

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2026
NAME OF PROVIDER OR SUPPLIER Angel Oak Nursing and Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4452 Socastee Blvd Myrtle Beach, SC 29588	

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	<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 interview, record review, and facility policy review, the facility failed to provide adequate supervision and accident prevention for 1 (Resident (R)65) of 3 residents reviewed for falls. The failure resulted in R65 sustaining a right 11th rib fracture on 09/02/2025 after the resident fell. Findings include: Review of a facility policy titled, Accidents and Supervision, revised on 10/06/2025, revealed, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. The policy revealed, . 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: a. Communicating the interventions to all relevant staff, and d. Documenting interventions (e.g. [exempli gratia, for example], plans of action developed through the QAA [quality assessment and assurance] Committee or care plans for the individual resident) e. Ensuring that the interventions are put into action. Review of R65's admission Record revealed the facility admitted R65 on 05/06/2025. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of muscle weakness, cognitive communication deficit, limitation of activities due to disability, and aphasia (impaired ability to process, produce, or understand language). Review of R65's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/04/2026, revealed R65 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for transfer and ambulating assistance. Review of R65's Care Plan Report, included a focus area initiated on 06/30/2025, that indicated the resident had a risk for falls. Interventions directed staff to keep the call light within reach and encourage the resident to use it if not cognitively impaired (initiated 06/30/2025), anticipate the resident's needs (initiated 06/30/2025), and offer to assist the resident to bed after dinner (initiated 08/08/2025). Review of R65's Morse Fall Scale dated 05/06/2025, indicated R65 was at high risk for falls. Review of R65's Progress Notes dated 08/08/2025, written by the Director of Nursing (DON), revealed R65 fell on [DATE] at 8:25 PM. The notes indicated the resident was not injured and fell when transferring from the recliner without assistance. The notes further indicated that the summary of the interdisciplinary team (IDT) meeting included to offer to assist the resident to bed after dinner. Review of R65's Progress Notes dated 09/02/2025, written by Licensed Practical Nurse (LPN)1, revealed R65 fell onto the floor attempting to get out of a geriatric recliner. The notes revealed the fall was unwitnessed, and the resident reported hitting their head and having shoulder pain. The notes revealed a small amount of bleeding in the right ear and redness to the right side of the resident's back was noted. The notes revealed the Medical Director</p> <p>(continued on next page)</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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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>(MD) was present and ordered for the resident to be sent to the emergency room. Review of a Five-Day Follow-Up Report dated 09/08/2025, revealed R65 had a fall on 09/02/2025. The report revealed an attached typed summary indicated a staff member was walking down the hallway and saw the resident sitting on the floor near their bed. The summary revealed the Medical Director (MD) was in the building, assessed the resident, and ordered for the resident to be sent to the hospital for further evaluation because the fall was unwitnessed and the resident was taking anticoagulant medications. The summary revealed the resident later returned that evening with diagnoses of right rib fracture and a urinary tract infection. The summary revealed the resident was seen prior to the fall sitting in a recliner around 6:00 PM when staff picked up dinner trays. The summary revealed the resident fell when they attempted to get up without assistance. The summary further revealed that the new intervention was to offer the resident to go to bed after dinner as tolerated. Review of R65's Progress Notes dated 09/02/2025 at 11:31 PM, written by LPN2, revealed R65 returned from the hospital with diagnoses of a rib fracture and urinary tract infection. The notes also revealed the resident denied pain or discomfort. Review of R65's Emergency Provider Report dated 09/02/2025, revealed the resident was seen due to hitting their head after a fall, and a computer tomography (CT) was completed that showed no acute intracranial abnormality. The report revealed the resident was discharged back to the facility with diagnoses of a right 11th rib fracture and urinary tract infection. During an interview on 02/06/2026 at 11:34 AM, the DON stated Certified Nurse Assistant (CNA)2 was assigned to R65 on 09/02/2025 at the time of the fall. Review of a Witness Statement, completed by CNA2, dated 09/02/2025, revealed CNA2 did not witness the fall that occurred at 09/02/2025 at 6:55 PM. During an interview on 02/05/2026 at 3:09 PM, CNA2 stated she would know what fall interventions a resident had because the nurse would tell her in report. CNA2 stated she had never seen R65 fall, and no one had told her to assist the resident to bed after dinner. During a follow-up interview on 02/06/2026 at 4:25 PM, CNA2 stated she was able to look on the computer to see what type of transfer assistance residents needed. CNA2 stated she was assisting another resident when R65 fell on [DATE]. CNA2 stated she did not recall the last time she had seen the resident prior to the fall or what time the resident fell. CNA2 stated R65's call light was within reach because it was lying on the bed next to the resident's chair, within the resident's reach. Review of a Witness Statement completed by LPN1, dated 09/02/2025, revealed LPN1 did not witness the fall that occurred on 09/02/2025 at 6:55 PM. During an interview on 02/05/2026 at 3:20 PM, LPN1 stated that she had never accessed the care plans at the facility. LPN1 stated that you would know what interventions were in place for a resident because of your experience, and you would know your residents. LPN1 stated the MD went with her into the resident's room after the resident fell (on 09/02/2025) and sent the resident to the emergency room because the resident was taking anticoagulant medications. LPN1 stated the intervention that was in place at the time of the fall was to check on the resident frequently, and she was not aware of any other interventions at that time. LPN1 stated R65 was not able to use a call light appropriately or understand what it was for. During an interview on 02/06/2026 at 10:31 AM, the MD stated he saw R65 sitting on the floor when he was walking down the hallway. The MD stated he called for the nurse and assessed the resident. The MD stated the resident was taking anticoagulant medications and complained of pain, so the resident was sent to the hospital. The MD stated he discussed falls with the DON, and the DON would ultimately determine what intervention to put into place. The MD stated that he expected new interventions to be shared with staff. The MD stated that if interventions were not shared with staff, then it would not be helpful. The MD stated R65 had a rib fracture after the fall on 09/02/2025, but it had not caused the resident to decline. During an interview on 02/05/2026 at 3:46 PM, the Unit</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Manager (UM) stated that if a resident fell, the root cause of the fall would be determined during the morning meeting with the DON, Director of Therapy, Social Worker, UM, Minimum Data Set (MDS) Coordinators, and the admission Nurse. The UM stated all residents that had fallen would be discussed during the meeting, and the MDS Coordinators would add to the care plans the interventions that the team determined were appropriate. The UM stated she then notified the nurses of the new interventions, and the information would be passed along in report. The UM stated the nurses also had access to the care plans. The UM stated she did not think CNAs were able to access the care plans, but the nurses were able to and should have been communicating the information to the CNAs. During an interview on 02/05/2026 at 4:03 PM, MDS Coordinator 5 stated that after a resident fell, it would be discussed in the morning meeting. She stated that they would determine an appropriate intervention that had not been previously used and add it to the care plan. MDS Coordinator 5 stated she updated the residents' care plans after the morning meetings. MDS Coordinator 5 stated she assumed the DON and UM would notify the nurses of the change. MDS Coordinator 5 stated that after she added the care plans, she was able to add the interventions to the Kardex. MDS Coordinator 5 stated CNAs would be able to view the interventions on the Kardex, and the CNAs were supposed to look at the Kardex for the residents they were providing care for. During an interview on 02/06/2026 at 2:15 PM, the DON stated staff would know if a resident was a fall risk because it would be communicated from the nurses to the CNAs, and it would be listed on the resident's care plan. The DON stated that the nurses and CNAs were able to view residents' Kardex and care plans. The DON stated that if a care plan were updated, she would notify the nurses, and the nurses would inform the CNAs. The DON stated that any updates or changes would also be reflected on the care plan. The DON stated that when R65 fell on [DATE], the resident fell when attempting to get out of the recliner without assistance. The DON stated the fall occurred after dinner, and the intervention put into place was to assist the resident to bed after dinner. The DON stated that on 09/02/2025, the resident attempted to get out of the recliner without assistance after dinner and fell. The DON stated she did not know why R65 was not assisted to bed after dinner unless the resident did not want to go to bed. The DON stated R65 was diagnosed with a rib fracture after the fall on 09/02/2025 and did not decline after the fall. The DON stated the resident had not had any additional falls since 09/02/2025. The DON stated she expected fall interventions to be effective and to be in place. The DON stated she expected staff to be aware of the interventions and how to access the care plans. The DON stated she was responsible for ensuring the fall interventions were updated, and she was responsible for ensuring staff were able to access the care plans with fall interventions. During an interview on 02/06/2026 at 2:54 PM, the Executive Director (ED) stated she expected interventions to be communicated to the staff. The ED stated that the MDS Coordinators were responsible for updating the care plans, and the UM was responsible for relaying information to the staff.</p>		