

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Wildewood Downs		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 Wildewood Downs Circle Columbia, SC 29223	
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, record review, observations and interviews, the facility failed to ensure proper personal protective equipment (PPE) was used for Resident (R)2 during a dressing change. In addition, the facility failed to follow proper procedures related to dressing changes for 1 of 1 resident reviewed. Findings include: Review of the facility's policy titled, Enhanced Barrier Precautions with a copyright dated 2001 Med-Pass, Inc. states, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organism (MDROs) during high contact resident care activities. 2. Enhanced barrier precautions apply when: b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained; and 4. Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status. 6. Examples of secretions or excretions include wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk of transmission of a pathogen. 7. EBPs employ targeted gown and glove use in addition to standard precautions during high-contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high-contact resident care activity (as opposed to before entering the room). 8. Examples of high-contact resident care activities requiring the use of a gown and gloves for EBPs include: a. dressing; j. wound care (any skin opening requiring a dressing). Review of the facility's policy titled, Dressings, Dry/Clean with a copyright dated 2001 Med-Pass, Inc. states, The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Steps in the Procedure 5. Wash and dry your hands thoroughly. 6. Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. 9. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. 10. Label tape or dressing with date, time and initials. Place on clean field. 11. Using clean technique, open other products (i.d., prescribed dressing; dry, clean gauze). 12. Wash and dry your hands thoroughly. 13. Put on clean gloves. 14. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage. 15. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward). 16. Use dry gauze to pat the wound dry. 19. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. 22. Clean the bedside stand. 23. Wash and dry your hands thoroughly. Review of R2's Face Sheet revealed R2 was admitted on [DATE] with diagnoses including, but not limited to, muscle weakness (generalized), dysphagia, oral phase,</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 425385	Facility ID: 425385 If continuation sheet Page 1 of 2

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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>and fusion of spine, lumbar region. Review of R2's Care Plan with a start date of 12/19/25, documented Pressure ulcer-stage II pressure injury to the sacrum. Further review of the care plan revealed the following interventions: Provide skin care per facility's guidelines and prn as needed, monitor ulcer for signs of progression or declination, and educate resident/resident representative (RR) about proper skin care to prevent skin breakdown. During an observation on 01/22/26 at 01:58 PM, Licensed Practical Nurse (LPN)1 entered R2's room without donning [putting on] a gown. The surveyor observed LPN1 washing hands and donning gloves to change R2's sacral dressing. LPN1 cleaned R2's sacral wound with wound cleanser with a 4x4 dressing. LPN1 removed the gloves and rewashed hands. LPN1 opened the bordered gauze, placed Medi honey on the gauze, and placed on R2's sacral wound. LPN1 removed the black marker from her pocket and labeled the dressing. LPN1 placed the dressing on R2's sacral area. During an observation on 01/22/26 at 02:05 PM, LPN1 removed R2's sock and donned gloves to remove the bordered gauze. The nurse washed her hands before labeling the gauze. LPN1 cleaned the wound with wound cleanser. LPN1 did not clean off the bedside table or the black marker. During an interview on 01/22/26 at 02:22 PM, LPN1 stated, When asked about the use of PPE, LPN1 stated, I forgot to put it on. I know we need to wear our PPE, I don't know why I forgot it. When asked about training related to PPE requirements, LPN1 stated, We do have in-person in-services and on Relias. Sometimes our training is one-on-one. On the weekend, staff are trained by our weekend nurse managers. During an interview on 01/22/26 at 04:58 PM, the Administrator stated, We will provide additional training on wound dressing changes.</p>		