STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425131	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks Post Acute	151 Lovely Drive Orangeburg, SC 29115

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety in 1 of 1 Kitchen, 1 of 3 Unit Nourishment Rooms, and 1 of 1 Medication Rooms.Review of the facility policy titled Food Receiving and Storage last revised in July 2014 revealed, Foods shall be received and stored in a manner that complies with safe food handling practices. Food Services, or other designated staff, will maintain clean food storage areas at all times. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. Refrigerated foods must be stored below 41F unless otherwise specified by law. Refrigerated foods will be stored in such a way that promoted adequate air circulation around food storage containers. Functioning of the refrigeration and food temperatures will be monitored at designated intervals thought the day by the Food Service Manager or designee and documented according to the state-specific requirements. Food items and snacks kept on the nursing units must be maintained, all food items to be kept below 41F must be placed in the refrigerator located at the nurses' station and labeled with a use by' date. All foods belonging to residents must be labeled with the resident's name, the item and the use by date. Other opened containers must be dated and sealed or covered during storage.Review of the facility policy titled Food Preparation and Service last revised in November 2022 revealed, Food and nutrition service employee prepare, distribute and serve food in a manner that complies with safe food handling practices. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.Review of the facility policy titled Foods Brought by Family/Visitors last revised in March 2022 revealed, Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs or residents brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility prepared food. Perishable foods are stored in re-sealable container with tightly fitted lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. During an observation and interview on 01/11/26 at 10:29 AM, revealed Kitchen Staff (KS)1 in the kitchen without a hairnet, KS1 stated that they recently returned to the kitchen after a break. KS1 further stated that they came through the back door of the facility and the hairnets are on the front door near the hallway entrance of the facility. Observation of the back door of the kitchen revealed no area for hairnets. KS1 finally stated that staff are required to have a hairnet on at all times in the kitchen. During an observation on 01/11/26 at 10:32 AM, in the Dry Storage Room of the Main Kitchen revealed the following food items not labeled/stored appropriately:A plastic grocery bag with 2 packs of Hazelnut Coffee with an expiration date of December 2025; during interview with KS1 they stated that they were unsure why this item was still in the grocery bag and why this item was not discarded prior to it's expiration date. 1 box of thickened liquids not dated when received.1 opened bag of Bread Crumbs in a plastic storage container with a use-by date on the lid dated for 10/19/25.During an observation and interview on 01/11/26 of the (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Riverside Unit Medication Room revealed two Pimento Cheese Sandwiches wrapped in plastic wrap on a snack tray at room temperature. Licensed Practical Nurse (LPN)1 revealed that this food item should have been refrigerated. During an observation on 01/12/26 of the Nourishment Room for Riverside and [NAME] Units revealed a personal food item (unable to determine due to frost) in the freezer area of the refrigerator in a tupperware container with the resident's last name (R33) written on the lid with no item description or use-by date. Further observation of the refrigerator revealed the door not adequately sealing, at time of observation there was no thermometer to determine temperature of refrigerator. Multiple food items were observed in the refrigerator.Review of the Electronic Medical Record (EMR) revealed R33 was discharged from the facility to the hospital on [DATE]. During an interview with Dietary Director (DD)2 on 01/13/26 at 11:50 AM, the DD2 stated Kitchen staff are required to wear hairnets when they enter the kitchen, if a hairnet is not available by the back-door then I would expect my staff to come around to the main door and get a hairnet and then enter the kitchen. All food items should labeled and dated when received and when to use by. During an observation and interview on 01/13/26 at 4:15 PM, LPN5 stated, regarding the Nourishment Room for Riverside and [NAME] Units of the facility, the refrigerator did not have a thermometer because it is out of order due to the refrigerator not adequately sealing, during time observation there were approximately 8 nutritional supplement drinks in the refrigerator, LPN5 discarded items at time of observation and stated that no food items should have been in the refrigerator. During an interview with DD1 on 01/13/26 at 5:08 PM, revealed Nursing staff are responsible for ensuring the nourishment room refrigerators are maintained and food items are being labeled/dated and discarded in a timely manner. DD1 further stated that the facility will be replacing the refrigerator in the Nourishment Room because it is not adequately sealing to ensure food items are being maintained at the correct temperature and food items should have not been in the refrigerator due to this reason.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, record review, and interview, the facility failed to maintain a clean, homelike environment for Residents (R)57, R71, and R95 for 2 of 3 units observed.Findings include: Review of the facility policy titled Resident's Rights revealed, Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. The rights include the resident's right to: a. A dignified existence . Review of the facility policy titled Cleaning and Disinfecting Residents' Rooms with a revision date of August 2013 revealed, General Guidelines: 1. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 2. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. During multiple observations on 01/11/26 and 01/12/26, a cart made of white PVC pipes was noted at the entrance leading behind the nursing station on the 400 Riverside Unit. This cart had dried brown liquid, crumbs, and dust on the bottom shelf. Further observation revealed a Hoyer lift in the alcove of the hallway where rooms 420-438 were located had dried debris and dust on the base and in the crevices. During an interview with the Lead Housekeeper on 01/13/26 at 9:15 AM, she revealed, The PVC pipe cart you are talking about on the Riverside Unit is an old snack cart. It shouldn't even be there, but yes, it should be cleaned by someone. I know maintenance does power wash equipment regularly, but I'm not sure how often. I want to say monthly, but it could be quarterly. During an interview with the Maintenance Director on 01/13/26 at 9:39 AM, he revealed, We don't have a set schedule for cleaning the equipment, such as Hoyer lifts. We try to do it quarterly. We try to do the residents' wheelchairs at the same time. During an interview with DON on 01/13/26 at 4:45 PM, she revealed, My expectation is that all staff, nursing and housekeeping, work together to keep the resident's rooms clean. If they see something, they should pick it up. It's everyone's responsibility. During an observation of room [ROOM NUMBER] on 01/11/26 at 12:25 PM, revealed a strong odor of urine and feces in room. The resident asked that I look in her closet. There were four used briefs noted on the floor of resident's closet. There was also a dirty hospital gown, and an empty ginger ale can on the floor of resident's closet. The Resident also stated that the wheel on her wheelchair was tied on with string. Further observation revealed that the left wheel on resident's wheelchair is held in place with zip ties, string and cloth. During an observation of room [ROOM NUMBER] on 01/11/26 at 2:30 PM revealed the closet in the same condition as earlier in the day. The left wheel on the resident's wheelchair continued to be held in place with zip ties, string and cloth. During an observation of room [ROOM NUMBER] on 01/12/26 at 9:54 AM revealed the closet in the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	same conditions as the previous day. The left wheel on resident's wheelchair continued to be held in place with zip ties, string and cloth. During an interview on 01/12/26 at 12:04 PM Resident (R)71 revealed the closet had soiled briefs on the floor, as well as a soiled gown and an empty ginger ale can for four days. R71 revealed that the left wheel on her wheelchair had been held in place with zip ties, string and cloth for months. During an interview on 01/13/26 at 9:15 AM, the Lead Housekeeper stated, We don't have housekeepers during night shift, so when the day shift comes in, they are playing catch up from the night before. The barrier thing you are talking about on the Riverside unit is an old snack cart. It shouldn't even be there, but yes, it should be cleaned by someone. I know maintenance does power wash equipment regularly, but I'm not sure how often. I want to say monthly, but it could be quarterly. During an interview with the Maintenance Director (MD) on 01/13/26 at approximately 12:04 PM revealed that he was not aware of any maintenance issues in room [ROOM NUMBER]. The MD revealed that R71 is a difficult resident. The MD confirmed that he was not aware that there was a problem with a loose left wheel on the resident's wheelchair in room [ROOM NUMBER] and he would get it fixed today. During an observation and interview of room [ROOM NUMBER] on 01/11/26 at 2:45 PM, revealed that the cover for the overhead light was off and the cover was noted leaning up against the wall in the resident's room. R57 revealed that a couple of weeks ago the cover on the overhead light came off. R57 revealed that she is glad it was not the light directly above her bed or it would have hit her and possibly injured her. During an observation of room [ROOM NUMBER] on 01/12/26 at 10:30 AM revealed the overhead light cover continued to be leaning against the wall. During an observation of room [ROOM NUMBER] on 01/13/26 at 9:00 AM revealed the overhead light cover continued to be leaning against the wall. During an interview with the MD on 01/13/26 at 8:51 AM revealed that he was not aware of any maintenance issues in room [ROOM NUMBER]. He confirmed that the facility has a QR code system to submit work orders. He further verified that there is no work order in the system right now for that room. The MD revealed that every nurse's station has a QR code posted and every manager has a QR code. They can scan the code and put in a work request. He further revealed that eventually, every resident room will have its own QR code. He confirmed that he was not aware that the cover fell from the overhead light in room [ROOM NUMBER] and he will get it fixed today. He just hired an assistant, and she will have a checklist for things like that. He revealed the assistant will be checking every week. The MD concluded, I am trying to take a proactive approach and not wait for something to break. During an interview with the Director of Nursing (DON) on 01/13/26 at 5:00 PM revealed, My expectation is that all staff, nursing and housekeeping, work together to keep the resident's rooms clean. If they see something, they should pick it up. It's everyone's responsibility. During an interview with the Administrator on 01/13/26 at 5:00 PM revealed, Anyone with a phone should be able to put in the work orders. It doesn't have to be a nurse. I think the CNAs are mistaken. The QR codes are needed to put the work orders in are at the nursing station, but anyone can use (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them. I think people misunderstood and thought only the nurses could do it. It sounds like we need to do a PIP to add closets to the things people need to check and ensure cleanliness. During an observation on 01/11/26 during the initial tour, on 01/12/26 at approximately 9:06 AM and 2:00 PM, and on 01/13/26 at approximately 4:30 PM, R95's bathroom (room [ROOM NUMBER]) had an offensive odor with a plastic wash basin filled with dirty towels and water sitting on the shower stall floor. On each of these days unidentified members of the housekeeping staff, certified nursing assistants and nurses were seen entering room [ROOM NUMBER]. During an interview on 01/11/26 at approximately 4:36 PM, Licensed Practical Nurse (LPN)3 confirmed the finding and stated sometimes R95 just throws stuff there and that she would notify housekeeping.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, record review, manufacturer labeling and interview, the facility failed to ensure proper storage of medications in 2 of 3 medications rooms and 1 of 6 medications carts.Findings include: Review of the facility policy titled Medication Labeling and Storage with a revised date of February 2023 documents, if the facility has discontinued, outdated or deteriorated medications, the dispensing pharmacy is contacted for instructions regarding or destroying these items and multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated . Review of the Aplisol Manufacturer (Endo) Labelling documented, Once entered, vial should be discarded after 30-days and the manufacturer package insert documented, Failure to store and handle Aplisol as recommended may result in a loss of potency and inaccurate test results. During an observation on 01/11/26 at approximately 11:31 AM, of the [NAME] (A Wing) Medication Room refrigerator revealed one opened and not dated as to opened date vial of Aplisol (Tuberculin Purified Protein Derivative) 1ml (milliliter) 10 tests. During an interview on 01/11/26 at approximately 11:42 AM, Registered Nurse (RN)1 confirmed this finding. During an observation on 01/11/26 at approximately 1:46 PM, of the Riverside (D Wing) inspection of the medication room revealed one [NAME] RCI Prefilled Humidifier Aqua Pak 340 ml Sterile Water lot 21B392, expired on 8/20/25 During an interview on 01/11/26 at approximately 1:56 PM, Licensed Practical Nurse (LPN)1 confirmed this finding. During an observation on 01/11/26 at approximately 2:31 PM, of the Riverside (D Wing) medication cart 2 revealed one Breztri Aerosphere inhaler by AstraZeneca dated by the facility as opened on 08/10/25. Review of the manufacturer labelling documented, Discard . within 3 months of opening . During an interview on 01/11/26 at approximately 2:38 PM, LPN2 read the manufacturer labeling and confirmed this finding. During an observation on 01/11/26 at approximately 12:10 PM, of the Palmetto-[NAME] (C Wing) medication room revealed one opened bottle of Stool Softener (Dioctyl Sodium) by Equate expired on 01/2025 and one opened bottle of Levocetirizine 5 mg (milligram) Allergy Relief by Equate expired on 04/2024. During an interview on 01/11/26 these findings were confirmed by an unidentified RN. During an interview on 01/11/26 at approximately 3:00 PM, the Director of Nursing stated that expired medications should be removed from active storage.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review and interview, the facility failed to provide quarterly account statements for Resident (R)7's personal fund for 1 out of 1 resident reviewed for Personal Funds. Findings include:Review of the facility policy titled Accounting and Records of Personal Funds with a revision date of April 2021 revealed, Policy Statement: Our facility maintains accounting records of resident funds on deposit with the facility. Policy Interpretation and Implementation: . 5. Individual accounting records are made available to the resident through quarterly statements and upon request.Review of R7's Face Sheet revealed R7 was admitted to the facility on [DATE], with diagnoses including but not limited to type 2 diabetes, dementia, major depressive disorder, epilepsy, and high blood pressure. Review of R7's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/25 revealed R7 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating she had severe cognitive impairment. During an interview with R7's Responsible Party (RP) on 01/12/26 at 10:20 AM, the RP revealed, She gets $30 a month. You know, now that you mention it, I haven't gotten a statement since the new management took over. I used to get one for her account every quarter.During an interview with the Business Manager (BM) on 01/13/26 at 9:41 AM, the BM revealed, I haven't sent a statement out to her RP because we don't put any money into her account. When I send the quarterly statements out, I make a note at the bottom of the list indicating the statements were sent out. It's a general statement. No, I don't make notations on individual accounts or save records (such as copies of envelopes) to show they were sent out.During an interview with the Administrator on 01/13/26 at 2:26 PM, the Administrator revealed, Everybody's account is different. I think it would depend on if we are keeping their funds. I believe it just went up at the start of this year to $60 a month; the resident can keep each month. The statements, I'm pretty sure, go out quarterly. I would have to ask my Business Manager to be absolutely sure.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, record review, drug manufacturer recommendation and interview, the facility failed to notify a medical doctor or nurse practitioner of a clinical concern related to Resident (R)23. Furthermore, the facility failed to maintain stock of an ordered medication for R6. Findings include: Review of the facility policy titled Acute Condition Changes - Clinical Protocol with a revised date of January 2025 documented, The nursing staff will contact the physician based on the urgency of the situation. Review of the facility policy titled Medication Labeling and Storage with a revised date of February 2025 documented, The nursing staff is responsible for maintaining medication storage . in a . safe manner . and if the facility has . the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Review of R23's Face Sheet revealed R23 was admitted to the facility on [DATE] with diagnoses including but not limited to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. On 01/11/26 at approximately 10:40 AM, during an initial tour interview, R23 expressed a concern about her body by pointing to the area. On 01/13/26 at approximately 11:05 AM, a review of R23's medical record, revealed a progress note, dated 01/09/26 which stated, Res (resident) noted to have a yellowish vaginal discharge. No c/o (complaint of) itching/burning. On 01/13/26 at approximately 1:32 PM, Licensed Practical Nurse (LPN)3 was interviewed about the vaginal discharge progress note dated 01/09/26, for R23. After reviewing the progress note LPN3 stated this should have been reported to the physician or nurse practitioner via the QR (quick response) code On Site. On 01/13/26 at approximately 1:50 PM, Nurse Practitioner (NP)1 reviewed R23's progress note, dated, 01/09/2026, and stated the concern should have been reported to him via On Site and that it had not been reported. On 01/13/26 at approximately 3:20 PM, during an interview, the Director of Nursing (DON) stated nurses were expected to notify the physician/NP of any concern about a resident. Review of R6's Face Sheet revealed R6 was admitted to the facility on [DATE] with diagnoses including but not limited to cardiac heart failure and dementia. On 01/11/26 at approximately 2:31 PM, an inspection of the Riverside (D Wing) Medication Cart #2 revealed, 1 empty dispensing vial belonging to R6 and labelled to contain Nitroglycerin 1 sublingual every 5 minutes x 2 as needed for chest pain with no bottle of nitroglycerin in the vial or medication cart. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/11/26 at approximately 2:38 PM, this finding was verified by LPN2, who searched the medication cart and was unable to locate a vial of nitroglycerin belonging to R6. On 01/13/26 at approximately 3:00 PM, during an interview, the DON stated that medications are to be ordered, according to the pharmacy contract, in time to prevent residents from running out of a prescribed medication.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policy, observation, interview, and record review, the facility failed to ensure proper usage or the hoyer lift, for 1 of 1 Resident R(49), reviewed for accident hazards/supervision/devices.Findings include:Review of the facility policy titled Lifting Machine, Using a Mechanical documents, Purpose: The purpose of this procedure is to establish the general principles for using a mechanical lifting device. It is not a substitute for manufacturer's training and instructions. General Guidelines: 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift . 4. Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility . Steps of Procedure: . 2. Measure the resident for proper sling size and purpose, according to manufacturer's instructions. 3. Select a sling bar that is appropriate for the resident's size and the task. 4. Prepare the environment: a. Clear an unobstructed path for the lift machine; b. Ensure there is enough room to pivot; c. Position the lift near the receiving surface; and d. Place the lift at the correct height . 8. Make sure that all necessary equipment (slings, hooks, chains, straps and supports) is on hand and in good condition. 9. Double check the sling and machine's weight limits against the resident's weight. 10. Place the sling under the resident. Visually check the size to ensure it is not too large or too small . 12. Attach sling straps to the sling bar, according to manufacturer's instructions. a. Make sure the sling is securely attached to clips and that it is properly balanced. b. Check to make sure the resident's head, neck and back are supported. c. Before resident is lifted, double check the security of the sling attachment. d. Examine all hooks, clips or fasteners. e. Check the stability of the straps. f. Ensure that the sling bar is securely attached and sound. 13. Lift the resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution . 15. Slowly lift the resident. Only lift as high as necessary to complete the transfer.Review of the Medline Manufacturer Instructions for Full Body Slings revealed, Do not exceed the maximum weight capacity of sling or patient lift. Always confirm the weight capacity of the sling against the patient's weight and ensure proper placement before performing a lift. Always confirm the compatibility between the connection style of the patient sling and the patient lift before use. Medline loop - style 6-point cradles are compatible with these slings. If other lift cradles are being used, the user should confirm compatibility between the hoist and the sling. Reach out to your Medline Representative with questions.Review of R49's Face Sheet revealed the facility admitted R49 on 05/10/24 with diagnoses including, but not limited to, Type 2 Diabetes Mellitus, pain, muscle spasm, hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side, and systemic lupus erythematosus.Review of R49's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/25, revealed R49 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates that R49 is cognitively intact.Review of R49's admission MDS with an ARD of 11/05/25, also revealed R49 is dependent with all transfers.Review of R49's Fall Care Plan initiated on 05/17/24, documented approaches that included, Ensure proper lift pad is used when transferring resident.Review of a facility incident report dated 01/09/26, revealed, resident fell during hoyer lift transfer. No injuries were observed at the time of incident. Intervention: Ensure proper size lift pad is used when transferring resident.Review of Resident Lifting or Assisting in Transfer Training revealed that the nursing assistants involved in the incident received mechanical lift training on 10/10/22 and 02/10/23. There is no further documented lift/transfer training noted for the two nursing assistants involved in the incident. During an interview on 01/11/26 at 12:37 PM, R49 revealed, I fell from the lift on Friday. They lifted me way up and I fell out on my left side. I went to the hospital on Friday. Nothing was broken but now I am scared to get out of bed. I do not want to fall again. The lift is the only way I get up.During a phone interview on 01/12/26 at 4:07 PM, Certified Nursing Assistant (CNA)2 revealed she was actually down the hall when CNA4 asked her to spot her while using the lift. (continued on next page)

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	425131	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks Post Acute	151 Lovely Drive Orangeburg, SC 29115

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA2 stated, I went in the room as she was getting the resident out of the bed with the lift. The lift gave way as we were transferring the resident to the chair, as the other CNA pulled the lift from out from under the bed, the resident's weight shifted and she fell. The type of lift pad we use depends on the resident. Usually, we use the lift pad that crosses over in the front with this resident but that one was not available. It happened so fast. We were just trying to catch her. I do not remember what lift pad was used but she slid completely out of that lift pad.On 01/12/26 at 4:07 PM attempted to contact Certified Nursing Assistant CNA4 for a phone interview. Phone message revealed, the wireless caller is unavailable. Message left. Awaiting return call.During a phone interview on 01/12/26 at 4:20 PM, Registered Nurse (RN)2 revealed CNA4 informed her that she and CNA2 were transferring R49 from the bed to the gerichair. The sling was not the pad that crossed over to prevent the resident from falling. The pad they used was straight with no criss crosses for the legs. We did not have the one that criss crossed at the time. R49 was adamant to get up and go outside to meet a friend that was coming to visit. The CNA's got R49 up with the wrong lift pad. The sling gave way and R49 fell. CNA4 has been here long enough that she should know what sling to use with R49.During an interview on 01/12/26 at 4:50 PM, the Director of Nursing (DON) revealed that the lift pad that the CNAs used on R49 is a new type of lift pad that does not cross over in the front. She stated this is new technology.During an interview on 01/12/26 at 1:45 PM, Licensed Practical Nurse (LPN)6 revealed that she does not know how the certified nursing assistants know what size lift pad to use with residents that require a lift for transfers. LPN6 verified that the size of the lift pad is not located on the care plan, physician orders or nursing assistant assignment sheets.During an interview on 01/13/26 at 1:35 PM, the Director of Therapy revealed R49 was evaluated today after a fall from the lift. Occupational Therapy will begin working with R49 regarding transfers. He revealed, the lift pads are chosen based on the resident's weight. There are two sizes of lift pads, a smaller lift pad and a larger lift pad. He further revealed that bigger never hurts anything. The sling we have in the therapy department crosses over the resident in the front. I do not know why. He further revealed, the nursing assistants know the type and size of sling that should be used on a resident through nursing communication.During a follow up interview on 01/13/26 at 4:45 PM, the Director of Nursing revealed, We have the morning meetings every morning with all of administration present. We discuss anything that has come up in the past 24 hours. We discuss everything under the sun at those meetings. We use the sling that comes with the Hoyer lift, for example that holds 400 pounds. I'll be honest. This is the first time I've learned about measuring the girth of the resident to determine the size of the sling needed. I never heard of that before.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation, record review and interview, the facility failed to provide respiratory care in accordance with professional standards. Specifically, the facility failed to ensure Resident (R)122's nebulizer machine, oxygen mask and medication chamber were clean and stored properly when not in use for 1 of 1 resident. Findings include:Review of the facility policy titled Oxygen Administration with a revised date of October 2010 documented, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure, if no order in place initiate nursing measure of oxygen administration when applicable. 2. Review the resident's care plan to assess for any special needs of the resident. Steps in the Procedure: . 7. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.On 01/13/26 at 9:00AM, a request was made to review the facility policy on maintenance and storage of equipment associated with respiratory therapy tasks particularly nebulizer machines. On 01/13/26 at 12:00 PM, the Regional Nurse Consultant stated there was no policy for the cleaning and storage of a nebulizer machine. She further stated, it should be included in the oxygen policy. Review of the Oxygen Administration policy did not reveal documentation regarding maintenance and storage of respiratory equipment.Review of R122's Face Sheet revealed R122 was admitted to the facility on [DATE] with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease (COPD), anxiety disorder and Dementia.Review of R122's Physician Orders with a start date 01/08/26 revealed an order for Albuterol Sulfate Solution 108 (90 base) MCG/ACT 2 puffs inhaled orally every 4 hours as needed for COPD, rinse mouth without swallowing after use and Oxygen at 2 liters per Minute (LPM) via nasal cannula continuous per concentrator/tank every shift. During an observation and interview on 01/11/26 at 12:45 PM, revealed R122's Oxygen (O2) concentrator was set to 3.5 LPM and oxygen tubing is not dated. The nebulizer was in the seat of a chair beside resident's bed, next to the resident's tennis shoes. The oxygen mask was propped up against the nebulizer machine. The mask was attached to the medication chamber and the tubing. The nebulizer tubing was not dated. The mask was not bagged. There was a clear liquid noted in medication chamber. The medication chamber was attached to the mask and the oxygen tubing. The medication chamber was not bagged. R122 stated she is on oxygen due to Chronic Obstructive Pulmonary Disease, but she is not certain how many liters of oxygen she receives. During an observation on 01/12/26 at 10:00 AM, revealed R122 resting in bed with eyes closed. O2 concentrator was set to 3.0 LPM and the oxygen tubing was not dated. R122's nebulizer was in a chair beside the resident's bed, next to the resident's tennis shoes. The nebulizer tubing was not dated. There was a clear liquid noted in medication chamber. The oxygen mask was propped up against the nebulizer machine. The mask was attached to the medication chamber and the tubing and the mask was not bagged. During an interview on 01/12/26 at 4:15 PM, Licensed Practical Nurse (LPN)6 revealed that she had not bagged R122's nebulizer mask or washed out the medication chamber. LPN6 stated, I did not even know she had a nebulizer. I did not see it when I gave her medication earlier. LPN6 also verified that the resident's oxygen was on 3.0 LPM and the doctor's order was for 2 LPM. LPN6 proceeded to adjust the oxygen to the correct rate. During an interview with the Director of Nursing (DON) on 01/13/26 at approximately 5:15 PM revealed, Nebulizers are kept in the rooms usually at the bedside. The tubing is changed weekly. The machine is covered when it's not being used. The mask is also changed weekly or as needed. The mask should also be covered when not in use. The DON also revealed that her expectation would be for the nurse to check the oxygen order for the rate and adjust it to the correct rate. They would need to look at the rate at eye level. If the resident is the one who is known to change the rate of their oxygen, we would care plan for it and re-educate the resident. My expectation is that the oxygen rate be checked every shift.

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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 observation, interview, and facility policy review, the facility failed to provide a safe and sanitary environment to help decrease the risk of infections. Specifically, the facility failed to offer residents hand hygiene prior to dining in the 400 Riverside Unit. Furthermore, the facility failed to prevent potential cross-contamination by housekeeping staff. ^^^^^^^^ Review of the facility policy titled Handwashing/Hand Hygiene with a revision date of October 2023, revealed, The Oaks Post Acute Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: Administrative Practices to Promote Hand Hygiene: . 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies . 6. Residents, family members, and/or visitors are encouraged to practice hand hygiene.During an observation on 01/11/26 at 12:55 PM, the staff began bringing residents to the dining room on the 400 Riverside Unit. The staff did not offer residents any hand sanitizer prior to serving their meals. One resident was noted to eat his hamburger patty with his hands. During an interview with Certified Nursing Assistant (CNA)1 on 01/11/26 at 1:37 PM, CNA1 revealed, I know we are supposed to sanitize the residents' hands before they eat. I'm not going to lie to you. I haven't seen the sanitizer on the container with the meal trays lately. They used to put one on there, but lately, they haven't.During an interview with the Administrator on 01/13/26 at approximately 2:26 PM, he revealed, I don't think we have a policy on hand hygiene for residents. We can certainly make sure there is hand sanitizer on all the dining carts to make sure the supplies are available.During an observation on 01/11/26 at 12:20 PM, the Housekeeper left the 400 Riverside Unit with blue disposable gloves still on. She went into a utility room in the main hallway outside the unit's locked doors. She re-entered the hallway with a mobile mop/cleaning unit still wearing blue gloves. During an interview with the Housekeeper on 01/11/26 at 12:20 PM, she revealed, No, they didn't train me on infection control measures.During an interview with the Lead Housekeeper on 01/13/26 at 9:15 AM, she revealed, No, staff should not be wearing gloves when they leave the unit. They are told to remove them before leaving. When a new employee starts, I teach them about infection control standards, such as removing gloves when leaving the unit, changing the mop liquid, etc. No, there is no online or written training. I have a housekeeper who has been here for about four years. The new employee works with her at least two full weeks before being on their own.