STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425088	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Rock Hill	1915 Ebenezer Road Rock Hill, SC 29732

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 3 residents in a total sample of 35 residents (Resident (R)52, R73, and R131) whose assessments were reviewed. The facility failed to accurately assess R52's cognitive patterns and mood, R73's use of an indwelling urinary catheter, and R131's fall history. These failures placed the residents at risk of having unmet care needs and services. Findings include: Review of the RAI Manual 3.0, dated 10/19 revealed, . If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected . 1. Review of R52's undated Face Sheet, located in the Resident tab in the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to: muscle weakness, difficulty in walking, lack of coordination, muscle wasting and atrophy, osteoporosis, and pressure ulcer of left buttock. Review of R52's quarterly MDS, with an Assessment Reference Date (ARD) of 02/12/25, located in the RAI tab of the EMR, did not include information on the residents' Cognitive Patterns, which included a Brief Interview for Mental Status (BIMS) score or the resident's Mood which included a Mood interview and staff assessment of the resident's mood. During an interview on 03/11/25 at 4:20 PM, R52 answered questions appropriately and displayed no problems with her memory recall or her mood. During an interview on 03/13/25 at 2:10 PM, the Assistant Director of Nursing (ADON) confirmed staff failed to assess R52's cognitive patterns and mood on the resident's 02/12/25 Quarterly MDS. 2. Review of R73's undated Face Sheet, located in the Resident tab in the EMR, revealed the was admitted to the facility on [DATE], with diagnoses including but not limited to: cerebral infarction (stroke), neuromuscular dysfunction of the bladder, and personal history of urinary tract infections. Review of R73's current Care Plan, located in the RAI tab in the EMR, indicated, Problem: At risk for further UTI r/t indwelling foley cath [catheter] due to Neuromuscular dysfunction of bladder and hx [history] of UTI. The care plan Problem had a start date of 02/22/22. (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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R73's current March 2025 physician's orders, located in the Resident tab in the EMR, indicated, Foley catheter 14FR 3CC related to neuromuscular dysfunction of the bladder. The order's start date was 08/05/24. Review of a 12/27/24 nursing note for R73, located in the Resident tab in the EMR, indicated, Indwelling urinary cath [catheter] patent and intact. Cath bag replaced, dated, and initialed. Review of R73's annual MDS with an ARD of 01/08/25, located in the RAI tab of the EMR, indicated R73 did not utilize an indwelling urinary catheter. Observation on 03/11/25 at 11:37 AM, revealed R73 was in bed with a urine collection bag, which contained urine, hanging from the side of her bed. During an interview on 03/13/25 at 2:10 PM, the Assistant Director of Nursing (ADON) stated R73 currently utilized an indwelling urinary catheter and had an indwelling urinary catheter when her 01/08/25 annual MDS was completed. The ADON confirmed R73's 01/08/25 annual MDS was not accurate because it specified the resident did not have an indwelling urinary catheter present at this time. 3. Review of R131's undated Face Sheet, located in the Resident tab in the EMR, revealed R131 was admitted to the facility on [DATE], with diagnoses including but not limited to: restlessness and agitation, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of a 08/28/24 nursing note for R131, located in the Resident tab in the EMR, indicated, Alerted by staff that resident was laying [sic] on the floor in his room. Noted resident laying [sic] beside bed near closet. Review of a 08/29/24 nursing note for R131, located in the Resident tab in the EMR, indicated, Res [Resident] fell yesterday and x-rays revealed res has a R [right] hip fx [fracture] r/t [related to] same. Review of R131's quarterly MDS with an ARD of 09/26/24, following his fall on 08/29/24, located in the RAI tab of the EMR, indicated that R131 had not experienced any falls. During an interview on 03/13/25 at 10:52 AM, the Administrator stated R131 experienced a fall on 08/29/24 which resulted in a fracture. The Administrator confirmed R131's quarterly MDS dated 09/26/24 was inaccurate because it indicated the resident had not experienced any falls.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, interview, and facility policy review, the facility failed to provide resident care as ordered by the physician for 1 (Resident (R)20) of the 4 residents observed during medication pass. The failure to have a physician's order increased the risk of residents receiving unnecessary or inappropriate care. Findings include: Review of the facility policy titled Oral Medication Administration Procedure, reviewed 08/16/21, lacked direction to verify a physician has ordered all medications the nurse has prepared to administer to the resident. Review of R20's electronic medical record (EMR) under the Census tab revealed an admission date of 11/23/22, with diagnoses including but not limited to: epilepsy, cerebral vascular accident (stroke), and chronic obstructive pulmonary disease. Review of the physician orders under the EMR Orders tab revealed no order for a multivitamin with minerals to be administered to R20. Observation of Licensed Practical Nurse (LPN)2 on 03/13/25 at 9:12 AM, revealed LPN2 prepared and administered the multivitamin with minerals to R20 without a physician's order. During an interview on 03/13/25 at 10:19 AM, the Director of Nursing (DON) confirmed LPN2 administered a medication to R20 without a physician's order.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to serve an alternate food for a dessert that contained eggs and served cheese at a meal to a resident with known allergies to eggs and milk for 1 of 2 residents (Resident (R)180) reviewed for food allergies out of 35 sampled residents. This failure had the potential to cause health and/or nutritional complications for this resident. Findings include: Review of the facility's policy titled, Allergies, with a revision date of 12/07/10, indicated, Objective: 1. To prevent anaphylaxis [a severe, life-threatening allergic reaction]. 2. To prevent allergic reactions. Equipment 1. Resident admission record indicating food and drug sensitivities. Procedure 1. Obtain information on admission of resident - if allergic to drugs or specific food items or has any contact allergies . 6. Notify Dietary Department if allergic to certain foods. Key Points Indicate of diet slip . Review of R180's undated Face Sheet located under the Resident tab of the electronic medical record (EMR), revealed R180 was admitted to the facility on [DATE], with diagnoses including but not limited to: type 2 diabetes, chronic kidney disease, and chronic obstructive pulmonary disease. Food allergies listed on the resident's Face Sheet included eggs, milk, pineapple, and shrimp. Review of R180's current care plan, with an initiation date of 02/20/25, located under the RAI (Resident Assessment Instrument) tab of the EMR, contained the following Problem which specified, [R180] . multiple food allergies. The care plan's Goal indicated, [R180] will not experience undesired, significant wt [weight] change through review date or have adverse reactions to consuming food allergies. A care plan approach indicated, Avoid food allergies. Review of R180's current physician orders, located under the Resident tab of the EMR, revealed the following diet order, Regular Special Instructions: Multiple food allergies: apples, pineapple, grapes, eggs, milk, and shellfish. The diet order's start date was noted as 02/22/25. Review of R180's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/25/25, located in the EMR under the RAI tab, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated R180 was cognitively intact. Review of R180's Nutritional Screening/Review, dated 02/25/25 and located in the Resident tab of the EMR, indicated, . Food allergies to apples, pineapple, grapes, shrimp, eggs, milk, and shellfish honored. [R180] was admitted to facility on 2/19 on regular diet. She can communicate needs-dietary honors preferences/dislikes . During an interview on 03/11/25 at 12:16 PM, R180 was in her room waiting for her lunch meal to be served. R180 stated she had a list of food intolerances and allergies that she had informed the facility about but was frequently served foods at meals that she was allergic to and at times she was not served an alternate food on her meal tray in place of a food to which she was allergic. R180 specified she had an allergy to eggs and was lactose intolerant and was recently served egg noodles. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/11/25 at 12:36 PM, revealed R180 was in her room with her lunch meal tray. Observation of R180's meal revealed she was not served a dessert. Review of the tray slip served with the resident's meal indicated, Please be aware of allergies eggs, milk, pineapple, shellfish, apple, pears. The tray slip listed the foods the resident was to receive at this meal but did not indicate the resident was to receive a dessert. R180 stated she did not know why she was not served a dessert with her meal. During an interview on 03/11/25 at 12:41 PM, the Dietary Director (DD) stated R180 did not receive the banana cake that was planned on the lunch menu because it contained eggs, and the resident was allergic to eggs. The DD stated R180 should have been served an alternate dessert on her meal tray in place of the banana cake. During an observation on 03/11/25 at 12:44 PM, the DD provided R180 with a serving of mandarin oranges as a dessert to eat with her lunch and confirmed the resident was not served a dessert with this meal. During an observation on 03/12/25 at 12:49 PM, revealed R180 was in her room with her lunch meal tray. The resident was observed picking off the shredded cheese that was served on top of her salad. During an interview on 03/12/25 at 12:49 PM, R180 stated she was picking off the cheese from her salad because she was lactose intolerant and could not eat cheese. R180 specified she had previously informed the kitchen staff that she was unable to eat cheese, but she was still served cheese and foods that contained cheese at meals. During an interview on 03/12/25 at 1:10 PM, the DD observed R180's meal tray and confirmed she was served shredded cheese on her salad. The DD confirmed R180 should not have been served cheese due to her allergies.