STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425068	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Columbia	3001 Beechaven Road Columbia, SC 29204

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51682 Based on observation, record review, interview, and facility document and policy review, the facility failed to provide adequate supervision to prevent falls, failed to consider all causal factors related to falls, and failed to update a resident-centered care plan with appropriate interventions to prevent further falls for 1 (Resident (R)3) of 4 sampled residents reviewed for falls. Specifically, R3, a resident with a history of multiple falls, sustained falls on 08/18/2024, 09/03/2024, and 01/16/2025, and the facility failed to consider all causal factors related to these falls in an effort to develop and implement appropriate fall prevention interventions. Subsequently, on 02/07/2025, the resident sustained a fall that resulted in an injury. In addition, the facility failed to ensure staff performed an appropriate transfer from the floor to the bed following the fall on 02/07/2025. After hospital evaluation, R3 was diagnosed with a right humeral neck fracture. R3 sustained an additional fall on 02/23/2025. Findings included: (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 - Actual harm Residents Affected - Few	An undated facility policy titled, Falls Management Program indicated, INTRODUCTION: To attempt to provide an environment as free from accidental hazards as possible and provide adequate supervision and assistive devices to attempt to reduce the risk for occurrences. The policy revealed, 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 comprehensive analysis of physical, mental and psychosocial conditions and the development and implementation of individualized plan of care. The section of the policy titled, DOCUMENTATION specified, -Fall Investigation *This form is to be completed upon occurrence of any fall *Documentation should include date, time and exact location of fall; prior history of falls; reason/circumstances surrounding the fall; review of care plan and update of interventions; review need for placement in Fall Management Program, review of medication, diagnosis, assistive and protective devices, environmental factors, mental status and action taken to reduce risk of a fall. The section of the policy titled DOCUMENTATION also specified, -Care Plan *When developing a plan of care to reduce the incidence of falls, staff need to review the factors that can contribute to, or directly cause, these types of incidents. In addition, the policy specified, -Following a fall an Occurrence Report, Witness Statement and Fall Investigation are completed. - Any resident who experiences a fall is reviewed by the Safety / QI [Quality Improvement] Committee for recommendations of possible changes in interventions and communicated to the facility care team. The policy included a NURSING FALL PROTOCOL, revised 12/22/2022, that specified nursing responsibilities for resident falls included, -Investigate cause of the fall, using witness if it was witnessed -Educate resident and staff on interventions needed -Occurrence Report, including witness statement, -Complete Fall Investigation, -Refer to Physical / Occupational Therapy for evaluation and possible additional equipment or preventive devices as appropriate, -Refer to Safety / QI Committee for review. A Resident Face Sheet revealed the facility admitted R3 on 03/11/2019 and most recently admitted the resident on 02/01/2025. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of paranoid schizophrenia, insomnia, lack of coordination, unsteadiness on feet, muscle weakness, Alzheimer's disease with early onset, Parkinson's disease, and repeated falls. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/11/2024, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required partial/moderate assistance with putting on and taking off footwear and required supervision or touching assistance when transitioning from a sitting to standing position, with toilet transfers, and with walking distances of 10 feet, 50 feet with two turns, and 150 feet. Per the MDS, the resident had sustained two falls without injury and one fall with injury (not major) since admission or reentry to the facility or their prior MDS assessment. An annual MDS, with an ARD of 09/10/2024, revealed R3 had a BIMS score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required partial/moderate assistance with putting on and taking off footwear and required supervision or touching assistance when transitioning from a sitting to standing position, with toilet transfers, and with walking distances of 10 feet, 50 feet with two turns, and 150 feet. Per the MDS, the resident had sustained two falls without injury since admission or reentry to the facility or their prior MDS assessment. An Event Summary List for the timeframe from 08/01/2024 through 04/16/2025 revealed R3 sustained falls on 08/18/2024, 09/03/2024, 01/16/2025, 02/07/2025, and 02/23/2025. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Care Plan History included a problem statement, with a start date of 08/16/2018, that indicated the resident was at risk for falls due to general weakness; a history of falls/falls with major injury; potential medication side effects; episodes of incontinence and pain; cognition that waxed and waned with episodes of confusion or agitation; and diagnoses of Parkinson's disease, Alzheimer's dementia, schizophrenia, and anemia. Interventions in place prior to the above-listed falls directed staff to ensure the resident used a wheelchair for long distance locomotion (started 11/20/2018); conduct safety checks during rounds and as needed (started 11/20/2018); ensure the resident's room and hall were free from clutter, spills, or other tripping hazards (started 11/20/2018); administer Parkinson's medications as ordered and monitor for and report any adverse side effects (started 03/11/2019); physical therapy (PT) to evaluate and treat as needed (started 07/05/2021); encourage the resident to use their call light for assistance (started 10/01/2021); assist the resident to the bathroom after breakfast (started 10/08/2023); utilize a defined perimeter mattress on the resident's bed due to attempts to stand from the bed by self and unable to do so (started on 01/29/2024); assist the resident with early morning care and get up as tolerated (started 03/23/2024); assist the resident with toileting before bedtime as tolerated (started 05/06/2024); ensure the resident had non-skid socks on at all times/in bed as tolerated (started 05/15/2024); toilet the resident before lunch as tolerated (started 06/01/2024); use non-slip material on the resident's mattress (started 07/10/2024); and ensure when the resident was in bed that the resident's wheelchair was at the resident's bedside with brakes locked with shoes in the wheelchair for easy access (started 07/25/2024). R3's Care Plan History also included a problem statement, started on 05/24/2024, that indicated the resident was noncompliant with calling for staff assistance and waiting for staff assistance related to fluctuating cognitive status; poor safety awareness; and diagnoses of Alzheimer's dementia, schizophrenia, and Parkinson's disease. During an interview on 04/18/2025 at 3:45 PM, the Director of Nursing (DON) stated she left all falls and fall investigations for the Assistant Director of Nursing (ADON) to handle. During an interview on 04/17/2025 at 1:49 PM, the ADON described the fall investigation process and indicated that following falls, she spoke with the resident, the resident's roommate (if applicable), and staff but did not document any notes of the details discovered during the investigation or any details obtained when speaking with individuals about the fall. The ADON stated if anything struck her as unusual, she asked more questions. The ADON further stated nursing staff turned in a fall packet after a resident fall, and the packet was reviewed during the facility's morning meeting the following day and during Friday risk assessment meetings. An Event Report, completed by the ADON on 08/19/2024, revealed R3 was found on the floor in their bathroom on 08/18/2024 at 12:40 AM without injury. Per the Event Report, immediate measures taken included assessing the resident for an acute process. The Event Report reflected a Progress Note, dated 08/18/2024 at 3:02 AM, that indicated the resident reported to staff they were trying to go to the bathroom when they fell . The Progress Note indicated staff told the resident to use their call light when they needed assistance. The Event Report also reflected the following Progress Notes: - a note dated 08/19/2024 at 10:33 AM that indicated new orders for a urinalysis and urine culture were received related to an assessment for acute processes r/t [related to] fall; and - a note 08/22/2024 at 10:44 PM that indicated the resident's laboratory results (urine culture) were received, and there were no new orders. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's fall risk care plan revealed an intervention was added on 08/18/2024 to assess for acute processes, and the intervention was discontinued as of 08/21/2024. The fall risk care plan revealed no additional updates or revisions to prevent further falls or to ensure the resident's safety related to the fall on 08/18/2024. During an interview on 04/18/2025 at 3:05 PM, the ADON stated it was not appropriate for the nurse to educate the resident to use their call light when they needed assistance (due to the resident's cognitive function); however, the ADON stated they also evaluated the resident for an acute process. During an interview on 04/18/2025 at 3:45 PM, the DON stated she did not feel it was appropriate to educate R3 after the fall on 08/18/2024. The DON stated the interdisciplinary team also met and discussed the fall and had the resident assessed to determine if they may have had a urinary tract infection, which the DON stated she felt was an appropriate fall intervention. An Event Report, completed by the ADON on 09/09/2024, revealed R3 was found on the floor in their room on 09/03/2024 at 7:00 AM without injury. The Event Report revealed the resident had bare feet at the time of the fall, and the resident was trying to get out of bed. Per the Event Report, possible contributing factors included that the resident would not call for assistance. The Event Report indicated immediate measures taken included pillows for positioning and comfort. The Event Report reflected a Progress Note, dated 09/03/2024 at 2:52 PM, that indicated the resident was reeducated on using their call light and wearing non-skid socks. R3's fall risk care plan revealed an intervention was added on 09/03/2024 to provide extra pillows in bed for positioning. The fall risk care plan revealed no additional updates or revisions to address the contributing factor identified by the facility for the 09/03/2024 fall (resident would not call for assistance). There were also no updates or revisions to address the absence of non-skid socks as per the resident's care plan at the time of the fall. During an interview on 04/18/2025 at 3:05 PM, the ADON stated the addition of pillows after the fall on 09/03/2024 was decided upon to help the resident stay in bed. During an interview on 04/18/2025 at 3:45 PM, the DON stated that for the fall on 09/03/2024, R3 probably took their non-skid socks off while they were in bed, but it was not appropriate for staff to reeducate the resident on using their call light and wearing non-skid socks (due to the resident's cognitive function). The DON stated the facility placed pillows for the resident's comfort following this fall. An Event Report, completed by the ADON on 01/17/2025, revealed R3 was found on the floor in their room on 01/16/2025 at 3:25 PM without injury. The Event Report revealed the resident was getting up from their wheelchair when the fall occurred. The Event Report revealed no possible contributing factors were identified by the facility. The Event Report indicated immediate measures taken included a dental evaluation during the dentist's upcoming visit. The Event Report reflected a Progress Note, dated 01/16/2025 at 3:25 PM, that indicated the resident was at the nurses' station just prior to the fall and reported they needed to get their dentures. Per the Progress Note, the resident's dentures were observed on the counter in their room within arm's reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's fall risk care plan revealed an intervention was added on 01/16/2025 to have the resident's dentures assessed by the dentist for proper fit. The fall risk care plan revealed no additional updates or revisions to address the resident's fall from their wheelchair, such as non-slip material to the resident's wheelchair seat. There were also no updates or revisions to address the resident's need for assistance with their dentures and denture care in relation to this fall. An intervention was later added on 03/28/2025 to place the resident's dentures within reach when the resident was out of bed. During an interview on 04/16/2025 at 1:39 PM, Licensed Practical Nurse (LPN)11stated she was assigned to care for R3 on 01/16/2025. She recalled that on 01/16/2025, R3 was found on the floor after returning to their room to retrieve their dentures. LPN11further stated a member of the administrative nursing team implemented the intervention for a dental consultation following the fall. During a concurrent observation and interview on 04/17/2025 at 11:00 AM, the Therapy Director observed R3's wheelchair and verified the resident's wheelchair did not have any slip-resistant material. During an interview on 04/18/2025 at 9:35 AM, the Medical Director (MD) stated a dental evaluation would not prevent a fall. The MD stated he was not involved in the development of that particular intervention. During an interview on 04/18/2025 at 3:05 PM, the ADON stated that for the fall on 01/16/2025, R3 went back to their room to get their dentures, because their dentures were not in their mouth. The ADON stated that if the resident had their dentures in their mouth, the resident would not have had to go back to their room to get them and therefore would not have fallen. The ADON stated they felt the intervention to have the resident's dentures assessed was an appropriate fall intervention. The ADON further stated she was not aware of the interdisciplinary team ever discussing the implementation of non-slip material to the resident's wheelchair. During an interview on 04/18/2025 at 3:45 PM, the DON stated the interdisciplinary team felt having R3's dentures assessed for proper fit after the fall on 01/16/2025 was an appropriate intervention to prevent falls. An Event Report, completed by the ADON on 02/10/2025, revealed R3 was found on the floor in their room on 02/07/2025 at 5:00 PM. The Event Report revealed the resident was utilizing a wheelchair at the time of the event and was changing their clothes. Per the Event Report, the resident's footwear at the time of the fall consisted of plain socks, as opposed to non-skid socks as per their care plan. The Event Report revealed no possible contributing factors were identified by the facility. The Event Report indicated immediate measures taken included to assist the resident to change clothes before dinner as tolerated. The Event Report reflected a Progress Note, dated 02/08/2025 at 1:56 AM, that indicated during a neurological check, R3 was noted with no grip strength in their right hand and slight swelling to their right arm. The Progress Note further indicated that the resident was only able to raise their right arm by lifting their right arm with their left hand, and the resident was sent to the emergency room for further evaluation. Another Progress Note, dated 02/08/2025 at 7:19 AM, indicated the resident would be returning to the facility with a mildly displaced femoral neck fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's fall risk care plan revealed an intervention was added on 02/07/2025 to assist the resident with changing clothes before dinner as tolerated. There were no updates or revisions to address the absence of non-skid socks as per the resident's care plan at the time of the fall or to interventions to address the fact that the resident was utilizing their wheelchair at the time of the fall, such as non-slip material to the resident's wheelchair seat. During an interview on 04/18/2025 at 3:45 PM, the DON stated the interdisciplinary team felt assisting the resident to change clothes and get ready for bed before dinner would prevent the resident from falling. A Confidential Occurrence Statement or Interview, signed by LPN11 on 02/07/2025, indicated LPN11 was not present at the time of R3's fall but was notified by the resident's roommate. According to the statement, LPN11 assessed R3 for injuries and assisted R3 back to bed with the assistance of Certified Nursing Assistant (CNA)12 and CNA16. During an interview on 04/16/2025 at 1:39 PM, LPN11 stated she was assigned to care for R3 on 02/07/2025. LPN11 stated that on 02/07/2025, R3 was on the floor of their room with their legs stretched out straight towards the top of their bed. She stated the residents' right side was parallel to the bed. LPN11 stated she assessed the resident and found no injuries, then she, CNA12, and CNA16 lifted the resident into the bed. She stated the transfer from the floor to the bed was completed by CNA12 and CNA16 lifting the resident under the resident's arms and LPN11 lifting the resident's legs. During an interview on 04/17/2025 at 11:42 AM, CNA12 stated she was on duty on 02/07/2025 and was assigned to R3 when the resident was found on the floor. CNA12 explained that R3 was positioned on the floor in a seated position with their right side towards the bed, their left side parallel to the sink, and their legs outstretched towards the head of the bed. She stated the resident had removed the clothing from their lower body and was wearing plain socks or TED hose (stockings to prevent blood clots and swelling in the legs) at the time of the fall. She stated the resident had also removed their incontinence brief. CNA12 further stated that after the nurse assessed the resident, she and CNA16 lifted the resident under the resident's arms while LPN11 lifted the resident's feet, and the three of them placed the resident into bed. CNA12 stated she was under the resident's right side, CNA16 was under the resident's left side, and LPN11 held the resident's feet/legs during the transfer. CNA12 recalled that while assisting the resident into the bed, she fell over into the bed against the resident on the resident's right side. During an interview on 04/16/2025 at 1:32 PM, CNA16 stated she was not assigned to R3 on 02/07/2025 but assisted with R3's transfer from the floor to the bed. She stated R3 was disrobed from the waist down. CNA16 stated R3 was unable or refused to bear weight to assist staff with the transfer into bed. CNA16 stated she and CNA12 assisted LPN11 transfer R3 into the bed by placing their arms under each of the resident's arms, and LPN11 lifted the resident's legs. During an interview on 04/16/2025 at 4:00 PM, with both the ADON and DON present, the DON stated that when it came to lifting residents after a fall, the appropriate transfer status was based upon how well the resident could assist with that transfer. The ADON stated if the resident was not injured and was able to do 75 percent (%) of the work and bear weight, then the staff could use two people to manually lift and transfer the resident from the floor to the bed, but if the resident required more assistance, a mechanical lift should be utilized. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/18/2025 at 9:35 AM, the MD stated staff should not perform transfers by lifting under the arms of a resident because it increased the risk of an injury. An Initial Report, dated 02/08/2025, revealed the facility reported the fall on 02/07/2023 to the state survey agency as a bone or joint fracture due to a fall. A Five-Day Follow-Up Report, dated 02/12/2025, revealed staff had last seen R3 at approximately 4:30 PM self-propelling themself in their wheelchair toward their room after activities. The report indicated the resident was changing their clothes and slid out of their wheelchair. According to the report, to prevent future injuries, the facility implemented an intervention that directed staff to assist the resident with changing clothes before dinner as tolerated. The Five-Day Follow-Up Report revealed no documentation to indicate the facility considered new interventions related to the resident sliding out of their wheelchair or that non-skid socks were not in use at the time of the fall. In addition, there was no indication the facility identified any concerns related to the method of transfer to the bed following the resident's fall. During an interview on 04/17/2025 at 1:49 PM, the ADON stated she could not recall why the resident was found to be wearing plain socks instead of non-skid socks at the time of the fall. The ADON further stated that during the course of her investigation, she had not identified that the resident was placed into bed with the assistance of three staff members due to the resident not bearing weight, or that CNA12 had fallen into the bed with R3 during the transfer from the floor to the bed on 02/07/2025. During an interview on 04/18/2025 at 3:45 PM, the DON stated the facility had not identified any concerns with the method of transfer during their investigation into the resident's falls. An Event Report, completed by the ADON on 02/25/2025, revealed R3 was found on the floor in their bathroom on 02/23/2025 at 11:00 AM without injury. The Event Report revealed the resident was getting up from their wheelchair at the time of the fall. The Event Report revealed no possible contributing factors were identified by the facility. The Event Report indicated immediate measures taken included a therapy evaluation. The Event Report reflected a Progress Note, dated 02/23/2025 at 12:58 PM, that indicated the resident was in the bathroom in their room at the time of the fall and was being assisted by a staff member. The Progress Note indicated the staff member stepped out of the bathroom to obtain an item from the room, and upon returning to the bathroom, found the resident on the floor. R3's fall risk care plan revealed an intervention was added on 02/23/2025 for therapy to do safety training with the resident regarding transfers. There were no updates or revisions to address the fact that the resident was utilizing their wheelchair at the time of the fall, such as non-slip material to the resident's wheelchair seat. There were also no updates or revisions addressing the resident's needed level of supervision when being assisted by staff in the bathroom. During an interview on 04/16/2025 at 1:00 PM, the Therapy Director stated R3 was already on therapy caseload at the time of the fall on 02/23/2025. The Therapy Director stated the resident had been on caseload since 01/2025. (continued on next page)

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