services, the hospice nurse does the wound care. The DON stated that wound care was ordered by the physician, but the family no longer wanted wound care performed as of [DATE]. The DON stated that bed bound residents are turned every 2 hours and as needed. The DON further stated that staff do not document turning residents or ADLs, they just know to do it. During an interview on [DATE] at 2:30 PM, the Administrator stated that she has only been at the facility for 2 weeks and she could not attest to why care was not provided to R6. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:17 PM, the Ombudsman stated that the allegation was a referral from Department of Social Services and Agape Hospice. The Ombudsman further stated that R6 was being neglected. R6 had pressure wounds that were not being taken care of and R6 was bed bound and not being repositioned. During an interview on [DATE] at 11:48 AM, R6's Representative (RR) stated they never told the facility not to provide wound care. RR further stated, they wanted their mother to receive all comfort measures including wound care. During an interview on [DATE] at 12:00 PM, the Hospice Social Worker (HSW) stated that R6 has been receiving hospice services since 2023. HSW further stated R6 was not getting up as she use to and was always lying on her right side. A hospice Certified Nursing Assistant informed her that R6 was not being turned. The HSW stated she reported the incident to the police, Ombudsman, and Department of Social Services. And that is when the wounds were discovered. During an interview on [DATE] at 12:05 PM, the Hospice RN (HRN) stated hospice nurses did not change R6's dressing daily as ordered because they were not in the facility daily. On [DATE] at 6:18 PM, the facility provided an acceptable IJ Removal Plan, which included the following: Criteria One: Unable to correct for resident six (R6) due to her being on hospice and her expected death on [DATE]. Criteria Two: [DATE] The CEO/Nurse met with the Agape Nurse to ensure treatments for residents under their care were being documented in the hospice notes and the staff of the facility will complete on days they are not in the facility. All residents had a head-to-toe assessment completed by licensed nurses on [DATE]. All identified areas were provided treatment if warranted. The attending physician and resident's representative were notified by [DATE]. All residents will have a head-to-toe skin assessment upon admission and weekly skin assessment thereafter. All current residents will have a weekly skin assessment completed completed to ensure the skin remains intact by [DATE]. Criteria Three: All licenses and certified staff will be educated on ensuring residents preventative measures are in place for wound care to include. 1. Weekly Skin Assessment and prevention. 2. Shower Skin Audit (completed by C.N.A.). 3. New Admission Skin Assessment and prevention. 4. Turning and repositioning. 5. Abuse and Neglect. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Licenses nurses were educated on the protocol for identifying risk and wounded residents on [DATE] and ongoing to include notifying the MD and RR. The Director of Nursing or designee will audit the treatments weekly to ensure the residents have been provided proper wound care treatment per the MD order. The Director of Nursing will review the audit with the administrator weekly for 4 weeks, monthly for 5 months to ensure the protocol is being followed. Criteria Four: The Administrator and DON will review the completed weekly skin audits with the monthly QAPI Committee for further follow-up and recommendations. Date of Correction of [DATE] Education Started [DATE]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 43313 Based on observations, record review, interviews, and facility policy review, the facility failed to provide adequate supervision to prevent the elopement of 1 of 3 residents reviewed for accidents related to elopement. Specifically, Resident (R)1 had a successful elopement from the facility on 03/30/24. On 4/09/24 at 4:30 PM, the Administrator was provided a copy of the CMS Immediate Jeopardy Template and informed that the failure to provide R(1) with adequate supervision to prevent elopement from the facility constituted Immediate Jeopardy (IJ) at F689 with a start date of 03/30/24. The IJ was related to 42 CFR 483. 25 - Quality of Care. On 4/10/24 the facility presented an acceptable IJ Removal Plan. On 04/10/24, the survey team validated the facility's corrective actions and removed the IJ as of 04/09/24. The facility remained out of compliance at F689 at a lower scope and severity level of D. An Extended Survey was conducted in conjunction with the Complaint Survey for non-compliance at F689, constituting substandard quality of care. Findings include: Review of the undated facility policy titled, Wandering, Unsafe Resident documented, Policy Statement The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for resident who are at risk for elopement. Policy Interpretation and Implementation 1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). 2. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. 3. the resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included. Review of R1's Face Sheet, revealed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to: major depressive disorder, fibromyalgia, bipolar disorder, vascular dementia, chromic pain, essential (primary) hypertension, muscle weakness, panic disorder, and altered mental status. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/21/24, revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating R1 had severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Care Plan with an initiated date of 04/26/21 and a revision date of 04/10/24, revealed, Behavior: [R1] is at risk for elopement r/t cognitive impairment, ambulatory with walker. Resolved 2021 no further issues. 03/30/24 at approximately 2030, door exit alarms heard and resident was outside xx feet ambulating with rollator, returned to facility with no injuries. Continue care plan 03/30/24 Noted exit seeking behavior, redirected, Medication changes, continue care plan. The goal indicated, [R1] will ambulate safely within specified boundaries. Will not have any successful elopements through review Date initiated: 03/30/24 Target date: 05/22/24. Further review of the care plan revealed, R1 was at risk for falls and impaired vision. Review of R1's Elopement Evaluation dated 02/21/24, revealed, Late Entry: Evaluation: Elopement Score: 2. 0 At Risk History of elopement while at home: No. History of attempting to leave the facility without informing staff: Yes. Verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: Yes. Wanders: Yes. Wandering behavior, a pattern or goal-directed: No. Wanders aimlessly or non-goal-directed: No. Wandering behavior likely to affect the safety or well-being of self/others: No. Wandering behavior likely to affect the privacy of others: No. Recently admitted or readmitted (within the past 30 days) and has not accepted the situation: No. Review of R1's Progress Notes dated 03/31/24 at 7:53 AM, revealed, Note Text: At approximately 2030, door exit alarms heard. Panel displays Hallway 4 backdoor. 400 hall rooms checked to account for all residents. [R1] not in room. [R1] observed outside of facility; means of egress, hallway 4 emergency exit backdoor. [R1] was approximately 200 feet from the building, ambulating with assistive device, rollator walker. On contact, [R1] alert and oriented to situation. [R1] stated, I went out the wrong door. [R1] fully and appropriately dressed for weather and wearing tennis shoes. [R1] alert and no distress and injuries observed. [R1] was returned inside with only a brief moment of no exit seeking behavior. [R1] did not want to return to her room. [R1] ambulated to front and attempted to exit thru front door. The director of nursing [DON] was made aware. An unsuccessful attempt was made to contact person representative. [R1] continues exit seeking behavior. Unable to redirect. MD made aware. New order received for every 15 minute checks initiated to maintain safety and accountability. Exits checked at regular intervals. At change of shift, multiple exit seeking attempts made. (2) two of those attempts resulting in door alarms going off. During an interview on 04/09/24 at 11:36 AM, Registered Nurse (RN)1 stated, [R1] is alert with confusion. She self ambulates and frequently exit seeks. We have to constantly redirect her. During an interview on 04/09/24 at 11:39 AM, Certified Nursing Assistant (CNA)1 stated, I was not here the day she had the elopement but staff told me they heard the alarm sounding and went looking to see who was missing and found [R1] walking alone on the path outside the door. [R1] exit seeks and she needs constant reminders. It appears that her memory has declined a bit in the past 2 months. During an interview on 04/09/24 at 12:20 PM, the Director of Nursing (DON) stated, I was not here the day of the elopement. I was called by the nurse on duty and she told me that they heard an alarm and they all thought it was the front door alarm. A certified nursing assistant on the 400-hall called out to us that the 400 hall door alarm was alarming. Staff observed [R1] wearing white shoes, as it was very dark outside because the light at the back of the building was not working. We could just see her shoes and her walker in the dark. [R1] was escorted back into the facility and staff was placed with [R1] to conduct 15-minute checks for 3 days. On 04/10/24 at 10:52 AM, the facility provided a removal plan, which included: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Criteria One: Resident 1 was leaving the facility and was escorted back in the facility and at no time was off the property on March 30, 2024. The IJ template identified the temperature outside was 50-degree Ferhenite [sic] and upon assessment the resident was without injury or hypothermic. The IJ template did not identify nor was it reported but by heresy witnesses of the resident dress. No interviews were conducted that witnessed the occurrence. The resident was returned to the facility, assessed without injury, placed on q15 minute checks, MD and RP notified. The elopement assessment was revised with a score of 4 indicating at risk for elopement and the care plan was updated with the new assessment information on 03/30/2024. The facility staff thought it was the smoke door on 400 but immediately identified it was the 400 door and retrieved the resident expeditiously per the elopement policy and procedure. All egress doors were checked by the Maintenance Director on 03/30/2024 AFTER the elopement and all doors were working properly. Criteria Two: The DON and Unit Coordinator are completing the wandering and elopement assessment on all residents (45) and will be complete by 04/09/2024. Any change in elopement status will be care planned, and the MD and RR notified. Criteria Three: The Director of Nursing and Administrator was educated on 04/09/2024 on the Elopement Resource manual and Elopement Policy and Procedure by the CEO who is a licensed nurse, Social Worker and LNHA. ALL departments will be educated on the Elopement Resource manual and Elopement Policy and Procedure by the Administrator and Director of Nursing to be completed by 04/09/2024. The Elopement Resource Manual and Elopement Policy and Procedure Education will be included in the new hire orientation on 04/09/2024. The maintenance or designee will audit the door daily and Manager on Duty on the weekend to ensure the egress doors are in good repair and enunciate correctly. The Administrator will review the completed audits for further follow-up if warranted. Criteria Four: The Plan of Correction for F689 was reviewed with the QAPI Committee to include the Medical Director [name] on 04/09/2024 without changes. The completed audits and identified listing of residents that are at risk of elopement will be reviewed monthly in the QAPI committee for further follow up and recommendations.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 43313 Based on interview and review of facility policy, the facility failed to ensure four (4) Certified Nursing Assistants (CNAs) had a minimum of 12 hours of annual training. Findings include: Review of the facility's undated policy titled, Nurse Aide Qualifications and Training Requirements revealed, Nurse aides must undergo a state-approved training program. In keeping with the Omnibus Budget Reconciliation Act of 1987 (OBRA) our facility will only employ those nurse aides who meet the requirements set forth in the federal and state statutes concerning the staffing of long-term care facilities. The employee must participate in a state-approved training and competency evaluation program. During an interview on 04/10/24 at 1:30 PM, a request was made to the Administrator for documentation related to CNAs annual training and she responded: I will look to see what I can find. During an interview on 04/10/24 at approximately 2:45 PM, the Administrator stated, I am new to the facility and I cannot find any supporting documents that the 4 CNAs have the required in-service and training for the minimum 12 hours of training required. I have called the agency to have them send in the supporting training for the CNAs.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31846 Based on record reviews and interviews, the facility failed to ensure weekly body audits were completed on all residents and further failed to ensure the weekly treatment audits were completed as stated in the plan of correction. The facility further failed to review the completed weekly skin audits and the treatment audits with the monthly Quality Assurance and Performance Improvement (QAPI) committee for further follow-up and recommendations. The findings include: No documentation could be found to ensure the weekly skin and treatment audits were reviewed by the QAPI Committee. During an interview on 06/13/2024 at 02:05 PM with the Administrator and the Administrator in Training, it was confirmed that the weekly body audits for all residents was not being completed as stated in the plan of correction. During an interview on 06/13/2024 at 02:25 PM with the Director of Nursing, she stated she was completing the audits of wound care, but did not have documentation to ensure the treatments were audited and completed as stated in the plan of correction.