STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425290	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Estates	400 Webber Road Spartanburg, SC 29302

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** 46934 Based on interviews, record review, and review of facility policy, the facility failed to maintain resident safety for 1 of 4 residents reviewed for accidents. Specifically, a Hospice - Certified Nursing Assistant (HCNA) gave Resident R(38) a shower, without verifying R38's ambulation, transfer status, or Activities of Daily Living (ADL) care, resulting in a fall with R38 suffering minor injuries. Findings include: Review of the undated facility policy titled Fall Management Program documented, The Fall Management Program has been developed to assist facilities in identifying strategies to minimize the risk of falls for residents and still maintain the highest practicable level of functioning and mobility through a comprehensive analysis of physical, mental and psychosocial conditions and the development and implementation of individualized plan of care. The Fall Risk Data Collection Tool (electronic UDA) determines program placement. Review of the undated facility policy titled Safe Resident Handling Program documented, Purpose: To provide residents with the safe assistance of mechanical lifts as indicated by their condition; to eliminate unnecessary manual repositioning and lifting by employees. 4. Gait/transfer belts will be used as assessed for residents requiring less than 50 % manual assistance for ambulation and transfer activities. Review of R38's Face Sheet revealed R38 was admitted to the facility on [DATE], with diagnoses including but not limited to: mild cognitive impairment of uncertain or unknown etiology, dementia - without behavioral/psychotic disturbance, essential tremor, peripheral vascular disease and osteoarthritis. Review of R38's Significant Change in Status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/10/24, revealed a Brief Interview for Mental Status (BIMS) of 10 out of 15 indicating R38 was moderately cognitively impaired. Further review of R38's MDS revealed that R38 is dependent on staff for toileting, showering/bathing, and personal hygiene. R38's mobility is substantial/maximal assistance for sit-to-stand and dependent on staff for tub/shower transfer. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425290	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Estates	400 Webber Road Spartanburg, SC 29302

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	Review of R38's Care Plan, last care conference dated 01/02/25, documented, Category: Cognitive Loss/Dementia The resident is now under the care of Interim hospice with admitting dx of dementia. Start of care date 12/19/2024. Created: 12/19/2024. Goal - Resident will maintain a quality of life, as possible, with needs and comfort being met through Created: 12/19/2024. Approach Hospice providers visit schedule: CNA - 1-3 days per week, Nurse - at least weekly, Social Worker - at least monthly, and Chaplain - at least monthly. Category: Falls Resident is at risk for falls and fall-related injuries r/t weakness and cognitive impairment. Goals: Falls will not create injury Edited: 12/13/2024, Approach: Assist with ambulation. Category: ADLs Functional Status/Rehabilitation Potential Resident requires assistance for ADLs r/t cognitive impairment and generalized weakness Edited: 12/13/2024. Goal- Resident will participate in ADLs as able. Approach: Assist resident with bathing, hair care, toileting needs, oral hygiene, dressing, etc. Bathe per facility protocol, w/c for mobility. Review of R38's Physical Therapy Discharge Summary with dates of service 08/22/24 - 10/20/24, revealed the D/C Reason: Highest Practical Level Achieved. Clinical Impressions: Pt exibits slow velocity and narrow step widths. Conference with nursing regarding mobility and transfer status with recommendations GB x 1, and communicate with pt in a loud clear voice with strong eye contact due to communication deficits. Pt did not show signs of O2 desaturation or SOB going from sitting to supine position. Fall prevention measures taught and educated pt about safety strategies to reduce risks of falls including: not to attempt ambulating without assistance as pt is high fall risk. Review of R38's Progress Note dated 12/23/24 at 8:35 AM, written by Registered Nurse (RN)1 revealed, Called to room by primary nurse stating resident had fallen in the bathroom. Certified Nursing Assistant (CNA) with hospice was present. She stated she had the resident in the shower in room when the resident's legs gave out on her and resident went down on her knees. Upon entering room, resident back in bed, skin tear noted on left great toe and left 5th toe. The resident denies pain. CNA reports resident may have hit her head slightly on shower wall, no bruising or redness noted. Will place resident on HTP (Head Trauma Protocol) due to not being witnessed by staff at WOE. Educated CNA on not giving residents showers unless it is in the shower room in a shower chair or performing a bedbath on resident due to weakness. CNA stated understanding. Review of a follow-up Progress Note dated 12/23/24 at 5:49 PM revealed, Nurse saw pt multiple times today. At 0808, pt. was found on the floor of her bathroom naked with the hospice aide attempting to pick her up. Blood was on the floor beneath pt. The nurse came in, took pt.'s vitals, & assessed her body for wounds. The CNA came in & helped with putting pt. in bed. Multiple bruises, cuts, and scrapes were found on pt.'s knees, feet, & toes. Pt. was cleaned & dressed. Aide told the nurse that the pt. did hit her head when she fell . The nurse did not see a bruise. Pt. has been placed on head trauma protocol. Pt.'s family was notified. Hospice personnel did attend to the pt. & to do a report on the incident. Review of R38's Morse Fall Scale dated 12/01/24, revealed R38's gait is weak and her mental status overestimates/forgets limitations. The total score of 70.0000 indicating: Level: High Risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425290	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Estates	400 Webber Road Spartanburg, SC 29302

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	During a phone interview with R38's Representative (RP) on 01/08/25 at 9:35 AM, revealed R38 was admitted to hospice services early December 2024 and has been in hospice for about a month. The RP stated he received a call from the facility stating that hospice aide took R38 in the shower, and R38's legs gave out and fell . The RP states the facility called him and notified him immediately. The RP states he doesn't remember who he spoke too, resident obtained scrapes on knees and her feet as a result, no broken bones. During an interview with Certified Nursing Assistant (CNA)1 on 01/08/25 at 12:44 PM, CNA1 confirmed she worked the day of the incident, and that she is R38's aide. CNA1 stated R38 has transitioned to hospice services in December 2024, approximately 1 month. CNA1 stated that R38 is generally weak and has not ambulated much since admitting to hospice services, however, when she is out of bed she is a one-person assist. CNA1 stated on 12/23/24, Hospice Aide came to the building, stopped by the nurses station and communicated with a Licensed Practical Nurse (LPN)1 that she was with the hospice company and that she was going to give R38 a shower since that day was shower day and continued to walk to R38's room. CNA1 stated Hospice Aide never got the report or asked questions related to how R38 received her showers or ambulated since that was her first encounter with the patient. CNA1 stated hospice aide only asked LPN1 where R38's shower things were located and LPN1 replied bed bath. CNA1 stated approximately 20 minutes later R38's bathroom call light was activated as she could see from the nurse's station, and upon walking in R38's room CNA1 stated she saw R38 naked in the shower kneeling, and wet. CNA1 stated she asked Hospice Aid what occurred and the hospice aide replied that R38's knees bucked and she thought R38 hit her head. CNA1 stated she told the hospice aide to cover R38 up while she grabbed LPN1. LPN1 arrived to the room, and assessed R38, with vitals within normal limits, no evidence of fractures, and the nurse gave the okay for R38 to be placed in bed. CNA1 stated R38 was bleeding from her right foot. CNA1 stated once R38 was placed back in bed, the Hospice aide then gave the resident a bed bath while LPN1 assessed R38's right foot and bleeding came from scratches on R38's right toes. CNA1 stated hospice nurses came in the next day to apologize for what had occurred with R38 and assigning a new hospice aide. During an interview with Registered Nurse (RN)1 on 01/08/24 at 1:36 PM, via phone call, revealed she was called to the room by LPN1, with a Hospice Aide present. RN1 stated upon entering the room, resident was in bed, skin tear was noted on left great toe and left 5th toe. R38 denied pain. The Hospice Aide stated she had the resident in the shower in the room when R38's legs gave out on her and R38 went down on her knees. RN1 stated Hospice Aide reported that R38 may have hit her head slightly on the shower wall, she couldn't remember. RN1 stated she explained to the Hospice Aide she should have never done that because the resident is fragile and weak. RN1 stated Hospice Aide didn't speak to any facility staff related to how the resident received baths, or the amount of assistance the resident needed. RN1 stated Hospice Aide assumed that the resident had a shower in her room, got her up, and walked her in the shower. RN1 stated Hospice Aide called her boss and discussed what had occurred with her boss. The next day, the Hospice Nurse and Hospice Liaison came on site, apologized, and agreed that the Hospice Aide should have never given the resident a shower. RN1 stated a few days later, the resident's family decided to use another hospice company. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425290	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Estates	400 Webber Road Spartanburg, SC 29302

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	During an interview with Licensed Practical Nurse (LPN)1 on 01/08/24 at 2:18 PM, LPN1 confirmed she is R38's nurse and is familiar with the incident. LPN1 stated right before Christmas 2024, a Hospice Aide came up to the nurses station, stated her name, and that she was here to see R38 and to shower her. LPN1 stated she corrected the Hospice Aide and told her the resident received a bed bath. LPN1 stated a few minutes later she saw R38's bathroom call light was on and went to R38's room and saw the resident naked, wet, and kneeling in the shower. LPN1 stated Hospice Aide told her, She fell because she didn't hold on to the grab bar. LPN1 stated that she yelled for R38's aide to assist her with assessing R38 and placing her back to bed. LPN1 stated no visible broken bones, and R38's vitals were within her normal limit, however, blood was in the shower floor. LPN1 stated that R38's knees were slightly bruised, and the hospice aide told her that R38 hit her head as she was falling, head trauma protocol (HTP) was initiated. LPN1 stated Hospice Supervisor came and did a report. LPN1 states the Hospice Aide didn't ask level of assistance, despite telling her twice she was a bed bath and not a shower, she still didn't understand. LPN1 stated the situation really bothered staff because R38 is weak and fragile. During an interview with Registered Nurse (RN) Supervisor on 01/08/25 at 3:33 PM, the RN Supervisor stated due to the holidays, the Facility Medical Director (MD) was not in the building until 01/03/25, which is when he signed the document, and the hospice plan of care was in medical records awaiting to be scanned. Per the RN Supervisor she is not sure what documentation the Hospice Aide went by due to it not being in R38's hospice binder. During a phone interview with the Hospice Aide on 01/08/24 at 3:49 PM, the Hospice Aide confirmed knowing the resident and being her aide the day of 12/23/24. The Hospice Aide stated the encounter was her first encounter with R38 back in December 2024. The Hospice Aide stated she went to R38's room, got her out of bed, walked R38 to her bathroom, sat her on the toilet to use the restroom, got her back up, undressed her and got her in the shower. The Hospice Aide stated the resident stood up for a little bit then her legs bucked up and she fell . The Hospice Aide stated she used no assistive devices or a gait belt when she got R38 up from the bed and to the shower. The Hospice Aide further stated she spoke with R38's nurse however, she doesn't remember what the nurse told her. The Hospice Aide stated when the resident fell , she pressed the call light located in R38's bathroom for assistance because she was having trouble getting her up. The Hospice Aide stated she did not know her transfer status and states she did not look when reviewing her plan of care, just the shower part. The Hospice Aide stated she called the hospice company she is employed through and explained what occurred that day to them. The Hospice Aide stated that R38's plan of care said shower, and that's what she went by. During an interview with Social Services (SS) on 01/09/24 at 11:23 PM, revealed she was notified that morning that the Hospice Aide got R38 up, walked her to her private shower located in her room, had her stand up, she got weak and fell . SS stated the Hospice Aide should have placed her in a shower chair, and took her to the shower room on the unit. SS stated she contacted the hospice company liaison and explained what happened, confirming R38 should not have been showered. SS stated from what she gathered, the Hospice Aide asked the nursing staff if the resident gets showered, the nursing staff replied yes, in the shower room, or a bed bath. SS stated she believed the Hospice Aide misunderstood and gave the resident a shower in her room instead of the shower room located on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425290	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Estates	400 Webber Road Spartanburg, SC 29302

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	During an interview with the Assistant Director of Nursing (ADON) on 01/09/25 at 1:59 PM, revealed she was working the day of the incident. The ADON stated RN1 reported that the Hospice Aide came in the building, went straight to the resident's room, got her up, and gave her a shower without communicating with the facility staff that was caring for R38. The ADON stated the Hospice Aide thought R38 could stand, however didn't verify. The ADON states CNA1 walked in the room and saw the Hospice Aide attempting to pick the resident up from the floor. RN1 was notified and assessed R38 which she had minor injuries such as scrapes on her knees, and bleeding from her toes. The ADON stated the Hospice Liaison asked the Hospice Aide what happened, and the Hospice Aide replied that she was rushing because she had somewhere to be. The ADON stated typically when Hospice Aides or nurses come in, they are required to speak with facility staff and discuss the residents prior to providing care, and that's the expectation every time they enter the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425290	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Estates	400 Webber Road Spartanburg, SC 29302

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49918 Based on observation, interview and review of facility policy, the facility failed to ensure that medication and biologicals were properly stored in 3 of 3 medication carts. Findings include: Review of the facility policy dated 09/21/22, titled Medication Storage in the Facility documents, medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure 9. Outdated, contaminated, 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 destruction, and reordered from the pharmacy, if a current order exists. During an observation on 01/08/25 at 2:34 PM, of the Unit 2 Wound Treatment Cart revealed [NAME] Calcium Alginate Dressing 4-inch x 4 3/4 inch: sterile open with the expiration date and lot number torn off. Licensed Practical Nurse (LPN)3 verified and discarded the dressing in a trash can. During an observation on 01/08/25 at 4:47 PM, of the Unit 1 Wound Treatment Cart revealed an open 3% Xeroform 4 inch x 4 inch sterile dressing which was open, MFR# 2206. A colostomy bag loose not in original package. LPN2 verified and discarded the items in trash can. During an observation on 01/09/25 at 8:01 AM, of Treatment Cart 4 revealed a Suture Removal Kit Metal forceps which was open and no longer sterile, MFR# 240P, Manufacturer [NAME], Lot# CZ09-02. During an interview on 01/09/25 at 08:01 AM, the Director of Nursing (DON) stated, We have three treatment carts. It is the responsibility of all the nurses to check the cart to keep it cleaned out and check for expiration dates.