STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425128	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Charleston	9285 Medical Plaza Dr Charleston, SC 29406

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 Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51682 Based on facility policy review, resident record review, facility document review and staff interviews, the facility failed to ensure staff adhered to a resident ' s individualized transfer plan as recommended by Physical Therapy for 1 of 3 residents Resident (R)4 reviewed for accidents. Specifically, on 05/06/25, Licensed Practical Nurse (LPN) 1 transferred R4 without using the required sit-to-stand lift. As a result of this improper transfer, R4 fell and sustained a fractured arm, necessitating surgical intervention. Findings include: Review of an undated facility policy titled Safe Resident Handling Program revealed, Purpose: To provide residents with the safe assistance of mechanical lifts as indicated by their condition; to eliminate unnecessary manual repositioning and lifting by employees. Policy: 1. Each resident will be assessed for the need for mechanical list assistance, the type of mechanical lift indicated, the number of staff needed to use the lift, and the appropriate size sling. Review of an undated untitled facility document revealed, 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. Further review revealed, CLINICAL PRACTICE, RISK FACTORS, OTHER, Falls may occur while residents are being cared for by staff during transfers, and while lifting or using mechanical lift devices. Review of R4's Face Sheet indicated the facility admitted R4 on 10/02/23 with diagnoses that including but not limited to: age-related osteoporosis without pathological fracture, muscle weakness, other reduced mobility, unsteadiness on feet, abnormal posture, dementia, restless leg syndrome, macular degeneration, functional quadriplegia, and primary osteoporosis of the right shoulder. Review of R4's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/10/25, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicated the R4 was cognitively intact. Further review noted, R4 was dependent on staff for going from a sitting position to standing and for chair/bed-to chair transfers. Review of R4's Care Plan initiated on 10/20/23 revealed the following: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425128	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Charleston	9285 Medical Plaza Dr Charleston, SC 29406

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 Note: The nursing home is disputing this citation.	1. R4 was at risk for recurrent fractures due to osteoporosis and had interventions to monitor the placement of the resident's extremities during transfers (initiated 07/17/24) and assist with transfers per the Safe Handling Tool Form. 2. R4 required various levels of assistance with activities of daily living (ADLs) due to osteoarthritis of the right shoulder, glaucoma, weakness, and macular degeneration. Interventions directed staff to assist with all ADL care tasks for completion (initiated 10/20/23). 3. R4 as at risk for recurrent falls related to impaired mobility and weakness. Interventions directed staff to transfer the resident per safe handling tool (initiated 05/07/25). Review of R4's Physical Therapy [PT] Discharge Summary, dated 07/04/24, revealed discharge recommendations included to use a sit-to-stand lift for transfers with nursing staff. Review of R4's Progress Note dated 05/06/25 electronically signed by Nurse Practitioner (NP)9, revealed she was called by nursing staff emergently to examine R4. The note indicated that upon evaluation, R4's arm appeared to be internally rotated at the right shoulder joint. The note indicated the R4's shoulder ball joint did not appear to be at the clavicle joint, and although it could not be felt by the NP9 as a fracture, the resident was sensitive to touch. Per the note, 911 was called and Emergency Medical Services (EMS) personnel transported the resident to the emergency room (ER). Review of an Event Report dated 05/06/25 and created by LPN1, indicated that R4 had a fall with injury. The report indicated that R4 exhibited or complained of pain to their right arm related to the fall, rating their pain at a 3, on a scale of 0-10, with 10 being the worst possible pain. The report indicated that at 12:10 PM the resident had a fall into their recliner when transferring from their wheelchair to the recliner. The report indicated the resident was sent to the hospital with complaints of right arm pain. Review of R4's Hospitalist History Physical dated 05/06/25 indicated R4 arrived at the ER following a transfer from bed to wheelchair and developed excruciating pain. The record indicated that while in the ER, R4 was found to have a dislocation and an acute fracture of the proximal (situated close to the center of the body or to the point of attachment of a limb) humeral (referred as the humerus, the largest and only bone in the upper arm) diaphysis (in the shaft) near the distal (situated away from the center of the body or from the point of attachment) tip of the humeral component (used to replace the humeral head during a total shoulder arthroplasty) of the resident's prior shoulder arthroplasty (a surgical procedure that restored the function of a joint by replacing, remodeling, or realigning the articular surface of a musculoskeletal joint). The record indicated R4 had an open reduction internal fixation (ORIF, a type of surgery used to stabilize and heal a broken bone) on 05/14/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425128	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Charleston	9285 Medical Plaza Dr Charleston, SC 29406

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 Note: The nursing home is disputing this citation.	Review of a Confidential Occurrence Statement or Interview signed by LPN1 indicated that on 05/06/25, R4 was in the hallway crying, so LPN1 went to see what was wrong. The statement indicated that R4 had complaints of pain in their lower left leg, to which LPN1 applied ordered pain-relieving cream. LPN1 sat with the resident and asked the resident why they did not sit in their recliner. R4 voiced that the recliner was not working. Per the statement, LPN1 plugged the recliner's power cord into an outlet, and R4 propelled herself from her wheelchair to the recliner. LPN1 thought R4 was reaching to get into the recliner, so LPN1 attempted to assist the resident with transferring to the recliner by grabbing the back of the resident's pants. R4's legs began to buckle like they were going to fall, so LPN1 grabbed R4 with both hands on the resident's hips to keep the resident from falling while she yelled for assistance. Certified Nurse Aide (CNA)2 entered the room and assisted with completing the transfer to the recliner. After R4 was in their recliner, LPN 1 and CNA2 noticed the resident's arm was injured. Per the statement, LPN 1 left CNA 2 with the resident and got a supervisor. Review of a Confidential Occurrence Statement or Interview signed by CNA2 indicated that on 05/06/25 at approximately 12:30 PM, she was at a linen closet when she heard a noise that sounded like a resident calling out, and she asked nearby staff if they had heard the sound and from what direction the sound was coming. The statement indicated that as CNA2 approached R4's room, she heard a nurse calling for assistance. Upon entering R4's room, she observed the resident seated on the edge of the recliner with the LPN1 positioned on the resident's left, appearing distressed. CNA2 then instructed the LPN1 to get additional help and proceeded to assist the resident back into the recliner. The statement indicated that upon observation, CNA2 noticed the resident's right arm appeared deformed. Review of a facility document titled, Review Discussion Form dated 05/09/25, indicated that an Educational/Counseling/Warning Notice was provided to LPN1. The document revealed that on 05/06/25, [LPN1] did not use a lift to transfer a resident to a chair. This resulted in a fall into the recliner resulting in a fractured arm to the resident. This is a final warning for [LPN 1]. She must check the outside of the door before assisting a resident with transfer. The document was signed by the Director of Nursing (DON) and indicated that the document was sent to LPN1 via email. During an interview on 05/20/25 at 1:32 PM, the Therapy Director stated she was familiar with R4 and recalled that the resident required one person to assist with transfers awhile back but had a decline, so they changed it to requiring two people to assist with transfers. The Therapy Director stated that then, sometime during the previous year, it was changed to indicate the resident required a sit-to-stand lift, but she did not recall the exact date. During an interview on 05/20/25 at 3:23 PM, CNA2 stated she was in the hallway near the linen cart on when she heard someone yelling. CNA2 stated she initially could not identify where the voices were coming from; however, as she approached R4's room, she saw the resident sitting sideways in the recliner on their right side, and R4's lower body barely in the chair, with their buttocks almost sliding off the chair. She stated the nurse asked her to come stay with the resident while she contacted the doctor. CNA2 stated she thought the resident was going to come out of the chair if she did not get the resident repositioned but realized there was no place for her or the nurse to grab the resident in order to move the resident more safely in the chair, so she stayed with the resident until the nurse returned, to ensure the resident did not further slip off the chair to the floor. She stated she could immediately tell something was wrong with the resident's arm by the way it was placed, and stated the R4's arm was kind of limp and flaccid. She stated R4 was yelling they were afraid they were going to fall out of the chair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425128	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Charleston	9285 Medical Plaza Dr Charleston, SC 29406

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 Note: The nursing home is disputing this citation.	During an interview on 05/21/25 at 11:00 AM, LPN1 stated she had been taught that the resident's transfer status was listed on the outside of the resident's room door, or they could ask a nurse aide. LPN1 stated that on 05/06/25, R4 was observed upset and crying in the hallway. She stated that when she approached the resident, R4 complained of pain to their lower extremities, so she applied ordered pain relief cream to the resident's lower extremities, then participated in an art activity with the resident. LPN1 stated she asked R4 why the resident never used their recliner. LPN1 stated that she plugged the recliner's cord in to an outlet and attached a battery cord and it then worked. She stated R4 became excited and propelled their wheelchair to the recliner and reached out to touch the recliner. LPN1 stated she thought the resident wanted in the recliner, so she approached the resident and grabbed the back of the resident's pants and tried to assist the resident to their recliner. She stated that during the transfer, the resident's legs buckled, and LPN1 did her best to get the resident into the recliner, but the resident's buttocks did not fully land on the recliner. LPN1 stated the resident landed on their arm in the recliner. She stated she noticed the resident's shoulder had a large, raised area, and the arm appeared slightly flaccid. LPN1 stated she left an aide with the resident while she notified her supervisor and the medical provider, who was in the building at that time. She stated that the resident was sent to the ER after the provider thought the resident's shoulder was dislocated. She stated that she was aware the resident required a sit-to-stand lift for transfers, but she forgot in the moment. She stated she should have gotten assistance. During an interview on 05/21/25 at 2:55 PM, the Medical Director (MD) stated NP9 evaluated R4 on the date the injury occurred (05/06/25). She stated the nurse should have sought assistance from other staff members and used a sit-to-stand lift to transfer R4. She stated that with the resident's comorbidities, R4 was at very high risk for falls if the proper lifting technique was not utilized. During an interview on 05/21/25 at 3:41 PM, NP9 stated she evaluated R4 on 05/06/25. She stated that when she arrived at the resident's room, R4's right arm was observed to be internally rotated, and as she felt down the arm in an attempt to assess for a fracture. She stated that she thought the resident's shoulder was dislocated. NP9 stated that not using the correct transfer placed R4 at higher risk injuries from falls. During an interview on 05/21/25 at 4:20 PM, the DON stated she completed the investigation for R4's fall with injury. She stated that R4 required the use of a sit-to-stand lift for transfers. She stated she discovered LPN1 transferred R4 to the recliner without the use of a sit-to-stand lift and by herself, and the resident landed on their right arm when the resident reached the chair. She stated the nurse had been trained on how to identify the proper transfer status, which was posted on the outside of the resident's door, and the nurse should have transferred the resident with a sit-to-stand lift.