STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425408	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak at North Grove Inc	290 N Grove Medical Park Drive Spartanburg, SC 29303

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 interview, record review and review of facility policy, the facility failed to ensure R1 was free from accidents. Specifically, R1 was being ambulated with the assistance of Certified Nursing Assistant (CNA)1, who failed to use a gait belt to assist with ambulation. R1 suffered a fall resulting in a fracture of the left hip, for 1 of 2 residents reviewed for falls.Findings include:Review of the facility policy titled Fall Management Program with a revision date of 06/30/22, revealed, Staff education: Interventions: Prevent unsafe transfer and ambulation.Review of R1's Face Sheet revealed that R1 was admitted to the facility on [DATE], with diagnoses including but not limited to; osteoarthritis, vitamin deficiency, cognitive communication deficit, and age related osteoarthritis without current pathological fracture. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/17/25, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating R1 had severe cognitive impairment. Further review of the MDS revealed mobility devices of a walker and a wheelchair. Review of R1's Progress Note dated 09/06/25, documented, Notified by house supervisor and attending care staff that resident fell to the floor in resident room with CNA present transferring/ambulating from bathroom; getting setup to go to the dinning room table for breakfast. Shoes present at the time of incident and CNA care attended present w/ resident at time of fall .Review of R1's Assessment Safe Resident Handling Data Collection form dated 06/17/25, revealed, . gait/transfer belt required (GB) . and Resident continues to require use of GB (gait belt) and walker for transfers with staff.Review of R1's Orders revealed no order for the use of a gait belt. Review of R1's Care Plan revealed R1 had decreased abilities to perform activities of daily living/self care with approach to assist with . transfers, encourage/assist with ambulation, as tolerated and provide adaptive equipment and encourage safe use, as tolerated. Review of a Progress Note dated 09/11/25, revealed, readmission NOTE: [R1] was readmitted to the facility on [DATE]. She was transported back to the facility from [local hospital]. She is alert, but not oriented. She has been cooperative since her return. She is verbal, but can only make her simple needs known. Review of a document with an admission Date of 09/10/25, documented, Chief Complaint / Nature of Presenting Problem: Patient returned from the hospital after falling on the sixth sustaining a subcapital femoral neck fracture on the left side. She had surgical repair and returns to our facility for rehab and strengthening. Patient was confined to a wheelchair prior to this fall and it is unlikely that we will progress past his previous level of activity. Patient had a fall and sustained a left hip fracture she is back in our facility for rehab and strengthening. She is on some pain medicine at the present but will probably be gradually withdrawn from this medication.Review of CNA1's Witness Statement (unspecified date and time) states, I was giving resident AM care. We were walking from bathroom. I was holding her pant, her feet got twisted and she fell, I notified nurse. During an interview on 03/10/26 at 1:12 PM, Certified Nursing Assistant (CNA)1 revealed that she was transferring R1 to the restroom and the resident fell. CNA1 stated, She fell and it was my fault. CNA1 further stated, I said what I said and my statement is correct.During an interview on 03/10/26 at 3:40 PM, with the Administrator and the Director of Nursing (DON). The Administrator revealed that R1 was assessed (continued on next page)

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	for gait belt on 6/17/25 and 9/10/25.During a follow up interview on 03/10/26 at approximately 4:32 PM, the Administrator was asked if the resident should have been wearing the gait belt when the CNA was ambulating the resident to the restroom, the Administrator stated, I think it's when she was bringing her back from the restroom back, and there was some kind of question when we talked to the CNA, if [R1] got up and she was on the way back. The Administrator further stated, our thought is, if the CNA went in there, sometimes that happens, someone is in mid movement or something, our thought is she probably should have held her and called for help, instead of trying to walk her on to the recliner. The Administrator stated, sometimes patient's get up and they don't have the proper equipment on. He further explains that the resident did not have on a gait belt when she fell. The Administrator explains that his expectation is for staff to follow the plan that it provided. The Administrator explains that the way a resident should be transferred is listed on their name tag outside of their room door and the transfer method is determined by transfer assessments. The DON and the Administrator stated that the resident has a history of tripping over her own feet and falling. The Administrator further revealed that they do not have orders for the use of gait belts nor are gait belts listed on the care plans because of how often the transfer methods change. The Administrator reiterates, our system is to list it on the name tag on the resident's door and everybody knows that.