STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425068	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Columbia	3001 Beechaven Road Columbia, SC 29204

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 - 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. (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: 425068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Columbia		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 Beechaven Road Columbia, SC 29204	

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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, interview, and record review, the facility failed to provide appropriate supervision for Resident (R)4, during medication administration, resulting in R4 not swallowing 2 of his medictions, for 1 or 1 resident reviewed.Findings include:Review of the facility's undated policy titled Oral Medication Administration Procedure indicated: 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. b. If resident is in bed, head of bed should be elevated prior to administration of medication.Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE] with diagnoses including but not limited to dysphagia following cerebral infarction, constipation, acquired absense of left leg above knee, acquired abscence of right leg above knee, sacral pain, Type 2 Diabetes Mellitus with diabetic neuropathy, hypocalcemia, chronic obstructive pulmonary disease, and generalized anxiety disorder.Review of R4's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out 15, indicating R4's cognition was intact.Review of R4's Care Plan revealed, [R4] is at risk for nutritional decline/weight loss and aspiration due to mechanically altered diet and dx of dysphagia . Start Date:09/18/2025. The approach directed staff to, Administer vitamins as orderd by provider. Monitor for adverse medication side effects (reference drug handbook as needed) and report any adverse medication effects to provider created: 04/25/2025. Further review of the Care Plan revealed, Resident has a mild cognitive deficit r/t dementia, senile degeneration of brain, and Alzheimer's disease. Start Date: 11/19/2021. Review of R4's Medication Administration Record (MAR) for the month of September 2025 revealed, acetaminophen [OTC] tablet; 500 mg; Amount to Administer; 2 tab; . Further review revealed, gabapentin capsule; 100 mg .During an observation on 09/23/25 at 10:40 AM, R4 was observed in a semi-supine position in bed, with their head slightly leaning to the left side. On R4's chest was one white oblong pill and hanging out of the left corner of R4's mouth was one white capsule. During an interview on 09/23/25 at approximately 10:46 AM, Social Worker Assistant 1 acknowledged R4 was asleep with a white oblong pill on the chest and a white pill in the left corner of the mouth.During an interview on 09/23/25 at approximately 10:50 AM, Licensed Practical Nurse (LPN)1 revealed she administered R4's medications at 8:16 AM and R4 appeared to have swallowed the medications with water. LPN1 acknowledges she saw a white oblong pill on R4's chest and a white pill in the left corner of R4's mouth. LPN1 states the pill on the chest of R4 was a 500 mg (milligram) Tylenol and the pill in the left corner of R4's mouth looked like a gabapentin capsule. LPN1 awakened R4 and asked if he had been pocketing medications and proceeded to administer medication with water. LPN1 asked the resident to open his mouth after medication administration to ensure the resident had swallowed the medication. LPN1 reports this is the first time the resident pocketed pills. LPN1 states her expectations are for the resident to take medications, and she will inspect the resident's mouth inside and out post medication administration to ensure no pocketing and that the resident has swallowed the medications. LPN1 states she will inform the unit manager of the incident and place the incident on the 24-hour report.During an interview on 09/24/25 at approximately 11:02 AM, LPN2 who is also the Unit Manager stated we will document on MAR (Medication Administration Record) and put the reason why the resident pockets medications. Expectations are to ensure the resident is swallowing medications, crush medications that are able to be crushed, and administer with applesauce to ensure the resident swallows meds.During an interview on 09/24/25 at approximately 10:53 AM, the Director of Nursing (DON) revealed that the procedure and expectations for medication administration are for the nurse to identify the medication before administering medication, ensure the resident swallows medications, and let the provider know if the resident had difficulty swallowing medication. The resident is on a regular mechanical soft diet. The DON revealed acute changes with residents are discussed every shift, and if there is an ongoing issue, it will be placed on the resident's profile sheet. The DON states the resident administration with R4 has not been an issue before this time. Reports that if R4 continues to have swallowing issues, she will have Speech Therapy to assess the resident after Veteran's Administaration (VA) approval.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Columbia		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 Beechaven Road Columbia, SC 29204	

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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Columbia		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 Beechaven Road Columbia, SC 29204	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, staff interviews, and a review of the facility's dietary policies, the facility failed to ensure proper sanitation of kitchen equipment and maintain overall cleanliness in the main kitchen. Additionally, the facility did not adhere to appropriate labeling and dating protocols for food items. These deficiencies could potentially pose a risk to the health and safety of the residents consuming food prepared in the kitchen. Findings include:Review of the facility's policy titled Storage of Food and Supplies last revised on 12/05/17, specifies that Time-Temperature Control for Safety (TCS) foods must be stored in the refrigerator to prevent cross-contamination. Meat, poultry, and fish products should be stored in a specific order: poultry at the bottom, followed by meat, fish, and then ready-to-eat items. The policy further mandates that all items must be labeled with a use-by date and contents if not readily identifiable. Additionally, any food removed from its original packaging should be labeled with identifying information, including the product name, the date the original package was opened, and the discard date. Staple items such as flour, sugar, cornmeal, and dried pasta should be stored in secure, designated bins, and the scoops used for these products should not come into contact with the food.During an initial walk-through of the kitchen, conducted on 09/23/25 at 9:50 AM with the Dietary Manager (DM), revealed the following: The two-door reach-in freezer in the main kitchen had a filthy appearance, with sticky residue throughout the bottom upon opening the doors. Plastic bins containing frozen meats were stuck to the freezer floor. One 2-gallon ziplock bag of Dice Chicken Mix, dated 09/22/25, was found inside the freezer but was not in its original packaging and lacked a use-by date. Several 20-quart plastic containers, located in Dry Storage, contained pasta products that were not in their original packaging and lacked use-by dates, including Spaghetti Noodles (opened 07/16/25), Macaroni Noodles (opened 09/12/25), and Egg Noodles (opened 09/21/25). Additionally, an unlabeled ingredient storage bin near the door contained a white substance with black spots, and a scoop was left inside the bin. The exterior of the ice machine had dried residue visible on the front and side. The interior of the ice machine, including the black lining, was also dusty. The dishwasher had dried residue on its exterior and was visibly dirty. Two metal racks housing clean cookware revealed a stainless-steel skillet that was rusted and covered with black residue, while two stainless-steel pots had similarly rusted bottoms with peeling black residue. A rectangular stainless steel food pan had grease build-up and brown/black residue on its bottom. The air conditioning unit located by the window had a panel with an accumulation of dust. The wall surrounding the three-compartment sink was visibly dirty, with yellow and brown dried substances. Above the sink, the window's metal panels were covered in dirt and appeared rusted with black spots. The ceiling tiles above the hood showed visible signs of damage and discoloration. The tiles, which were originally white, had turned an orange color. Several pieces of kitchen equipment were in poor condition. The conveyor toaster had dirty knobs, visible black rust, and brown residue on the bottom panel. The flat-top stove had dried grease and black residue on its front and side panels. The lid of the stove contained a brown substance and food crumbs. The burner stove had its side panel covered in dried grease, while the entire backsplash was coated with white and brown residue. The double-deck conventional ovens showed light brown buildup on the top oven and black buildup near the bottom doors. The handles of the bottom oven were covered in yellow residue.The locked freezer, located outside the building, contained various food items without proper labeling or dating. Items found included a 4-pound brown bag of waffle fries, opened and without a label or use-by date; a plastic bag of approximately twenty egg patties, with no label or use-by date; a plastic bag of approximately twenty-five pieces of brown cookie dough, with no label or use-by date; a plastic bag of approximately twenty-five pieces of white cookie dough, with no label or use-by date; a plastic bag of approximately fifteen rolls, with no label or use-by date; and a plastic bag of approximately twenty-five quesadillas, with no label or use-by date.On 09/23/25 at approximately 10:55 AM, an interview with the Dietary Manager (DM) revealed that everyone is responsible for ensuring that items are free from expiration and that items removed from their original packaging must be labeled with both open and use-by dates. She acknowledged the conditions of the kitchen, stating that the kitchen is old and staffing is limited on both the first and second shifts. She further explained that as far as deep cleaning is concerned, there is no set schedule that the dietary staff follows for these tasks. She stated that she has spoken to the Director of Housekeeping to assist with cleaning the floors and to the Maintenance Department about pressure washing the entire kitchen but stated that these actions have not yet been completed.During follow-up observations on 09/24/25 at 9:03 AM and again at 10:23 AM revealed the same conditions, with no