

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345301</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/24/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE OAK MANOR - BURLINGTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>323 BALDWIN ROAD</b> <b>BURLINGTON, NC 27217</b>		
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E 000	Initial Comments	E 000			
F 000	An unannounced recertification and compliant investigation survey was conducted on 2/21/22 through 2/24/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5AKK11  INITIAL COMMENTS	F 000			
F 580 SS=D	An unannounced recertification and compliant investigation survey was conducted on 2/21/22 through 2/24/22. Event ID # 5AKK11  3 of the 3 complaint allegation's were not substantiated.  Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580	3/25/22		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/15/2022

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.

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F 580	<p>Continued From page 1</p> <p>(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews the facility failed to notify the physician when medication was unavailable for administration for 1 resident for 4 days. The failure of notification occurred for 1 of 2 residents reviewed for notification (Resident #61).</p> <p>Findings included:</p> <p>Resident #61 was admitted to the facility in 2019 and had the diagnoses, included traumatic brain</p>	F 580	<p>White Oak Manor of Burlington ensures the resident representative and physician are notified of resident changes including when medication is unavailable.</p> <p>The physician for Resident #61 was notified on 2/23/22 regarding the resident's Fluoxetine not being available for administration from 2/12/22 through 2/15/22. The resident representative was notified on 3/14/22. There has not been</p>		

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F 580	<p>Continued From page 2</p> <p>injury, major depression, and dementia. A review of Resident 61 ' s recent Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, revealed that Resident #61 was moderately cognitively impaired. She received antipsychotic and antidepressants medications.</p> <p>A review of Resident 61 ' s plan of care, dated 10/25/21, revealed she was at risk for side effect of psychotropic medications.</p> <p>A review of the physician ' s order for Resident #61, dated 1/12/22 (initial order dated 9/30/21), revealed the order for Fluoxetine (antidepressant medication), 20 mg (milligram) in 5 ml (milliliter) solution, to take 2.5 ml (10 mg) via feeding tube daily.</p> <p>A review of Medication Administration Record (MAR) for February 2022 revealed that Fluoxetine was not administered on 2/12/22 - 2/15/22 for Resident #61. The comment showed "awaiting pharmacy".</p> <p>A review of the nurses ' notes, written by Nurse #6, dated 2/12/22 and 2/13/22, for Resident #61 revealed no documentation about physician ' s or family ' s notification, related to the Fluoxetine administration.</p> <p>A review of the nurses ' notes, written by Nurse #5, dated 2/14/22, for Resident #61 revealed that Fluoxetine was not administered. The comment was "awaiting pharmacy".</p> <p>A review of the nurses ' notes, written by Nurse #5, dated 2/15/22, for Resident #61 revealed that Fluoxetine was not administered. The comment was "arriving on 2/16/22".</p>	F 580	<p>any further incident(s) involving Resident #61's Fluoxetine since 2/15/22.</p> <p>An audit was completed by the director of nursing (DON) and nursing administration on 2/24/22 of current residents requiring solution medication (such as Resident #61's Fluoxetine) to ensure compliance.</p> <p>Current and newly admitted residents requiring solution medications will receive the medication as ordered, and the resident representative and physician will be notified of any issues with the medication including not being available.</p> <p>The licensed nursing staff were re-educated on notifying the physician and resident representatives regarding medications not being available and obtaining new orders from physician and documenting appropriately. The re-education was started on 2/23/22 and completed by the staff development coordinator (SDC) on 2/27/22. Newly hired licensed nursing staff will receive this education during their job orientation.</p> <p>The nursing administration will monitor for notification of 10 residents weekly for 4 weeks, then 5 residents weekly for 4 weeks, and then 3 residents weekly for 4 weeks and then as needed thereafter.</p> <p>The identified trends or issues from monitoring will be discussed during the periodic QI meetings, weekly for 12 weeks, and then brought to the QA committee meetings for further</p>		

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F 580	Continued From page 3  On 2/23/22 at 12:20 PM, during an interview, Nurse #5 indicated that the Resident #61 had an order of Fluoxetine 10 mg once a day in the morning. On 2/14/22 and 2/15/22, the facility did not have the medication Fluoxetine available for administration. The Nurse #5 did not notify physician or family about unavailable medication, because she thought that previous nurses already made notification.  On 2/23/22 at 1:20 PM, during the phone interview, Nurse #6 indicated that Resident #61 received Fluoxetine daily per physician ' s order. On 2/12/22 and 2/13/22, there was no Fluoxetine available for administration. The Nurse #6 placed the pharmacy order but did not notify physician or family about not administered Fluoxetine.  On 2/23/22 at 1:45 PM, during the phone interview, Nurse Practitioner (NP) expected the staff to notify physician if the medication was not available for administration. The NP confirmed that nobody notified her about not available Fluoxetine for Resident #61 in February 2022.  On 2/23/22 at 1:40 PM, during an interview, Director of Nursing (DON) indicated that per policy and according to the training, in the case of not available medication, the staff to notify nurse supervisor, pharmacy, family, physician, follow new order and document it. Nobody reported to DON that Resident #61 did not receive her prescribed medications for 4 days.	F 580	recommendations as needed.  The DON is responsible for ongoing compliance with F580.		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans	F 658		3/25/22	

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F 658	<p>Continued From page 4</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff and physician interviews the facility failed to administer antidepressant as ordered by the physician for 1 of 1 resident, reviewed for the provision of care according to professional standards (Resident #61).</p> <p>Findings included:</p> <p>Resident #61 was admitted to the facility in 2019 and had the diagnoses, included traumatic brain injury, major depression, and dementia. A review of Resident 61 ' s recent Quarterly Minimum Data Set (MDS) assessment, dated 1/12/22, revealed that Resident #61 was moderately cognitively impaired. She received antipsychotic and antidepressants medications.</p> <p>A review of Resident 61 ' s plan of care, dated 10/25/21, revealed she was at risk for side effect of psychotropic medications.</p> <p>A review of the physician ' s order for Resident #61, dated 1/12/22 (initial order dated 9/30/21), revealed the order for Fluoxetine (antidepressant medication), 20 mg (milligram) in 5 ml (milliliter) solution, to take 2.5 ml (10 mg) via feeding tube daily.</p> <p>A review of Medication Administration Record (MAR) for February 2022 revealed that Fluoxetine was not administered on 2/12/22 - 2/15/22 for Resident #61. The comments showed "awaiting pharmacy".</p>	F 658	<p>White Oak Manor -- Burlington provides services to meet professional standards.</p> <p>Resident #61 had no adverse effects from not receive the Fluoxetine used as an antidepressant from 2/12/22 through 2/15/22. The physician was notified on 2/23/22 and evaluated Resident #61 with no concerns identified and no changes made to the order. There has not been any further incident involving Resident #61's Fluoxetine since 2/15/22, and the medication has continued to be administered as ordered.</p> <p>An audit was started by the director of nursing (DON) for current residents on antidepressants and solution medications (such as Resident #61's Fluoxetine) and will be completed by 3/18/22.</p> <p>Current and newly admitted residents requiring solution medications will receive the medication as ordered.</p> <p>The licensed nursing staff were re-educated by the staff development coordinator (SDC) on ensuring the physician orders are being followed as instructed. If a medication is unavailable, the physician will be notified and follow any new orders, then notify the resident representative and document. This</p>		

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F 658	<p>Continued From page 5</p> <p>A review of the nurses ' notes, written by Nurse #6, dated 2/12/22 and 2/13/22, for Resident #61 revealed no documentation, related to Fluoxetine.</p> <p>A review of the nurses ' notes, written by Nurse #5, dated 2/14/22, for Resident #61 revealed that Fluoxetine was not administered. The comment was "awaiting pharmacy".</p> <p>A review of the nurses ' notes, written by Nurse #5, dated 2/15/22, for Resident #61 revealed that Fluoxetine was not administered. The comment was "arriving on 2/16/22".</p> <p>On 2/23/22 at 12:20 PM, during an interview, Nurse #5 indicated that the Resident #61 had an order of Fluoxetine 10 mg once a day in the morning. On 2/14/22 and 2/15/22, the facility did not have the medication Fluoxetine available for administration. The Nurse #5 was aware that Fluoxetine was ordered from pharmacy prior to her shift.</p> <p>On 2/23/22 at 1:20 PM, during the phone interview, Nurse #6 indicated that Resident #61 received Fluoxetine daily per physician ' s order. On 2/12/22 and 2/13/22, there was no Fluoxetine available for administration. The Nurse #6 placed the pharmacy order for Fluoxetine for Resident #61 on 2/12/22.</p> <p>On 2/23/22 at 1:45 PM, during the phone interview, Nurse Practitioner (NP) expected the facility to provide all the prescribed medications for Resident #61. The NP confirmed she was not aware that Resident #61 did not receive Fluoxetine on 2/12/22-2/15/22.</p>	F 658	<p>re-education started on 2/23/22 and completed on 2/27/22.</p> <p>New hired licensed nurses will receive this education during their job orientation by the SDC.</p> <p>The nursing administration will monitor physician orders administered as order for 10 residents weekly for 4 weeks, then 5 residents weekly for 4 weeks, and then 3 residents weekly for 4 weeks, and then as needed thereafter.</p> <p>Any identified trends or issues from the monitoring will be discussed during the morning quality improvement (QI) meetings weekly for 12 weeks, and then as needed.</p> <p>The DON is responsible for the ongoing compliance of F658</p>		

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F 658	Continued From page 6 On 2/23/22 at 1:40 PM, during an interview, Director of Nursing (DON) indicated that the facility automatically weekly received scheduled medications from pharmacy. The floor nurses were responsible to follow the pharmacy orders. He expected the staff to have all prescribed medications available for administration.	F 658			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)  §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and  §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations the facility failed to apply a splint as ordered for contracture management to 1 of 2 residents (Resident #96) reviewed for range of motion.  Findings include:	F 688	White Oak Manor -- Burlington ensures that residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably avoidable.	3/25/22	

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F 688	<p>Continued From page 7</p> <p>Resident #96 was admitted to the facility on 11/24/21 with diagnosis that included hypertension, stroke with right sided weakness and seizure disorder.</p> <p>A review of Resident #96's quarterly minimum data set assessment (MDS) dated 01/31/22 indicated Resident #96 was moderately cognitively impaired, required one-person physical assist with bed mobility and transfers and required one-person physical assist with activities of daily living (ADL).</p> <p>A review of Resident #96 plan of care dated 02/15/22 revealed a focus of splinting Resident #96's right upper extremity with a goal of Resident #96 not developing further contractures. Interventions were put into place to assist Resident #96 in meeting these goals such as apply right hand guard always except during hygiene, range of motion and splinting tasks.</p> <p>A review of the Physician's orders dated 02/16/22 revealed an order for Resident #96 to have a right hand guard on always except during hygiene, range of motion and splinting tasks as tolerated by the resident.</p> <p>A review of the facility staffing dated 02/21/22 through 02/22/22 revealed Restorative Aides #1 and #2 were assigned to staff the floor as Nurse Aides (NA).</p> <p>Observations conducted on 02/21/22 at 10:00am and 2/22/22 at 10:00am revealed Resident #96 right hand is contracted in a closed fist and the hand guard splint was on the adjacent bed.</p> <p>An interview conducted on 02/22/22 1:24pm with</p>	F 688	<p>Resident #61's right hand splint was applied when facility was notified by the surveyor on 2/2/22.</p> <p>The facility's licensed nurses/nursing administration completed an audit for the current residents with splint devices on 2/23/22 to ensure the devices were in place.</p> <p>New admitted residents or newly recommended devices for residents will be applied as indicated.</p> <p>Re-education to ensure safety devices are in place as ordered per restorative program and documented completed by the staff development coordinator (SDC) on 2/22/22 and completed on 2/27/22. Newly hired nursing staff will be educated during their orientation by nursing administration including the SDC.</p> <p>The restorative nurse will monitor by checking 5 residents randomly with have an order for a splint weekly for 12 weeks and then as needed their after.</p> <p>Results of the monitoring will be discussed during the morning quality improvement (QI) meeting weekly for 3 months and the brought to the Quality Assurance (QA) Meetings for further recommendations as needed.</p> <p>The DON is responsible for ongoing compliance with F688.</p>		



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F 688	<p>Continued From page 8</p> <p>a Nurse Aide (NA) #1 stated that she does not have any involvement in placing Resident #96's splints on and was not sure whether Resident #96 has worn them or not. The NA stated that it was the responsibility of the Nurse or the Restorative Aids to place the splints on the resident.</p> <p>An interview conducted on 2/23/22 at 1:13pm with Restorative Aide #2 stated when she was assigned as an NA then she will complete the restorative tasks for the residents she was assigned to. The Restorative Aide further stated that she was not assigned to Resident #96 on 02/21/22 through 02/22/22 and therefore it would be the responsibility of the Nurse to apply the splints as ordered.</p> <p>An interview conducted on 2/24/22 at 2:13pm with Restorative Aide #1 stated when she was assigned as an NA then she will complete the restorative tasks for the residents she was assigned to. The Restorative Aide further stated that she was not assigned to Resident #96 on 02/21/22 through 02/22/22 and therefore it would be the responsibility of the Nurse to apply the splints as ordered.</p> <p>An interview conducted on 02/24/22 at 1:00pm with Nurse #4 stated it is the responsibility of the Restorative Aides to apply splints. Nurse #4 stated that when the Restorative Aides are assigned to staff the floor then it is the responsibility of the Nurse assigned to the Resident to apply the splints. Nurse #4 further stated the facility is currently working on a process to ensure the splints are applied when the Restorative Aides are pulled to the floor.</p>	F 688			

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NAME OF PROVIDER OR SUPPLIER  <b>WHITE OAK MANOR - BURLINGTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>323 BALDWIN ROAD</b> <b>BURLINGTON, NC 27217</b>		
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F 688	<p>Continued From page 9</p> <p>An interview conducted on 02/23/22 at 11:15am with Nurse #2, assigned to Resident #96, stated that the Restorative Aides are responsible for placing splints and performing range of motion activities. Nurse #2 further stated that occasionally the Restorative Aides are assigned to the floor and then the splints and range of motion task are the responsibility of the Nurse. Nurse #2 stated that splints and range of motion tasks do not show on the medication administration record (MAR) or treatment administration record (TAR) and that is why Resident #96 did not have her splints applied.</p> <p>An interview conducted on 02/22/22 at 11:00am with the Restorative Nurse Coordinator (RNC) stated it is the responsibility of the Nurse assigned to the resident to apply the splints whenever the Restorative Aides are assigned to the floor. The RNC further stated that the restorative tasks do not show on the MAR and TAR which results in the assigned Nurse failing to apply the splints. The RNC stated that the facility is currently working on a process that will correct this issue.</p> <p>An interview conducted on 02/24/22 at 10:00am with Director of Nursing (DON) stated when the Restorative Aides are assigned to work as NA's then it should be the responsibility of the Nurse to apply the splints. The DON further stated that he is currently working to train NA's to be able to apply the splints when the Restorative Aides are assigned to the floor.</p>	F 688			