

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER White Oak Manor - York		STREET ADDRESS, CITY, STATE, ZIP CODE 111 South Congress Street York, SC 29745	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, staff interview, and review of facility policy, the facility failed to provide supervision consistent with the assessed needs of one of one resident reviewed for accidents (Resident (R) 111). Specifically, the facility failed to supervise R111 by leaving her unattended in the dayroom. This failure resulted in an unwitnessed fall and a right distal humerus fracture requiring emergency department evaluation and immobilization. Findings include: Record review of the facility's Fall Management Policy revealed newly admitted residents were to be evaluated for fall risk based on fall history, physical and cognitive status, symptoms, and medication regimen. The policy further revealed residents were to be placed in the Fall Management Program when they had fallen within the previous thirty (30) days, were physically or cognitively unable to request assistance, were non-ambulatory and attempted to get out of bed or a chair without assistance, or had individual factors compounding fall risk. The policy further directed staff to observe and monitor residents more closely, implement appropriate interventions based on identified risk factors, complete a fall investigation following each fall, and implement interventions to reduce the risk of future falls. R111 was admitted to the facility on [DATE] for short-term rehabilitation following hospitalization for a left intertrochanteric femur fracture sustained after a fall. Relevant diagnoses included dementia, history of cerebrovascular accident, repeated falls, hypertensive heart disease, congestive heart failure, coronary artery disease, debility, and insomnia. Record review revealed R111 was nonverbal at baseline and communicated by nodding yes and no. Record review of the admission Morse Fall Scale assessment completed on 04/29/26 revealed R111 scored 65, identifying the resident to be in the High Risk for Falls category. The assessment identified the resident as having a history of falling, multiple diagnoses, the need for staff assistance with mobility, and documented the resident overestimated or forgot personal limitations. Record review of the Physical Therapy Evaluation dated 04/29/26 revealed R111 was referred for decline in strength, endurance, balance, mobility, and independence following the recent left femur fracture. The therapist documented fall risk precautions, severe dementia, nonverbal status, impaired safety awareness, bilateral lower extremity weakness, poor sitting balance, poor standing balance, and dependence for bed mobility, transfers, and ambulation. The therapist documented R111 remained at increased risk for falls without skilled intervention. Record review of the Occupational Therapy Evaluation dated 04/29/26 revealed R111 demonstrated decreased strength, decreased functional mobility, impaired balance, impaired safety awareness, and decreased participation in activities of daily living. R111 required dependent assistance with toileting, hygiene, bathing, lower body dressing, toilet transfers, shower transfers, and mobility. The therapist documented R111 remained at increased risk for falls. Record review of the Physical Therapy Treatment Notes dated 04/30/26 and 05/07/26 revealed R111 continued to require extensive assistance for transfers and mobility. On 04/30/26, R111 required maximum assistance of two staff for bed mobility and therapeutic activities and moderate assistance of two staff for sit-to-stand activities. On 05/07/26, the therapist documented R111 remained dependent for bed mobility, transfers, and ambulation, became agitated during treatment, (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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(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	refused further participation, and demonstrated no improvement in functional mobility prior to the fall. Record review of the Care Plan initiated on 04/30/26 revealed interventions including referral to Physical Therapy, adaptive devices as needed, environmental safety monitoring, safety instruction, participation in the Fall Management Program, ensuring the call light and frequently used items were within reach, and assessment of contributing factors and fall patterns. Record review of Certified Nurse Aide (CNA) documentation dated 05/09/26 revealed R111 required dependent assistance for bed mobility, sit-to-stand, chair transfers, toilet transfers, ambulation, toileting hygiene, and bathing. Documentation further revealed R111 was incontinent of bowel and bladder. Record review revealed that on 05/09/26 at approximately 11:04 AM, R111 was found sitting upright on the floor against the wheelchair in the dayroom following an unwitnessed fall. Nursing documentation described the resident's right arm as twisted backward at the elbow. R111 nodded yes when asked if the arm hurt. Emergency Medical Services were activated, the Responsible Party was notified, and R111 was transferred to the emergency department. Record review of emergency department records dated 05/09/26 revealed R111 sustained a closed fracture of the right distal humerus. Radiographic studies included the right humerus, right forearm, chest, and pelvis. R111 was discharged the same day with the right upper extremity immobilized in a sling and instructions to follow up with orthopedic surgery within three to five days. Record review revealed R111 returned to the facility on [DATE]. New orders included Acetaminophen (an analgesic medication) for scheduled pain management, continuation of head trauma protocol, and orthopedic follow-up. Subsequent nursing documentation revealed R111 remained in a sling following the injury. An observation on 07/02/26 at approximately 10:00 AM, revealed the dayroom where R111 sustained the unwitnessed fall was located at the end of the 300 Hall, separate from the nurses' station. The dayroom was an enclosed room with two doorways providing visibility into the room. Due to the location and enclosed design of the dayroom, residents seated within the room were not within the direct line of sight of staff located at the nurses' station. An interview on 07/02/26 at approximately 10:15 AM, with Restorative Aide (RA) 1 revealed she provided R111 with a shower, dressed the resident, and placed R111 in the dayroom because she had been told the resident ate better when out of bed. RA1 stated she left R111 in the dayroom with other residents present but no staff while providing care to another resident. Upon returning to the dayroom, RA1 found R111 on the floor. RA1 stated another resident present in the room reported R111 had kept trying to get up. Record review of provider documentation dated 05/09/26 revealed staff reported R111 had a history of attempting to stand unassisted. Record review of the facility's post-fall quality assessment dated [DATE] revealed R111 was found sitting upright on the floor against the wheelchair following an unwitnessed fall. The investigation recommended implementation of non-skid socks, close supervision, and toileting every two (2) hours. The investigation did not identify a definitive mechanism for the fall, document why R111 was found on the floor, or explain why the supervision interventions implemented after the fall had not been implemented before the incident despite the resident's documented fall risk. Record review further revealed the Care Plan was revised following the fall to include placement of a fall mat and maintaining R111 in view of staff when out of bed. An interview with Director of Nursing (DON) on 07/02/26 at approximately 10:00 AM, revealed the facility revised R111's Care Plan following the fall to include maintaining the resident in view of staff while out of bed. The DON stated the intervention was added because the facility needed a new intervention following the fall and maintaining the resident in view of staff seemed appropriate. When asked why the intervention had not been implemented before the fall despite R111's documented high fall risk, severe dementia, impaired safety awareness, dependence for mobility, and recent left intertrochanteric femur fracture, DON stated she could not explain why the intervention had not been implemented earlier.		