

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER White Oak Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Webber Road Spartanburg, SC 29302	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and review of manufacturer instructions, the facility failed to ensure laundry equipment was maintained in a sanitary manner to prevent potential contamination of laundered items. Specifically, the facility failed to ensure the washing machine filter was cleaned and maintained as directed in 3 of three 3 washing machines observed. Failure to maintain laundry equipment in accordance with manufacturer instructions had the potential to contribute to unsanitary conditions and the spread of pathogens. Findings include: Review of the Alliance Laundry Systems washer manufacturer guidelines under Maintenance - End of Day revealed instructions to clean the AC invert drive filter, including removing the external plastic cover, removing the foam filter, and washing the filter with warm water and allowing it to air dry (or vacuuming the filter). During an observation and interview on 03/03/26 at approximately 2:15 PM, of the facility laundry area, revealed the filter located on the front of the washing machine was heavily soiled with lint and debris. A metal manufacturer label affixed directly beneath the filter stated, Clean Daily. The Laundry Supervisor was informed of the condition of the filter. The Laundry Supervisor immediately retrieved a rag and began cleaning the filter. The Laundry Supervisor stated that laundry personnel do not maintain the filter and that maintenance staff are responsible for cleaning it. During an interview on 03/04/26 at approximately 3:22 PM, the Maintenance Supervisor stated that maintenance staff usually clean it about three times a week on Monday, Wednesday, and Friday. When asked if documentation was maintained to verify that the filter was cleaned as required, the Maintenance Supervisor stated there was no log or record of the cleaning. The Maintenance Supervisor further stated they would begin documenting the cleaning in the facility's work order system, identified as TELS.</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, observations, and interviews, the facility failed to ensure that the resident environment remained free of accident hazards. Specifically, medications were left at the bedside for Resident (R)70 for 1 of 2 residents reviewed for accidents hazards. Findings Include: Review of the facility policy titled, Oral Medication Administration Procedure, with no revision date revealed, Policy: To administer oral medications in an organized and safe manner. Procedure: . 12. Administer medication and remain with resident while medication is swallowed. a. Never leave a medication in a resident's room without orders for self-administration. Review of R70's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses including but not limited to, post hemorrhagic anemia, gastrointestinal hemorrhage, irritable bowel syndrome, osteoarthritis. Review of R70's Brief Interview of Mental Status (BIMS) score performed on 03/02/26, revealed a score of 15 of 15, indicating no cognitive impairment. Review of R70's Baseline Care Plan revealed that R70 had decreased ability to perform activities of daily living/self-care related to debility/generalized weakness. Review of R70's orders revealed no order for self-administration of medication. During an observation and interview on 03/04/26 at 3:30 PM, revealed two white tablets located in a medication cup on R70's bedside table. Licensed Practical Nurse (LPN)2 verified the two white tablets on R70's bedside table. LPN2 revealed that medications should not be left in a resident's room without an order. LPN2 revealed that R70 does not have an order to self-administer medication. During an interview with R70 on 03/04/26 at 3:35 PM, it was revealed, the nurse brought those in for me last night. I was saving them until I need them. It is Imodium. During an interview on 03/04/26 at 5:15 PM, the Director of Nursing (DON) revealed, Nurses are not to leave medications at the bedside. The nurse should observe the patient and make sure they swallow the medication safely. The nurse should not leave the room until that happens. Anyone could come in and take the medication if it is left at the bedside.</p>		