STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425385	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wildewood Downs	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy, the facility failed to ensure Resident (R)4 had adequate supervision to prevent a fall. 1 of 3 reviewed for accident/hazards. Findings include: Review of facility policy, date unspecified, titled, Falls and Fall Risk, Managing revealed Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The staff, with input of the attending physician, will implement a resident-centered fall prevention plan the specific risk factor(s) of falls for each resident at risk or with a history of falls. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention has resolved. R4 was admitted to the facility on [DATE] with diagnoses including but not limited to fracture of left lower femur, encounter for orthopedic aftercare, and morbid severe obesity due to excess of calories. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date of 08/05/24 revealed that R4 has the Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicates that she is cognitively intact. Further review of the admission MDS revealed that R4 is dependent on staff for toileting hygiene. Record review of R4's Nurses Notes dated 08/05/24 revealed At approximately 7:45 PM Certified Nursing Assistant (CNA) approached nurse in hallway and requested help. Nurse entered room and bed was in highest position, resident was on floor lying on her left side. CNA stated that she was providing incontinent care without a second person. Nurses assessed resident for injury, resident stated repeatedly that she was okay. Nurse and CNA used Hoyer lift to assist resident back to her bed. Resident did not lose consciousness during this episode. She remained alert. Nurse assessed resident again when she was back in bed, and noted swelling and bruising to her left forearm, and a swollen spot to her head. Resident stated that she was in pain to her arm and head and needed pain medication. As needed pain medication administered to resident notified R4's resident representative informing her of incident. Nurse suggested to resident that she go to the hospital for evaluation, resident refused. Nurse re-emphasized the importance of going considering she hit her head, and her injured leg. She then agreed to go hospital. Resident left facility via stretcher to hospital. Director of Nursing (DON) and Resident Care Coordinator (RCC) notified of transfer and incident. (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	Record review of R4's Nurses Notes dated 10/07/24 revealed At around 3:00 pm reported by another nurse, patient noted sitting in front of her wheelchair. Per Therapy during her sliding board transfer training, patient begin to scoot off board interiorly and unable to scoot back in bed, patient requires maximum assist to slowly lower to ground with slide onto buttocks. Then other nurse and Therapy get patient up from floor using Hoyer lift to put back in the wheelchair. Assessment done no noted any injury and no verbalizes complaint of pain. Patient placed on monitoring; patient informed us to place a call to daughter at around 5-6 pm after her work from school. Review of R4's Care Plan dated 07/30/24 - present revealed R4 is at risk for falls related to overall weakness, history of fall resulting in left hip fracture. Interventions include resident requires two-person assist for all bed mobility and Activities of Daily Living (ADL)s. Re-educated therapy staff and nursing staff on safety precautions and ADLs. Footwear will fit properly and have non-skid soles. Keep areas free of obstructions to reduce the risk of falls or injury. Place call light within easy reach. An interview on 10/09/24 at 12:30 PM with R4 revealed that back in August (08/05/24), a CNA was providing incontinence care to them without a second person, and they rolled off the bed. R4 stated that she went to the hospital and had some bruising after the fall but did not have any injury. R4 continued to talk about having a second incident with therapy staff where she had to be lowered to the ground due to weakness. R4 stated that normally there are always two people with me, but the therapy staff member was working alone as well. A phone interview on 10/10/24 at 10:13 AM with R4's Resident Representative (RR) revealed that R4 had a fall due to the facility not having adequate staffing and not providing the resident with two-person assistance. R4's RR stated that she was told by staff that the CNA that assisted R4 with ADL care did not want the resident sitting in her waste for a long period of time and knew that the other CNAs were busy at the moment and that it would be a while before another person could assist the resident. When the CNA provided care, R4 accidently rolled off the bed. R4's RR was upset during the interview due to a second incident with therapy staff (10/07/24) having to lower R4 to the floor because they were also working alone. An interview on 10/10/24 at 2:11 PM with CNA5 revealed that the resident has had 2 falls at the facility due to staff not following the resident's care plan for two- person assist. CNA5 stated that the first fall occurred due to CNA attempting to provide ADL care for R4 without another CNA in the room and the second fall occurred because therapy staff did not have a 2nd person, and the resident had to be lowered to the floor. An interview with 10/10/24 at 3:46 PM with Physical Therapy Assistant (PTA) revealed they were working with the resident attempting to stand her up from a chair without assistance. PTA stated that resident should have been two-person assist and was re-educated related the incident. PTA confirmed that they were aware the resident had a fall with a CNA in August where they were also working alone as well. An interview on 10/10/24 with the Administrator and Director of Nursing (DON) revealed that the resident is a two-person assist and staff (therapy and nursing) have been re-educated on the importance of having adequate assistance when providing ADL care with R4.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and policy review, the facility failed to provide respiratory care in accordance with professional standards. The facility failed to clarify one of one sampled resident (Resident (R1) physician's orders regarding the correct CPAP Support Therapy mode and settings. Findings Include: A review of the facility policy titled CPAP/ BiPAP Support, with a complete revision date of March 2015 states - Preparation 3. Review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure (CPAP, IPAP, and EPAP) for the machine. 4. Review and follow the manufacturer's instructions for CPAP machine setup and oxygen delivery. Steps in the procedure 8. Set mode, CPAP, IPAP, and EPAP settings on the machine, as prescribed. Documentation- Document the following in the resident's medical record: 3. Mode and settings for the CPAP/IPAP/EPAP. A review of R1's Face Sheet revealed that R1 was admitted to the facility on [DATE] at 2:15 PM with diagnoses that included Pneumonia, Sleep Apnea, Parkinsonism, and Hypertension. A Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 08/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 07 out of 15, indicating R1 was severely, cognitively impaired. A Review of R1's Physician Orders revealed Orders: Hour of Sleep Continuous Positive Pressure (CPAP) AC Start Date: 08/18/2024 Start Time: 12:00 am Scheduled First scheduled time is 8/18/2024 on the Hour of sleep time period. Instructions: Use with home settings already set. Observation and interview with R1 on 10/08/24 at 12:18 PM revealed R1 in her room, sitting in a non-mechanical wheelchair with CPAP noted at the bedside, R1 stated that staff will put on a CPAP machine at night, R1 also stated she was unsure of the settings on the machine. An interview with a Licensed Practical Nurse, (LPN)1 on 10/09/24 at 11:42 AM revealed LPN1 confirmed he knew R1 and had provided care to her prior. LPN1 stated the doctor's order has the right pressure for the CPAP in it. LPN1 stated that distilled water, not regular water goes in the machine. When the machine comes in, it's the nurse's responsibility to ensure that the machine is set to the correct mode and settings per physician orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview with the facility's Nurse practitioner, (NP) on 10/10/24 at 1:31 PM revealed the following, NP confirmed she was familiar with the resident. NP stated typically when a resident brings a CPAP from home, the settings are just monitored. NP stated if the staff does not know the settings, oxygen is used until the staff finds out what the settings are on a resident's CPAP machine. NP stated if something occurs with the CPAP machine, the nursing staff is to call her. She then stated at that point she would then write an order for oxygen. She stated if the machine was in the incorrect setting, the CPAP machine will alarm, and that's how staff will know if something is wrong with that machine. NP stated there is no standard setting for the CPAP machine. The settings are determined by the sleep study. NP stated that R1's CPAP equipment was present upon admission. NP stated she was not aware that the mode and settings needed to be included in the CPAP order. NP verbalized the nursing staff can look at the display screen located on the CPAP to determine the mode and settings. NP thanked the surveyor for the information related to the CPAP policy. An interview with Registered Nurse (RN)3 on 10/10/24 at 3:05 PM revealed RN3 confirmed she was familiar with R1. RN3 stated when R1 was admitted she did not have a CPAP machine upon admission, however, she received one a few days after. RN3 stated R1 is required to wear a CPAP at night. RN3 verified R1's order and stated she was unsure of what the resident's home settings were. RN3 stated that nursing staff can call the resident's family to obtain more information in regard to the CPAP machine mode and settings. RN3 stated she would usually expect to see the mode and settings clarified in the physician orders in the case something happens to the machine such as if the CPAP machine falls or if the resident touches or changes the setting. An interview with the Director of Nursing (DON) on 10/10/24 at 3:16 PM revealed the DON confirmed she was familiar with the resident. DON stated R1's CPAP machine settings should be between 5-12. DON stated, R1's order needs to be more specific and confirmed the CPAP settings should have been included in the physician's order. DON stated moving forward, her expectation are for the nurses to be aware of the importance of the order to include CPAP mode and settings. DON stated if mode and settings are not included in the order, it would be the nurse's responsibility to clarify the physician's orders.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy the facility failed to ensure that opened food items were properly labeled and stored, 2 of 2 kitchens reviewed. Findings include: Review of an undated policy titled, Food Receiving and Storage, revealed Foods shall be received and stored in a manner that complies with safe food handling practices. Initial tour of the Skilled Nursing Kitchen on 10/08/24 at 10:00 AM revealed the following items opened, but not dated: In a overhead shelf: -2 bottles of Steak Sauce -A bottle of Ketchup -A bottle of Malt Vinegar -1 container of house blend coffee Observation and interview with the Dietary Manager for the Skilled unit on 10/08/24 at 10:05 AM revealed that staff did not update the Food Storage Bin Log to reflect the sugar that was added to the bin on 10/07/24. Review of the Food Storage Bin Log revealed that it was last updated in July 2024. Observation on 10/08/24 at 10:07 AM of a drying rack revealed several wet cups stacked on top of each other. An observation on 10/08/24 at 10:10 AM of a storage rack revealed personal items, belonging to some of the kitchen staff and a bin of bananas stored beside each other. During an interview with the Dietary Manager and Kitchen Staff, it was confirmed that personal items are not be stored in the kitchen. An observation on 10/08/24 at 10:15 AM of a double door refrigerator/cooler revealed the following item not labeled after opening: -1 gallon of milk An observation on 10/08/24 at 10:17 AM of the Main Kitchen revealed the following items not labeled after opening: In the dry storage room: -1 container of peanut butter (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-1 bag of cereal (corn flakes) In the freezer: -1 box of biscuit dough -1 box of stew vegetable mix -1 freezer bag of salami -1 freezer bag of cubed cheese An interview with the Kitchen Manager on 10/08/24 at 10:30 AM revealed that all food items are to be labeled and dated after opening and personal items are not be stored near food items.