STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425024	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Spartanburg	295 East Pearl Street Spartanburg, SC 29303

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 28270 Based on record review, interview, and facility policy review, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) when residents completed Medicare A therapy services for 2 of 2 residents (Residents (R)22 and R32) reviewed for beneficiary notices out of a sample of 33 residents. This failure to provide the SNF ABN prevented the residents from knowing how many days were remaining under Medicare A. Findings include: Review of the facility's undated policy titled, Skilled Nursing Facility Advance Beneficiary Notice indicated, . The Business Office is to initiate and deliver the SNF-ABN (CMS-10055) form when a Medicare resident is, or will be, receiving a service normally covered by Medicare, but the Provider believes is not (a) medically necessary or (b) is custodial care and the technical requirements for the coverage are met. The SNF-ABN form is required to be issued no later than 2 days before the resident's Medicare coverage is ending . 1. Review of R22's Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), revealed R22 was admitted to the facility for long-term care and was receiving skilled in therapy on 11/27/24. Review of the SNF Beneficiary Notice Form, completed by the facility, indicated R22's last day of Part A service was 02/06/25. The form indicated the SNF ABN, Form CMA 10055 was not provided to the resident because of a mistake on the business office part. 2. Review of R32's Face Sheet, located in the Face Sheet tab of the EMR, revealed R32 was admitted to the facility for long-term care and was receiving skilled in therapy on 10/08/24. Review of the SNF Beneficiary Notice Form, completed by the facility, indicated R32's last day of Part A service was 11/15/24. The form indicated the SNF ABN, Form CMA 10055 was not provided to the resident because of a mistake on the business office part. During an interview on 03/13/25 at 11:23 AM, the Administrator confirmed the residents did not receive the ABN.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 30260 Based on observations, interviews, and review of facility policy, the facility failed to follow appropriate infection control practices for hand hygiene and glove wearing for 1 out of 1 resident (Resident (R)211), observed during wound care and 1 out of 5 residents (R37), observed during medication administration out of a total sample of 33 residents. These failures increased the risk of the spread of infections. Findings include: Review of undated facility policy provided by the facility titled Hand Hygiene indicated, Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: . After removing gloves or aprons . Putting on and Taking off Personal Protective Equipment (PPE) . Types of PPE and Purpose Gloves: Protect hands from body fluids and other contaminates . PPE Guidelines - Wash or sanitize hands prior to donning PPE . - Remove PPE at resident doorway and perform hand hygiene immediately . - During removal of PPE, if at any time your hands become contaminated, perform hand hygiene immediately and then proceed with removal of the other articles of PPE . 1. During wound care observation for R211 on 03/13/25 at 12:22 PM, Registered Nurse (RN)2 and the Infection Preventionist (IP). The IP was assisting to hold R211. The IP donned a pair of gloves with a gown. During the observation, the IP removed the pair of gloves and donned a new pair of gloves without performing hand hygiene between the glove change. During an interview on 03/13/25 at 1:30 PM, the IP acknowledged that she had changed gloves without performing hand hygiene in between glove changes. 2. During medication administration observation on 03/14/25 at 9:15 AM, with Licensed Practical Nurse (LPN)2, LPN2 entered R37's room carrying a wrist blood pressure cuff, a cup of oral medications, a cup of water, and a lidocaine patch. Once in the room, LPN2 donned a pair of gloves without first performing hand hygiene. While applying the lidocaine patch, LPN2 removed the right glove briefly and laid the glove on the bedside table. LPN2 put the same glove back on to continue applying the lidocaine patch. After applying the lidocaine patch on R37, LPN2 removed gloves, gathered all her supplies (medication cup, water cup, and wrist blood pressure machine) in one hand and touched the wall hand sanitizer dispenser to apply sanitizer on the other hand. LPN2 exited R37's room. LPN2 laid the supplies on her medication cart and rubbed her hands together to apply the hand sanitizer. During an interview on 03/14/25 at 9:20 AM, LPN2 acknowledged she had removed one glove, put the same glove back on, and had failed to sanitize her hands before gloving and immediately after ungloving. During the closing conference on 03/14/25 at 4:00 PM, the IP, DON and Administrator were informed of and acknowledged the above findings.