STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425077	A. Building B. Wing	12/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Newberry	2555 Kinard Street Newberry, SC 29108

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document review, the facility failed to ensure a Head Trauma Protocol was completed after an unwitnessed fall for 1 (Resident (R)2) of 3 residents reviewed for accidents. Findings include: Review of a facility protocol titled Head Trauma, revised on 12/07/2010, revealed under the section titled Objective included, 1. To provide close observation of any resident sustaining a suspected or actual blunt trauma to the head. 2. To provide early medical intervention in the event of brain injury. Under the section titled Procedure included, 2. Take baseline vital signs and record. Monitor vital signs as follows: q. [every] 1 hour x [times] 4 hours, then q. 2 hours x 4 hours, then q. 4 hours x 24 hours, then q. shift x 48 hours. 3. Complete neuro [neurological] documentation. Further review revealed, 4. Notify physician immediately if any of the following symptoms occur: Dizziness Nausea/Vomiting Increased pain Change in neuro determination Convulsions Inappropriate behavior Temp [temperature] elevation above 100 [degrees Fahrenheit]. Under the section titled Key Points included Wake q. 2 hours x 24 hours. Review of R2's Resident Face Sheet revealed the facility admitted R2 on 09/04/2025. According to the Resident Face Sheet, the resident had a medical history that included but was not limited to diagnoses of difficulty walking, lack of coordination, history of malignant neoplasm of bladder, and overactive bladder. Review of R2's Discharge (return anticipated) Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/14/2025, revealed R2 had short- and long-term memory problems and modified independence with cognitive skills for daily decision-making, per a Staff Assessment for Mental Status (SAMS). The MDS revealed the resident required supervision or touching assistance with toileting hygiene and was independent with toilet transfers. Review of R2's Care Plan included a problem area, initiated on 09/05/2025, that indicated the resident had a history of falls prior to arrival at the facility and was at risk for re-occurrence. Review of an Event Report dated 09/14/2025 revealed R2 sustained a fall on 09/11/2025. The Event Report revealed the resident was observed on the floor around 2:12 AM. Per the report, the resident was sitting in the doorway against the wall. The report revealed the resident stated they slid down while using the bathroom and crawled to the door. The report revealed that the fall was not witnessed, and the facility's head trauma protocol was initiated. Review of R2's Head Trauma Protocol form for the timeframe from 09/11/2025 through 09/13/2025 revealed that the neurological and symptoms section for the 4:15 AM and 5:15 AM checks on 09/11/2025 were blank. The Head Trauma Protocol form revealed that the vital signs, neurological, and symptoms section for the second shift on 09/13/2025 were blank. During an interview on 12/06/2025 at 10:31 AM, Licensed Practical Nurse (LPN)2 stated that when R2 fell on [DATE] she was the nurse assigned to provide care to the resident. She stated that she found the resident on the floor near their door. LPN2 stated that the fall was unwitnessed, so she initiated the head trauma protocol. She stated that she always completed the neurological checks but could not remember why she did not fill out the Head Trauma Protocol form for the checks at 4:15 AM and 5:15 AM on 09/11/2025. She stated it was possible the resident had just calmed down or was sleeping, and she did not want to disturb the resident, or she completed them and forgot to write them down. She stated that the resident was very irritable, and she would not want to wake them. LPN2 stated that she could not remember the reason for not completing the form. During an interview on 12/06/2025 at 4:44 PM, LPN3 stated that on 09/13/2025 at 7:15 PM, she switched assignments to work on the medication cart and care for residents, which included R2. She stated that she worked on that assignment for approximately two and a half hours. She stated that the nurse she received the assignment from did not inform her that R2 had experienced a fall that required the Head Trauma Protocol form to be completed. She stated she did not complete the required checks because she was unaware they were needed. LPN3 further stated that she did not report or pass on the need to complete the checks to the next shift because she did not know they were in place. She stated that nurses were aware of the required checks through passing down the information from shift to shift. During an interview on 12/06/2025 at 11:21 AM, the Director of Nursing (DON) stated she was responsible for reviewing the Head Trauma Protocol form for accuracy. She stated that she missed R2's Head Trauma Protocol form for the resident's fall on 09/11/2025. She stated that if the resident was sleeping, she would not expect the staff to wake the resident up, especially if they finally got the resident to rest, even though the protocol said to wake the resident. She then stated that she expected staff to follow the protocol.