STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425017	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Lancaster	253 Craig Manor Road Lancaster, SC 29720

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, the facility failed to ensure staff did not refer to Resident (R)65 as a feeder during meals, for one (1) of one (1) dependent resident. Additionally, the facility failed to ensure that residents were able to use the bathroom in their rooms, causing R27 to be incontinent of bowel and bladder, for 1 of 1 dependent resident. Findings include: 1. Review of the facility policy titled, Points to Remember in Respecting Dignity revised on 08/16, revealed, . Promote good dining (no disturbances in dining room, etc.) Review of R65's Electronic Medical Record (EMR) revealed R65 was admitted to the facility on [DATE], with diagnoses including but not limited to: Alzheimer's disease, dementia, psychotic disturbance, mood disturbance, anxiety, muscle weakness (generalized), right bundle-branch block, osteoarthritis, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of R65's Quarterly Minimum Data Set with an Assessment Reference Date (ARD) of 04/02/25, indicated R65 had severe cognitive impairment, and the resident was dependent on staff for assistance with meals and activities of daily living (ADL). During an observation on 05/05/25 at 12:54 PM, R65 was being assisted with lunch meal by a certified nursing assistant (CNA). CNA referred to R65 as a feeder. During an interview on 05/05/25 at 1:04 PM, CNA1 revealed she has been in her position for 10 years. CNA1 stated R65 is a feeder. CNA1 continued, We have feeders, that's what we call residents that we are assisting with their meals. I have always called residents that need assistance with their meals feeders, and no one has ever corrected me. Staff use this verbiage all the time. We have a white binder at the nurse's station and it has the feeders list in it, this list has feeding assignments for staff. During an interview and record review on 05/05/25 at an unspecified time, Licensed Practical Nurse (LPN)1 showed this surveyor a document from a white binder that was labeled Unit 2 assignment book, the book was located on the front counter of the nurse's station, where anyone could have access to it. The first document in the binder was labeled Feed List - For all shifts. LPN1 stated this is the feeding list so that we know who is feeding who, so that we don't miss a resident. LPN1 stated she has occasionally heard staff refer to resident as feeders. (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: 425017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Lancaster		STREET ADDRESS, CITY, STATE, ZIP CODE 253 Craig Manor Road Lancaster, SC 29720	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/05/25 at 1:28 PM, CNA2 revealed she has been in her position for 14 years; she has heard staff refer to residents that require assistance with their meals as feeders, CNA2 stated, but it's not supposed to be that way. During an interview on 05/06/25 at 4:19 PM, the Director of Nursing (DON) revealed staff should use the verbiage dependent diners instead of feeders when referring to residents that require assistance with meals. 2. Review of the facility policy titled, Points to Remember in Respecting Dignity revised on 08/16, documented, . Any treatments that dehumanizes a resident or creates an environment that perpetuates a disrespectful and/or potentially abusive attitude toward the resident(s) will be considered grounds for disciplinary action and/or termination. Review of 27's EMR revealed R27 was admitted to the facility on [DATE], with diagnoses including but not limited to: other cholangitis, nausea with vomiting, urgency of urination, other abnormalities of gait and mobility, and overactive bladder. Review of R27's Quarterly Minimum Data Set with an Assessment Reference Date (ARD) of 03/30/25, revealed R65's cognition was intact, and the resident was dependent on staff for assistance with activities of daily living (ADL). During an interview on 05/04/25 at 11:32 AM, R27 stated she cannot use the bathroom in her room because her wheelchair will not fit in that bathroom. I must use the hall bathroom, and it takes 30 to 45 minutes most of time to get someone to take me to the bathroom. I wet myself frequently and then I must sit there in wet clothes. During an observation on 05/06/25 at 9:52 AM, R27 was sitting in a wheelchair fully dressed in a rose and blue blouse, paired with jean and shoes. R27's call bell was within reach and functioning. R27's bathroom opens out directly beside her bed, however R27's wheelchair would not fit in the bathroom. During an interview on 05/06/25 at 11:55 AM, the Maintenance Director (MD) stated that this is the first of him knowing that R27 could not get into her bathroom with her wheelchair. The MD states that all problems are reported by the nurse and he was going to see what solution that he could come up with regarding R27's issue of not be able to utilize the bathroom in her room. During an interview on 05/06/25 at 2:52 PM, R27 stated that she does not drink a lot because then she will have to go to the bathroom and she does not want to go to the bathroom a lot, it takes staff very long to respond to the call bell. R27 stated she promised the staff that she would not go into the bathroom in her room because her chair got stuck because the bathroom is not large enough for her wheelchair. R27 further stated she does not feel comfortable going to the bathroom in her room without her wheelchair, because there are not enough rails to hold onto, and the one that is in there is elbow shape and it is awkward and hard for her to hold onto and she is afraid of falling. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/06/25 at 2:53 PM, Certified Nursing Assistant (CNA)1 revealed she does recall a time when R27 had a hard time getting out of her bathroom with the wheelchair. CNA1 stated it is hard to maneuver the wheelchair and the resident in the bathroom because the bathroom is small. CNA1 confirms that there have been times that R27 was soiled before she can get to the bathroom down the hall and around the corner. During an interview on 05/06/25 at 2:57 PM, CNA2 stated she never assisted R27 to the bathroom in her room, she always brings her to the central bathroom down the hall, because there is rail in that bathroom. CNA2 further stated there is not enough room in her bathroom for staff, the resident, and the wheelchair. All the bathrooms are the same. CNA2 stated R27 does experience many incontinent episodes of bladder and bowel due to having go so far to the bathroom. During an interview on 05/06/25 at 4:29 PM, the Director of Nursing (DON) revealed she is not sure if R27 can walk into the bathroom in her bedroom. The DON stated R27 has use of the central bathroom and she was not aware that this was an issue for R27.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policy, the facility failed to monitor and manage Resident (R)64's pain to the extent possible in accordance with the comprehensive assessment and care plan, as well as professional standards of practice, for 1 of 1 resident reviewed for pain. Findings include: Review of the facility policy titled, Pain Management Program revised on August 2016, documented, Objective: To enable the resident to be at a consistent level of comfort while maintaining as much function as possible. 5. Residents with uncontrolled pain levels will have a pain management program implemented to include a Pain Flow Sheet form N(079). 7. The documentation will be monitored by the licensed nurse and the interdisciplinary team to determine the effectiveness of the pain relief for the resident. 8. The plan will be adjusted as needed to assure adequate pain relief is obtained, while maintaining the resident's highest quality of life, both physically and psychosocially with the fewest side effects possible. Review of R64's Face Sheet revealed R64 was admitted to the facility on [DATE], with diagnoses including but not limited to: dementia, pressure ulcer stage 4 right heel, age related osteoporosis, atrial fibrillation and heart failure. Review of R64's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 04/09/25, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R64 was moderately cognitively impaired. This Quarterly MDS also revealed that R64 is in constant pain with a pain intensity score of 8 out of 10. Review of R64's Care Plan with a start date of 11/30/21 and target date of 01/30/25, documented, Focus At risk for episodes of uncontrolled pain r/t dx of polyosteoarthritis, osteoporosis, current pressure ulcers and h/o R hip fx. The goal documented, Will be free of any s/s of uncontrolled pain. The interventions directed staff to, Monitor for s/s of pain (verbalization, grimacing, guarding, restlessness, irritability, change in mood or behavior, decline in physical functioning). Review of the Physician's Order, located in the Electronic Medical Record (EMR) under the Physician's Order tab, revealed R64 is scheduled to receive two tablets of acetaminophen 500 mg three times a day for pain. Further review of the Physician's Order did not reveal an order to monitor the resident's pain level. Review of R64's EMR did not reveal a Pain Flow Sheet to monitor the resident pain. During an interview on 05/04/25 at 2:54 PM, R64 revealed, I hurt all the time. Nothing helps. I just stay in bed because I hurt so bad. During an observation and interview on 05/05/25 at 8:30 AM, R64 was laying in bed. R64 stated, I do not want to do nothing but lie here. I hurt all the time. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/06/25 at 11:47 AM, Licensed Practical Nurse (LPN)1 revealed, A resident's pain regimen is reevaluated every six months. If the pain medication is PRN (as needed), it is reevaluated every 14 days. A resident's pain is addressed using a 1-10 pain scale. If the resident is nonverbal, we watch for grimacing, moaning and facial expressions. We have a standing order for Tylenol, and we log them for the doctor to see the next morning. The nurse should make a progress note that details why the doctor needs to see the resident. I do not work this hall usually, I am not familiar with these residents. I can't help you. During an interview on 05/06/25 at 11:52 AM, the Restorative Aide revealed, I do active range of motion on his arms and legs once a day. He does it himself. He verbalizes pain sometimes due to that sore on his heel. He is no longer ambulating due to the sore on his heel. The hope is that the sore will heal, and we will refer him back to therapy. During an interview on 05/06/25 at 7:51 PM, the Resident Assessment Coordinator (RAC)1 talked to the nurse practitioner as well as his nurse after that interview about his pain. RAC1 stated that the nurse practitioner ordered Tylenol three times a day for him. He stated that the site of his pain was his right heel. During an interview on 05/06/25 at 8:35 PM, the Medical Director revealed that the resident and family have declined narcotics, but it is her expectation that the nurses should be monitoring resident's pain every shift and reporting that to myself and the nurse practitioner. During an interview on 05/06/25 at 8:03 PM, the Director of Nursing (DON) revealed pain medication should work and if not we should reevaluate in a day or two. The DON stated it should be on the MAR (medication administration record) for the nurses to be evaluating the resident's pain every shift after a new pain medication is started.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and review of facility policy, the facility failed to ensure that all drugs and biologicals were stored in locked compartments for one of one resident, Resident (R)57. Findings include: Review of the facility's policy titled, Medication Storage In The Facility, last revised on 09/21/22, revealed, Policy: Medications and biologics are stored safely, securely, and properly following manufacturers recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personal, pharmacy personal, or staff members lawfully authorized to administer medications. Procedure : 2. Only licensed nurses, consultant pharmacist, designated pharmacy staff and those lawfully authorized to administer medications (e.g. medication aides) are allowed access to medications. Medication rooms, carts and medication supplies are locked or attended by persons with authorized access. Review of the facility's policy titled, Self Administration Of Medication, last revised on 09/21/22, revealed, Policy: Residents are not allowed to practice self- administration of medication unless specifically ordered by the physician and determined to be safe by the interdisciplinary team . Procedure: 1. The determination by the interdisciplinary resident assessment team that a resident may self - administer medications is documented on the plan of care. Documentation of this assessment should be indicated by the following, Resident prefers nursing to administer all medications except (enter medication(s)) which is/are kept at the bedside or in resident's immediate possession for self-administration per physician's order and facility policy or a similar statement. Review of the facility's policy titled, Bedside Storage Of Medication, last revised on 09/21/22, revealed, Bedside medication storage is permitted for residents who are able to self- administer medications upon the written order of the prescriber and when it is deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team. Procedure: 1. A written order from the attending physician for the bedside storage of medication is placed in the resident's medical record. 2. Bedside storage of medications is indicated on the resident's medical record and in the care plan for the appropriate medications. During an observation on 05/04/25 at 10:35 AM, a Pain patch Lidocaine 4% x2 was noted at R57's bedside. Review of R57's Electronic Medical Record (EMR) did not reveal order to keep medication at bedside or an order for R57 to self administer medications. During a telephone interview on 05/04/25 at 4:52 PM, Licensed Practical Nurse (LPN) confirmed R57 does not have an order to self administer medication and R57 does not have an order to keep medication at bedside. LPN1 stated the Lidocaine patches should not be at bedside if there is no order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/04/25 at 4:55 PM, the Nursing Supervisor revealed the pain patches should be placed on the resident at 8:00 AM and off at bedtime. The Nursing Supervisor verified there was no order for R57 to keep the patches at bedside and there was no order to self administer medications. During an interview on 05/05/25 at 2:20 PM, the Director of Nursing (DON) revealed her expectations are that nurses do not leave medications at a resident's bedside without a doctor's order.

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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. Based on review of the facility policy, observations, and interviews, the facility failed to ensure the kitchen was free of expired food items. Findings include: Review of the facility's policy titled, Storage of Food and Supplies, revised on 12/05/2017 revealed: Food and supplies are received, stored, and monitored according to federal, state, and local guidelines. Under Procedures, Food and supplies are received and checked for accuracy, damage, and appropriate temperature . Any food not stamped with a manufacturer's expiration or use-by date will be marked with the date of delivery. During the initial tour of the kitchen on 05/04/25 at 10:10 AM, observation of the beverage nourishment refrigerator revealed the following: -40, 4 ounce (oz). cups of Dannon Light and Fit Yogurt, flavored Strawberry, Blueberry and Raspberry with an expiration date of 5/01/25. -1, 1/2 pint of Chocolate milk expired 4/14/25. -1, 1/2 pint of Chocolate milk expired 4/28/25. -4, 1/2 pints of Chocolate milk expired 5/01/25 These items were confirmed as expired by Cook1. During an interview on 05/04/25 at 10:18 AM, Cook1 stated, Items are supposed to be checked in here daily to make sure they aren't expired. During the initial tour of the dry storage room on 05/04/25 at 10:22 AM, observation revealed the following: -1, 0.7 oz bag of Cheetos Puffs with an expiration date of 04/08/25. This was confirmed as expired by Kitchen Aide (KA)1. During an interview with the Certified Dietary Manager (CDM) on 05/04/25 at 10:35 AM, the CDM was made aware of the previous findings and agreed expiration dates should be checked daily.