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	06/04/2026

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policy, the facility failed to ensure resident safety and prevent avoidable accidents for 1 of 1 residents (R)124) reviewed for accidents/hazards. Specifically, on 10/15/2025, while a staff member was providing ADL care, the resident fell from the bed to the floor and sustained injuries, including bilateral femur fractures. Further, the resident required a twoˆperson assist for care, yet only one staff member was providing care at the time of the incident.Findings Include:A review of the facility policy titled Fall Management Program with no revision date states that [NAME] Oak Management, Inc. considers all newly admitted residents to be at risk for falls, as residents entering the facility have experienced some degree of decline and are transitioning into a new environment. The policy notes that fallˆrisk determination may also be made by the Interdisciplinary Team or Safety Committee. The policy outlines recommended steps for implementing the Fall Management Program, including completion of the Fall Risk Data Collection Tool (electronic UDA) during the admission or readmission process and quarterly thereafter; conducting medication reviews and clinical condition assessments as needed; assessing each resident for a history of falls; performing environmental checks of the resident's immediate surroundings based on identified environmental factors; and developing an interim plan of care during the admission process for each resident.A review of R124's Face Sheet revealed the resident was admitted to the facility on [DATE] at 1:45 AM with diagnoses including, but not limited to, unspecified severe proteinˆcalorie malnutrition; osteoarthritis; other specified disorders of bone density and structure; unspecified fracture of the lower end of the right femur, subsequent encounter for closed fracture with routine healing; unspecified fracture of the lower end of the left femur, subsequent encounter for closed fracture with routine healing; and pathological fracture of the unspecified tibia and fibula, subsequent encounter for fracture with routine healing.A review of R124's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/14/2025 revealed a Brief Interview for Mental Status (BIMS) score of 04 out of 15, indicating the resident was severely cognitively impaired. Further review of the MDS showed the resident was dependent for all ADLs, including personal hygiene and toileting, and transfers were not attempted. In addition, the resident was coded with a prognosis of life expectancy less than six months, and Section O indicated the resident was receiving hospice services.A review of R124's care plan revealed a documented problem stating that the resident has a history of falls with major injuries and is at risk for reˆoccurrence related to muscle weakness, cognitive impairment, and the medication regimen secondary to hypertension, diabetes mellitus, vascular dementia, degenerative joint disease, and osteoporosis. The care plan approach included assisting the resident in completing safe transfers per the facility's safeˆhandling tool.A review of R124's Safe Resident Handling Data Collection Form dated 08/15/2025 revealed the resident required a total lift, which required two staff members to turn and reposition the resident in bed. The form also indicated that a lift sheet may be used.A review of R124's Fall Event Details Form dated 10/15/2025 revealed the fall was documented as a witnessed fall. The report stated the resident was being bathed by a hospice CNA and flipped out of the bed while being turned on her side (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	during a sheet change. The form further indicated that prior to the fall, the resident was receiving a bath and the staff member was in the process of changing the bed linens.A review of R124's Hospital Summary dated 10/15/2025 revealed the chief complaint was documented as a fall. The summary stated the 91ˆyearˆold nonambulatory female presents to the ED from [NAME] Oaks Manor secondary to a witnessed fall. Patient is DNR on hospice care currently. According to staff, patient rolled out of bed while being bathed. There is concern for lower extremity injury at this time. Denies any head injury, loss of consciousness, nausea, or vomiting. Patient has severe dementia at baseline. Bilateral knee Xˆrays showed distal femur fractures bilaterally, while hip and pelvis Xˆrays were essentially negative. The resident remained neurovascularly intact. The case was discussed with the orthopedic surgeon, who recommended nonˆoperative outpatient treatment with bilateral knee immobilizers and followˆup in two weeks. Hospice nurses were present at the bedside, and precautions were discussed with them.A review of R124's Hospice Clinical Note Postˆ Fall, charted by the hospice nurse and dated 10/15/2025, revealed the hospice [Certified Nursing Assistant (CNA)] contacted the nurse at 6:14 AM, reporting she was very distraught. The CNA stated she had been providing morning care to R124 and, when she walked around the bed to loosen the sheets for a linen change, the resident began moving and rolled off the bed. The CNA reported she attempted to grab the resident to prevent the fall but was unable to hold her, and the resident fell to the floor. The hospice nurse notified the resident's son and began traveling to the facility. While en route, the nurse was informed that the resident was being sent to a local hospital for evaluation and Xˆrays due to crying out in pain when her legs were touched. The nurse attempted to notify the facility that Xˆrays could be completed onsite, but the resident had already been transported. The hospital is located one parking lot away from the facility. The hospice nurse met the resident in the emergency department. Xˆrays were taken, and the nurse requested 50 mg of Tramadol, which was part of the resident's routine medication regimen, to address pain. The physician reported that both femurs were fractured above the patella and stated the orthopedic surgeon would also review the Xˆrays. The physician noted the bones appeared twisted, but the hospice nurse and the resident's son confirmed the leg positioning was affected by a previous fracture that had not healed in a straight alignment. The note documented that, prior to this incident, R124 required only one staff member for assistance with ADLs; however, hospice and the facility agreed the care plan would be updated to reflect a twoˆperson assist for all ADLs except feeding. Hospice assigned two CNAs to the resident's care, and the facility nurse practitioner was asked to add an additional scheduled dose of Tramadol and an extra PRN dose to address increased pain during healing. The resident was provided bilateral leg immobilizers, which could be removed for bathing or if skin breakdown was noted. The hospital physician requested a twoˆweek orthopedic followˆup. The hospice nurse contacted the orthopedic office to determine whether Xˆrays completed at the facility and placed on a disc would be acceptable; the orthopedic office confirmed that Xˆrays must be provided on a disc for review. The hospice nurse ensured safe transport back to the facility and discussed potential careˆplan changes with facility leadership. The team agreed that the low airˆloss mattress, placed on the resident's bed the previous evening to reduce the risk of skin breakdown, may have contributed to the incident, as such mattresses have a [NAME] and less stable surface for providing care. This was a new surface for both the resident and staff. The hospice nurse documented the following changes to the resident's plan of care: 1. Change from a oneˆperson assist to a twoˆperson assist for all ADLs except feeding for both facility and hospice staff. 2.Addition of longer side rails, replacing individual halfˆrails. 3.Application of bilateral leg immobilizers for pain control and healing. 4.Temporary increase in scheduled pain medication. 5.Addition of an extra PRN painˆmedication dose for breakthrough pain.6.Increased nursing visits for the next two weeks, including three nursing visits and three weekly CNA visits performed by two CNAs, to provide additional monitoring and safety oversight. 7.Ensuring side rails are raised and the bed is in the lowest position when staff leave the room. 8.Hospice to order fall mats for placement beside the bed, pending facility approval.An interview conducted on (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	06/03/2026 at 12:52 p.m. with the resident's son and responsible party revealed he had no complaints regarding the facility and described it as a good facility. He stated the resident was on hospice services and was a DNR at the time of the incident. He reported that on 10/15/2025, the facility notified him that the resident had reportedly fallen and that both of her legs appeared to be injured. He stated he did not believe the resident fell but believed she was dropped by a hospice CNA during a bed bath and linen change. He explained the resident was bedbound, unable to get up, and declining due to multiple comorbidities and being in the final days of life. He stated the resident had previously been dropped at another facility and believed the injuries sustained at this facility were a reinjury of prior injuries. He reported he had no concerns with the quality of care at this facility and could not recall whether one or two staff members were required to provide care. He stated there were no surgical interventions related to the injuries and that the resident had soft casts applied to both legs.An attempt was made to contact CNA 1 on 06/03/2026 at 1:11 p.m. A detailed voicemail message was left requesting a return call.An interview on 06/03/2026 at 1:41 PM, CNA 2 reported she had been employed with the hospice agency for over one year and was familiar with the resident. She stated she provided care to the resident three times per week and that the resident was bedbound and required a oneˆperson assist at the time. She reported that on the morning of 10/15/2025, she was providing the resident's morning care. She stated she had turned the resident onto her left side and then walked around to the opposite side of the bed. She observed the resident beginning to move and attempted to grab her but was unable to hold onto her, and the resident fell behind the bed onto the floor. She stated she had no additional staff present in the room at the time. CNA 2 stated she immediately pressed the call light and notified the nurse. She reported that staff used a Hoyer lift to assist the resident from the floor and return her to bed after the nurse completed an assessment. She stated she contacted her supervisor, who met her at the hospital. She reported she had the resident on her side while attempting to change the bed linens when the fall occurred and noted the resident's bed was not positioned against the wall. She stated she was not aware that the resident had a new mattress. She reported that following the incident, the resident was changed to a twoˆperson assist for care. She confirmed she received an inˆservice related to lift use after the event.An Interview conducted on 06/04/26 at 12:25 PM, the Director of Nursing (DON) stated that reportable's are handled by herself and the Administrator. She confirmed she is familiar with the R124 and the circumstances surrounding the reportable incident from October 2025. The DON stated she does not recall exactly how she was notified of the event, only that it occurred on a weekday. She recalled being informed that the resident had experienced a fall from the bed during care and was being transferred to the hospital. stated that the day prior to the incident, an airˆreducing mattress had been placed on the resident's bed. She explained that the hospice nurse's assessment triggered the addition of the mattress, noting that this was a hospice intervention rather than a facilityˆinitiated change. Facility staff were aware of the mattress change; however, it was unclear whether the hospice company communicated this change to their CNA staff. She reported that the contracted hospice CNA was providing care at the time of the incident. The resident had been turned onto her side, and the CNA was removing the sheet from one side of the bed. DON stated that this may have shifted the resident's weight to the opposite side, contributing to the fall and resulting injuries. She described the resident as a routine CNAˆcare resident with consistent care patterns. She noted the mattress was similar to an air mattress in texture and movement. DON stated the resident sustained bilateral femur fractures. Based on hospital records, the resident reinjured a previous fracture originally sustained at another facility prior to admission to this facility. She confirmed that the witnessed fall on 10/15/2026 was the only fall the resident experienced during her stay at this facility. She reported that the resident required a total twoˆperson assist for transfers and repositioning. At the time of the fall, two staff members were not present in the room. Hospice staff came onsite the same day and provided inˆservice training to the CNA involved, as well as to all other hospice CNAs, as a precautionary measure. The resident was transferred to the hospital on [DATE] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and did not undergo surgical intervention. Knee immobilizers were applied. The resident was already on hospice care at the time, and the responsible party was notified of the event. DON stated the resident returned to the facility the same day.Attempts were made to contact LPN 5 (Licensed Practical Nurse) on 06/04/2026 at 1:27 p.m. and again at 1:57 p.m. via phone. Both attempts were unsuccessful. A detailed voicemail message was left requesting a return call.A phone interview with Hospice Registered Nurse (RN) on 06/04/2026 at 1:34 PM revealed she is the clinical operations manager, she's familiar with R124 and the incident that occurred on 10/15/2025. Hospice RN stated it was an unfortunate situation. Hospice RN states that per the documentation she has, the resident was a 1 person assist during that time. She has been a 1 person since admission to the facility. The decision at that time was based on the current status of the patient during that time of assessment. She wasn't a patient that required a 2 person assist. Prior to the fall on 10/15/2025, the hospice company ordered the a pressure reliving mattress, however once the mattress is ordered the company does not notify the staff once its installed, that's a communication that the facility staff should have communicated to the CNA. The Hospice RN confirmed she received the call from CNA4 and confirmed what was written in her clinical note. As far as the in-service, it was a verbal in-service. The RN states that the hospice staff were invited to care plan meeting by the son back in February 2025 and that was the only meeting hospice staff were in attendance for. Any changes or updates made after February 2025, such as resident becoming a 2 person assist instead of 1, the hospice staff were not made aware of by facility staff. When hospice aides arrive at the facility, they are to check in at the nurses station, and any type of communication, should be done at that time. An interview with the Facility Nurse Consultant on 06/04/2026 at 2:29 p.m. revealed that communication between the facility and hospice staff requires the facility nursing department to verbally communicate any updates to the resident's current plan of care to hospice staff, and hospice staff are likewise expected to verbally communicate updates to the facility.An interview with the Facility Administrator on 06/04/2026 at 3:17 p.m. revealed she was notified of the incident after the nurse who first received the report, and the reportable process was initiated at that time. She stated that, to the best of her knowledge, the hospice CNA who routinely provided care to the resident had been changing the bed linens when the resident slid off the mattress and the CNA was unable to catch her. She reported that the day prior to the incident, a pressureˆrelieving air mattress had been placed on the resident's bed, which may have contributed to the fall. She stated the resident was admitted to the facility already on hospice services at the request of the family, under a oneˆtime hospice contract. The Administrator stated that door tags identify the resident's transfer and repositioning status, and both hospice staff and facility staff are expected to review the door tag. She stated that hospice staff are required to report to the nurse's station upon arrival, and any communication regarding the resident's status should occur at that time. She reported that facility staff instructed hospice staff to check with the resident's son to determine whether he wished to continue care with the same CNA following the incident. She stated that any changes in transfer status are updated on the door tag, which serves as the reference point for all staff. The Administrator reported the resident was transported to the emergency department located next to the facility, did not undergo surgical intervention, and returned to the facility later the same day. Review of the facility's corrective actions, revealed the facility put forth due diligence in addressing the non-compliance, considering this citation at past non-compliance.

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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. Based on review of the facility policy, observations and interviews, the facility failed to ensure expired medications and uncontaminated medications were removed and not stored with current medications in use for residents in 2 of 5 med carts and 1 of 3 medication rooms.Findings Include: Review of the facility policy titled, Medication Storage In The Facility, revised September 21, 2022 revealed, Policy: Medications and biologics are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. 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 pharmacy, if a current order exists.During an observation on 06/04/2026 at 12:37 PM of medication cart 300C revealed, Medichoice Povidone- Iodine Prep Pad expired on 06/15/2025. Dermal Wound Cleanser First Aid Antiseptic spray with an expiration date of 07-2028 however, there was a black substance floating around in the bottle. An interview on 06/04/2026 with Licensed Practical Nurse (LPN)2 at approximately 01:40 PM revealed that the medications were confirmed to be expired and contaminated. During an observation on 06/04/2026 at 01:05 PM of medication cart 300A revealed, Dermal Wound Cleanser First Aid Antiseptic spray expired 09/2025. An interview on 06/04/26 with LPN1 at approximately 02:05PM revealed that the medications were confirmed to be expired. During an observation on 06/04/2026 at 01:10 PM of the 300 unit medication room revealed, Children's Acetaminophen 160mg per 5 ml Pain Reliever- Fever Reducer 4 fluid ounces floor stock that expired in October 2025. An interview on 06/04/2026 with LPN1 at approximately 02:05 PM revealed that the medications were confirmed to be expired. During an interview on 06/04/2026 at 01:15PM with the Director of Nursing revealed, I expect there to be no expired medications on the medication carts or in the medication rooms. The pharmacist does a monthly audit of the medication carts and the medication rooms. I cannot believe that he missed that.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of the facility policy, record reviews, and interviews, the facility failed to notify the ombudsman for (Resident (R)122')s discharge from the facility, for one of one residents reviewed for discharge. Findings include:Review of the facility policy titled Discharge Planning revised 2/19 documented, Transfer/Discharge to a Distinct certified unit /Facility: Notice of facility-initiated transfers and discharges are also sent to the local Ombudsman.Review of R122's Face Sheet revealed the facility admitted R122 on 02/20/26 with diagnoses including but not limited to; displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, and gastro-esophageal reflux disease without esophagitis.Review of R122's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 02/26/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R122 's cognition was intact.Review of R122's progress notes revealed the following:Nursing Progress Note - 03/17/26 at 3:56 PM: [R122] was discharge, I told his brother about his discharge and medications. The belongings paper was signed by his family member. He was discharge to go home and stay with his brother. Told the brother if they have any questions they are more than welcome to call. by Nursing.Social Services Progress Note - 03/18/26 at 11:02 AM: [R122] went home with his brother. He will be getting PT, OT, Nurse He went home last evening. by Social Services.During an interview on 06/03/26 at 1:21 PM the Social Services Director (SSD) reports that she and the Social Worker (SW) share the workload for the facility. The SSD reports that R122 was one of the residents on her caseload. SSD reports the discharge process for R122 involved contacting the Home Health agency for PT/OT/Nursing and securing equipment as needed, and documenting in the progress notes. SSD reports she did not send discharged information for R122 to the Ombudsman and has not been sending residents' discharged information to the Ombudsman. SSD states that going forward, she will send residents' discharge information to the ombudsman.During an interview on 06/04/26 at approximately 10:07 AM, the SSD confirmed again that she has not been contacting the ombudsman regarding resident discharges. During an interview on 06/04/26 at 10:16 AM, the Administrator reports her expectations is SS should contact the Ombudsman's office when residents are discharged from the facility. The Administrator acknowledged the SSD made her aware yesterday that they did not contact the Ombudsman office for R122 's 03/17/26 discharge from the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure Resident (R6)'s care plan was reviewed and revised to include catheter care related to the resident's indwelling catheter. This failure affected 1 of 3 residents reviewed for catheter care.Findings include:Review of the facility's policy titled RAI and Care Plan Process, revised 06/08/17, revealed that a comprehensive resident assessment and the development of the resident's plan of care shall be initiated on the day of admission and completed by representatives from Activities, Dietary, Nursing, the Restorative Nurse, Social Services, Therapies, and any other disciplines involved in the resident's care. The policy states that on admission day, the assessment and dataˆcollection process begins with all team members gathering resident information. The Business Office Manager/admission Coordinator initiates the electronic record by entering resident information into the computer. The admission Coordinator/Social Services enters the Entry Tracking Item Set upon admission or reˆadmission. The RAC then opens the electronic admission MDS by entering the reason for assessment into Section A0310 with signature and date, and by entering the assessment reference date into the system.Review of R6's Electronic Medical Record (EMR) Face Sheet revealed R6 was admitted to the facility on [DATE] at 2:32 PM with the following diagnoses: nontraumatic subarachnoid hemorrhage, vascular dementia, unsteadiness on feet, abnormalities of gait and mobility, and retention of urine, unspecified.Review of R6's admission Minimum Data Set (MDS) dated [DATE] revealed R6 was moderately impaired and scored 06 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. The assessment also indicated the presence of an indwelling catheter, coded under H0300. Urinary continence was not rated, as the resident had a catheter (indwelling or condom), urinary ostomy, or no urine output for the entire sevenˆday lookˆback period.Review of R6's active orders revealed the following: The resident had orders for the catheter bag to be changed as needed for leaking or clogging (PRN), and an additional order for the catheter bag to be changed every two weeks between 07:00 AM and 03:00 PM, initiated on 05/22/2026. There was an order to change the indwelling catheter as needed for clogging every shift (PRN). Another order directed that the indwelling catheter be changed monthly, specifying a #16 Fr Foley catheter with a 10 mL balloon, with instructions to change the catheter on the 20th of each month between 11:00 PM and 07:00 AM, effective 06/20/2026. Additional PRN orders included irrigating the indwelling catheter with 30 mL of normal saline as needed for clogging (PRN 1, PRN 2, PRN 3). The record also documented that the resident had an indwelling #16 Fr catheter with a 10 mL balloon related to urinary retention, with monitoring every shift (AM, PM, NOC). Nursing orders included providing daily catheter care by cleansing with a warm moist towelette once per day between 11:00 PM and 07:00 AM, starting 05/22/2026. Staff were also ordered to empty the catheter and document output at the end of each shift (AM 07:00 AM-03:00 PM, PM 03:00 PM-11:00 PM, NOC 11:00 PM-07:00 AM), effective 05/22/2026. An additional nursing order directed the use of a Foley 3ˆway StatLock, with special instructions to change the StatLock placement weekly on Mondays between 07:00 AM and 03:00 PM, alternating legs as tolerated.Review of R6's care plan revealed there was no problem, goal, approach, or discipline identified related to R6's indwelling catheter or catheter care.Observation on 06/02/2026 at 3:04 PM revealed R6 had an indwelling catheter in place. The catheter bag was covered with a privacy bag. The resident's husband, who was present in the room, reported that the resident was admitted with a catheter, had it removed a few days after admission, and had it reinserted in May 2026. No attempt was made to interview R6, as the resident was deemed unˆinterviewable.A followˆup observation on 06/03/2026 at 2:44 PM showed the catheter bag remained intact with the privacy bag in place and the resident was observed sleeping.An interview conducted on 06/03/2026 at 11:00 AM with Licensed Practical Nurse (LPN 1) revealed she was the resident's assigned nurse (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and was knowledgeable about the resident's catheter status. She stated the resident was admitted to the facility in March 2026 with an indwelling catheter. LPN 1 explained that the facility does not utilize a baseline care plan form and instead begins the care plan based on the assessment completed upon admission. LPN 1 reported there was an order dated 05/26/2026 from the Nurse Practitioner related to the catheter. LPN 1 further stated that a urinalysis was completed on 05/22/2026 due to the resident exhibiting symptoms consistent with a possible urinary tract infection (UTI). She reported that, based on her review of the progress notes, the resident was admitted from the hospital with an indwelling catheter, which was removed at some point during the stay and later reinserted. LPN 1 confirmed she did not see a problem, goal, or intervention in the resident's care plan addressing the resident's catheter status and stated that this should be included. She also reported that, to her knowledge, the resident did not currently have a UTI.An interview conducted on 06/04/2026 at 11:07 AM with the MDS Coordinator revealed he works full^time and has been employed at the facility for approximately five to six years. He stated that his partner, who typically completes the resident's MDS assessments, CAAs, and care plan updates, was currently out on leave. Based on his review of the physician orders and the resident's medical record, the MDS Coordinator confirmed that the resident does have an indwelling catheter. He also confirmed that the resident's care plan does not contain a problem, goal, or intervention addressing the resident's catheter status. The MDS Coordinator stated that upon admission, the facility does not use a baseline care plan; instead, the care plan is initiated at the time of admission, and based on the resident's records, the catheter^related information should have been reflected. He acknowledged this was an oversight and stated he would add the catheter^related problem and interventions to the care plan.An interview conducted on 06/04/2026 at 12:14 PM with the Director of Nursing (DON) revealed the resident was admitted with an indwelling catheter, had the catheter in place for three days, and then underwent a trial of voiding, which was successful at that time. The DON stated the catheter was reinserted on 05/22/2026. She reported that the facility holds morning meetings each day during which new orders are reviewed. She explained that upon admission, the MDS department conducts a review of the resident's information, including the 24^hour form for skilled residents, and that MDS staff have access to all documentation. The DON stated the care plan is reviewed during QAPI meetings; however, she acknowledged that interventions related to the resident's catheter were not being addressed. She reported that one of the MDS staff members had a medical issue and was out, leaving the department operating with only one person instead of the usual two. The DON stated that moving forward, the facility would conduct audits and develop a checklist to prevent similar oversights.An interview conducted on 06/04/2026 at 3:15 PM with the Facility Administrator revealed her expectation is that care plans are completed accurately and in a timely manner to reflect the resident's current care and status. She stated that the MDS staff member had been out on medical leave, and the resident's care plan may have been overlooked as a result.

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	425077	A. Building B. Wing	06/04/2026

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure effective coordination of care and communication with the contracted hospice provider for 1 of 1 residents (R)124) receiving hospice services. The facility did not ensure that hospice staff had accurate, upˆtoˆdate information necessary to safely provide care. These failures resulted in the hospice CNA providing care without knowledge of the newly installed pressureˆrelieving mattress and without updated information regarding the resident's assist level, contributing to a witnessed fall with injury. Findings Include:A review of R124's Face Sheet revealed the resident was admitted to the facility on [DATE] at 1:45 AM with diagnoses including, but not limited to, unspecified severe proteinˆcalorie malnutrition; osteoarthritis; other specified disorders of bone density and structure; unspecified fracture of the lower end of the right femur, subsequent encounter for closed fracture with routine healing; unspecified fracture of the lower end of the left femur, subsequent encounter for closed fracture with routine healing; and pathological fracture of the unspecified tibia and fibula, subsequent encounter for fracture with routine healing.A review of R124's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/14/2025 revealed a Brief Interview for Mental Status (BIMS) score of 04 out of 15, indicating the resident was severely cognitively impaired. Further review of the MDS showed the resident was dependent for all ADLs, including personal hygiene and toileting, and transfers were not attempted. In addition, the resident was coded with a prognosis of life expectancy less than six months, and Section O indicated the resident was receiving hospice services.A review of R124's care plan revealed a documented problem stating that the resident has a history of falls with major injuries and is at risk for reˆoccurrence related to muscle weakness, cognitive impairment, and the medication regimen secondary to hypertension, diabetes mellitus, vascular dementia, degenerative joint disease, and osteoporosis. The care plan approach included assisting the resident in completing safe transfers per the facility's safeˆhandling tool.A review of R124's Safe Resident Handling Data Collection Form dated 08/15/2025 revealed the resident required a total lift, which required two staff members to turn and reposition the resident in bed. The form also indicated that a lift sheet may be used.A review of R124's Fall Event Details Form dated 10/15/2025 revealed the fall was documented as a witnessed fall. The report stated the resident was being bathed by a hospice CNA and flipped out of the bed while being turned on her side during a sheet change. The form further indicated that prior to the fall, the resident was receiving a bath and the staff member was in the process of changing the bed linens.A review of R124's Hospital Summary dated 10/15/2025 revealed the chief complaint was documented as a fall. The summary stated the 91ˆyearˆold non ambulatory female presents to the ED from [NAME] Oaks Manor secondary to a witnessed fall. Patient is DNR on hospice care currently. According to staff, patient rolled out of bed while being bathed. There is concern for lower extremity injury at this time. Denies any head injury, loss of consciousness, nausea, or vomiting. Patient has severe dementia at baseline. Bilateral knee Xˆrays showed distal femur fractures bilaterally, while hip and pelvis Xˆrays were essentially negative. The resident remained neurovascularly intact. The case was discussed with the orthopedic surgeon, who recommended nonˆoperative outpatient treatment with bilateral knee immobilizers and followˆup in two weeks. Hospice nurses were present at the bedside, and precautions were discussed with them.A review of R124's Hospice Clinical Note Postˆ Fall, charted by the hospice nurse and dated 10/15/2025, revealed the hospice CNA contacted the nurse at 6:14 AM, reporting she was very distraught. The CNA stated she had been providing morning care to R124 and, when she walked around the bed to loosen the sheets for a linen change, the resident began moving and rolled off the bed. The CNA reported she attempted to grab the resident to prevent the fall but was unable to hold her, and the resident fell to the floor. While enroute, the nurse was informed that the resident was being sent to a local hospital (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for evaluation and Xˆrays due to crying out in pain when her legs were touched. The physician reported that both femurs were fractured above the patella and stated the orthopedic surgeon would also review the Xˆrays.The note documented that, prior to this incident, R124 required only one staff member for assistance with ADLs; however, hospice and the facility agreed the care plan would be updated to reflect a twoˆperson assist for all ADLs except feeding. Hospice assigned two CNAs to the resident's care, and the facility nurse practitioner was asked to add an additional scheduled dose of Tramadol and an extra PRN dose to address increased pain during healing. The team agreed that the low airˆloss mattress, placed on the resident's bed the previous evening to reduce the risk of skin breakdown, may have contributed to the incident, as such mattresses have a [NAME] and less stable surface for providing care. This was a new surface for both the resident and staff. The hospice nurse documented the following changes to the resident's plan of care: 1. Change from a oneˆperson assist to a twoˆperson assist for all ADLs except feeding for both facility and hospice staff. 2.Addition of longer side rails, replacing individual halfˆrails. 3.Application of bilateral leg immobilizers for pain control and healing. 4.Temporary increase in scheduled pain medication. 5.Addition of an extra PRN painˆmedication dose for breakthrough pain.6.Increased nursing visits for the next two weeks, including three nursing visits and three weekly CNA visits performed by two CNAs, to provide additional monitoring and safety oversight. 7.Ensuring side rails are raised and the bed is in the lowest position when staff leave the room. 8.Hospice to order fall mats for placement beside the bed, pending facility approval.An interview conducted on 06/03/2026 at 12:52 PM with the resident's son and responsible party revealed that on 10/15/2025, the facility notified him that the resident had reportedly fallen and that both of her legs appeared to be injured. He stated he did not believe the resident fell but believed she was dropped by a hospice CNA during a bed bath and linen change. He explained the resident was bedbound, unable to get up, and declining due to multiple comorbidities and being in the final days of life. He reported he had no concerns with the quality of care at this facility and could not recall whether one or two staff members were required to provide care. An interview on 06/03/2026 at 1:41 PM from CNA 2, reported she had been employed with the hospice agency for over one year and was familiar with the resident. She stated she provided care to the resident three times per week and that the resident was bedbound and required a oneˆperson assist at the time. She reported that on the morning of 10/15/2025, she was providing the resident's morning care. She stated she had turned the resident onto her left side and then walked around to the opposite side of the bed. She observed the resident beginning to move and attempted to grab her but was unable to hold onto her, and the resident fell behind the bed onto the floor. She stated she had no additional staff present in the room at the time. CNA 2 stated she immediately pressed the call light and notified the nurse. She reported that staff used a Hoyer lift to assist the resident from the floor and return her to bed after the nurse completed an assessment. She stated she contacted her supervisor, who met her at the hospital. She reported she had the resident on her side while attempting to change the bed linens when the fall occurred and noted the resident's bed was not positioned against the wall. She stated she was not aware that the resident had a new mattress. She reported that following the incident, the resident was changed to a twoˆperson assist for care. She confirmed she received an inˆservice related to lift use after the event.06/04/26 at 12:25 p.m. - Interview with RN, Director of Nursing (DON) who stated that reportable's are handled by herself and the Administrator. She confirmed she is familiar with the R124 and the circumstances surrounding the reportable incident from October 2025. The DON stated she does not recall exactly how she was notified of the event, only that it occurred on a weekday. She recalled being informed that the resident had experienced a fall from the bed during care and was being transferred to the hospital. stated that the day prior to the incident, an airˆreducing mattress had been placed on the resident's bed. She explained that the hospice nurse's assessment triggered the addition of the mattress, noting that this was a hospice intervention rather than a facilityˆinitiated change. Facility staff were aware of the mattress change; however, it was unclear whether the hospice company communicated this change to (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their CNA staff. She reported that the contracted hospice CNA was providing care at the time of the incident. The resident had been turned onto her side, and the CNA was removing the sheet from one side of the bed. DON stated that this may have shifted the resident's weight to the opposite side, contributing to the fall and resulting injuries. She described the resident as a routine CNAˆcare resident with consistent care patterns. She noted the mattress was similar to an air mattress in texture and movement. DON stated the resident sustained bilateral femur fractures. She reported that the resident required a total twoˆperson assist for transfers and repositioning. At the time of the fall, two staff members were not present in the room. Hospice staff came onsite the same day and provided inˆservice training to the CNA involved, as well as to all other hospice CNAs, as a precautionary measure. The resident was transferred to the hospital on [DATE] and did not undergo surgical intervention. Knee immobilizers were applied. The resident was already on hospice care at the time, and the responsible party was notified of the event. DON stated the resident returned to the facility the same day.A phone interview with Hospice Registered Nurse (RN) on 06/04/2026 at 1:34 PM revealed she is the clinical operations manager, she's familiar with R124 and the incident that occurred on 10/15/2025. Hospice RN stated it was an unfortunate situation. Hospice RN states that per the documentation she has, the resident was a 1 person assist during that time. She has been a 1 person since admission to the facility. The decision at that time was based on the current status of the patient during that time of assessment. She wasn't a patient that required a 2 person assist. Prior to the fall on 10/15/2025, the hospice company ordered the a pressure reliving mattress, however once the mattress is ordered the company does not notify the staff once its installed, that's a communication that the facility staff should have communicated to the CNA. The Hospice RN confirmed she received the call from CNA4 and confirmed what was written in her clinical note. As far as the in-service, it was a verbal in-service. The RN states that the hospice staff were invited to care plan meeting by the son back in February 2025 and that was the only meeting hospice staff were in attendance for. Any changes or updates made after February 2025, such as resident becoming a 2 person assist instead of 1, the hospice staff were not made aware of by facility staff. When hospice aides arrive at the facility, they are to check in at the nurses station, and any type of communication, should be done at that time. An interview with the Facility Nurse Consultant on 06/04/2026 at 2:29 p.m. revealed that communication between the facility and hospice staff requires the facility nursing department to verbally communicate any updates to the resident's current plan of care to hospice staff, and hospice staff are likewise expected to verbally communicate updates to the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility policy and procedures, observations, record reviews and interviews, the facility failed to ensure proper infection control practices as it relates to a foley bag remaining off of the floor for Resident (R)112, 1 of 3 residents observed for catheters. Findings Include: Review of the facility procedure titled, Closed Urinary Drainage, revised September 21, 22 revealed: Procedure: 3. Attach drainage bag to bed frame, below level of resident's bladder, not touching the floor; cover with a dignity bag (unless fig leaf bag used).Review of R112's Face Sheet revealed the facility admitted R112 on 11/17/25 with diagnoses including but not limited to, Vascular dementia, moderate, with psychotic disturbance (Admission), Acute embolism and thrombosis of unspecified deep veins of lower extremity, Neuromuscular dysfunction of bladder, and hesitancy of micturition.Review of R112's physician orders revealed Catheter Dx: Patient has an indwelling catheter #16 FR 5 ml bulb related to urinary retention.An observation on 06/02/26 at 11:49 AM of R112 revealed resident lying in bed watching television. Bed was in low position. Catheter bag noted resting on floor. During an observation on 06/02/26 01:30 PM revealed resident lying in bed watching television. Bed was in low position. Catheter bag noted resting on floor. During an interview on 06/02/26 at 04:10 PM Certified Nursing Assistant (CNA)3 confirmed that resident's catheter bag was resting on the floor. On 06/04/26 at 08:30 AM an interview with the Director of Nursing (DON) revealed, staff should always place the foley catheter bag on the bed frame below the bladder and the tubing should be placed across the resident's leg. The catheter bag should never be on the floor.On 06/04/26 at 02:05 PM an interview with Licensed Practical Nurse (LPN)4 revealed, the DON just gave us an in-service. The foley Catheter bags should be hooked to the bedframe off of the floor. The tubing should be draped over the resident's legs.