STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING ______ B. WING ______	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	**323 BALDWIN ROAD BURLINGTON, NC 27217**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 6/19/2023 through 6/22/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #B55V	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 6/19/2023 through 6/22/2023. Event ID# B55V11. The following intakes were investigated NC00192082, NC00193957, NC00195071, NC00195646, NC00198510, NC00198785, NC00199669, NC00199809, NC00201043, NC00202688. Additional information for citation was obtained from the facility after the exit, therefore, the exit date was changed to 6/23/23. 5 of the 28 complaint allegations resulted in deficiencies.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		7/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/14/2023

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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and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews, interview with the Resident Representative and record reviews, the facility failed to provide the resident and Resident Representative a written notification for the reason for transfer to the hospital for 2 of 3 residents (Resident #60 and Resident #26) reviewed for hospitalization.

Findings included:

1. Resident #60 was admitted to the facility on 7/22/22. He discharged to the hospital on 1/3/23 and was re-admitted to the facility on 1/12/23.

The medical record revealed Resident #60's contact person was a family member. The medical record demonstrated the resident was transferred to the hospital on 1/3/23 due to a change in condition. Resident #60 returned to the facility on 1/12/23. No written notice of transfer was documented to have been provided to the resident or Resident Representative.

A written grievance dated 1/11/23 and filed by the Resident Representative was reviewed. The grievance alleged the facility had not notified the Resident Representative when Resident #60 was transferred to the hospital on 1/3/23. The grievance further stated no paperwork was sent with Resident #60 when he was sent to the hospital.

The quarterly Minimum Data Set (MDS) assessment dated 4/19/23 indicated Resident #60 was cognitively intact.

F 623

White Oak of Burlington will ensure Residents and Resident Representatives will be provided with a written notification for the reason for the transfer to the hospital.

If transferred to the hospital, including Resident #60 and #25 and other current residents and resident representatives will be provided with a written notice of transfer to the hospital. The Social Services positions were filled to ensure notification of transfer of the residents to the resident representatives are completed. the Social Services staff will provide the transfer notification to the resident representative by mail on the day of transfer or the next business day if the transfer occurred after business hours.

Full-time Social Services Director (SSD) started her employment at the facility on 4/7/23, and received education on Transfer Notices on 4/27/23 by the Corporate Social Services Consultant during orientation. A Social Services Assistant (SSA) started full-time employment with in-house transfer to the Social Services Department in the facility on 6/27/23.

An audit was completed by the SSD and Corporate Social Services Consultant on 7/12/23 of discharged residents to the hospital from 4/7/23 to 7/12/23 regarding

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On 6/19/23 at 1:35 PM, an interview was conducted with Resident #60. He shared he went to the hospital earlier in the year and stayed 2-3 days. He stated his family member was typically notified when there was a change in his condition but said the family member was not notified in writing when he transferred to the hospital. Resident #60 said he was not provided with a written notice of transfer/discharge when he went to the hospital.

An attempt to interview Nurse #9, the nurse on duty when Resident #60 was transferred to the hospital, was unsuccessful.

Attempts to interview Resident #60's representative were unsuccessful.

Unit Manager #1 was interviewed on 6/21/23 at 1:14 PM. She explained when a resident was sent to the hospital, the nurse sent the following paperwork with the resident: face sheet, physician orders, notice of transfer/discharge, clinical information and bed hold policy. She said the forms were kept in a blue binder at the nurse's desk and any nurse could pull the forms and send them with the resident when they were transferred to the hospital.

During an interview with the Social Worker (SW) on 6/21/23 at 9:42 AM, she stated when a resident transferred to the hospital, she sent a copy of the transfer/discharge notice to the Resident Representative by the next business day. The SW said she began working at the facility in April 2023 and started sending the transfer/discharge notices in May 2023. She was unsure if the notices were sent to Resident

F 623

written notification with the reasoning for the transfer to the hospital.

The current Licensed Nursing staff and the Social Services Department was re-educated on the process of providing the written notice of transfer to residents/resident representatives when transferred to the hospital, and the reason for the transfer. The education included Transfer packets to the hospital are located in each resident's chart which includes the Transfer Notice, and is available for the staff to complete and provide to the residents/resident representatives. The re-education was completed by the Corporate Social Services Consultant and/or Staff Development Coordinator (SDC) initially completed on 6/27/23 and again started on 7/12/23 and completed on 7/17/23.

Newly hired Licensed Nursing staff and Social Services staff will receive this education during their job specific orientation by the SDC.
The clinical record for residents, who are transferred to the hospital, will be monitored to ensure the completion of the written transfer notice and a copy given to the residents/resident representatives for all discharges to the hospital for 4 weeks, than 5 transfers to the hospital for 4 weeks, and then 3 transfers to the hospital for 4 weeks. The monitoring will be completed by the SSD.
The identified issues or trends will be discussed during the morning Quality Improvement (QI) meeting weekly, and

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F 623	Continued From page 5 Representatives prior to her arrival at the facility. On 6/21/23 at 2:51 PM an interview was completed with the Corporate Social Services Consultant. She said typically when a resident discharged to the hospital, the next day the SW mailed a copy of the transfer/discharge notice to the Resident Representative. She acknowledged this was not completed at the time Resident #60 transferred to the hospital because there was no SW in the facility. She shared the new full time SW had started sending a copy of the transfer/discharge notice to Resident Representatives when a resident transferred to the hospital. 2. Resident #26 was admitted to the facility on 4/4/12. She discharged to the hospital on 3/10/23 and was re-admitted to the facility on 3/13/23. The medical record revealed Resident #26's contact person was a legal guardian. The medical record demonstrated the resident was transferred to the hospital on 3/10/23 due to a change in condition. Resident #26 returned to the facility on 3/13/23. No written notice of transfer was documented to have been provided to the Resident Representative. The quarterly MDS assessment dated 4/11/23 indicated Resident #26 was cognitively intact. An interview was conducted with Nurse #1 on 6/20/23 at 3:24 PM, during which she stated Resident #26 was transferred to the hospital 3/10/23 due to a change in condition. Nurse #1 was unable to recall if a written notification of transfer/discharge was provided to the Resident Representative after the resident was sent to the	F 623	then further recommendations reviewed with the Quality Assurance (QA) Committee. The Director of Nursing (DON) and SSD are responsible for the ongoing compliance of F623. Compliance date is 7/21/23.	

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F 623	Continued From page 6 hospital. In a telephone interview with Resident #26's Representative on 6/23/23 at 1:40 PM, she stated the facility called her when Resident #26 was transferred to the hospital in March 2023. She said she had not received any written notification from the facility of the transfer/discharge to the hospital. Unit Manager #1 was interviewed on 6/21/23 at 1:14 PM. She explained when a resident was sent to the hospital, the nurse sent the following paperwork with the resident: face sheet, physician orders, notice of transfer/discharge, clinical information and bed hold policy. She said the forms were kept in a blue binder at the nurse's desk and any nurse could pull the forms and send them with the resident when they were transferred to the hospital. During an interview with the SW on 6/21/23 at 9:42 AM, she stated when a resident transferred to the hospital, she sent a copy of the transfer/discharge notice to the Resident Representative by the next business day. The SW said she began working at the facility in April 2023 and started sending the transfer/discharge notices in May 2023. She was unsure if the notices were sent to Resident Representatives prior to her arrival at the facility. On 6/21/23 at 2:51 PM an interview was completed with the Corporate Social Services Consultant. She said typically when a resident discharged to the hospital, the next day the SW mailed a copy of the transfer/discharge notice to the Resident Representative. She acknowledged this was not completed at the time Resident #26	F 623		

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F 623	Continued From page 7 transferred to the hospital because there was no SW in the facility. She shared the new full time SW had started sending a copy of the transfer/discharge notice to Resident Representatives when a resident transferred to the hospital.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		7/21/23

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Based on record review and staff, resident and resident representative interviews, the facility failed to conduct care plan meetings with residents or resident representatives for 2 of 24 sampled residents reviewed for care plans. (Resident #91 and Resident #34)

Finding include:

1.Resident #91 was readmitted on 4/14/23. A record review of the admission Minimum Data Set (MDS) assessment dated 4/20/23 revealed Resident #91 was admitted on 4/5/21 and was assessed as cognitively intact.

Review of Resident #91's care plan revealed the care plan was reviewed and revised on 4/19/23, but there was no indication that resident participated in the care plan meeting or development of the care plan.

During an interview on 6/19/23 at 9:55 AM, Resident #91 indicated he had not been invited to attend a care plan meeting and did not recall participating in development of his plan of care.

During an interview on 6/21/23 at 10:15 AM, the Social Worker (SW), indicated she was hired in April 2023. She further indicated the MDS nurses would send out a monthly schedule for care plan meetings. A letter was sent out to the families and residents regarding the care plan meetings based on the schedule provided. The SW stated based on the documentation available, Resident #91's previous care plan meeting was conducted on 1/4/22. The Social Worker indicated there was no documentation regarding other care plan meetings and she was unable to confirm if there was one conducted in past few months for

F 657

White Oak of Burlington will ensure care plan meetings are conducted with residents and/or resident representatives.

Resident #91 discharged home as planned discharge on 6/21/23. Resident #34 and Resident Representative received invitation and participated in the care plan meeting on 6/27/23.

An audit will be completed from 6/26/23 to 7/14/23 regarding care plan meetings and the invitation / participation of Residents and Representatives. The audit will be completed by the Corporate Director of RAI and Clinical Reimbursement by 7/17/23.

Current and newly admitted residents and the resident representative will be invited to care plan meetings, and the care plan meetings will be conducted.

Full-time SSD started her employment at the facility on 4/7/23. The Interdisciplinary Team were re-educated on conducting care plan meetings with the Residents and/or Resident Representative along with documentation that the care plan meetings were conducted. This re-education was completed by the Corporate Director of RAI and Clinical Reimbursement on 6/27/23.

Newly hired Interdisciplinary Team will receive this education during during their job specific orientation by the Resident Assessment Coordinator (RAC) Nurse and /or SSD.

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F 657	Continued From page 9 Resident #91. She stated she was unsure if there was any social worker available in the facility to complete the care plan meeting. During an interview on 6/22/23 at 9:42 AM, MDS Nurse #1 and MDS Nurse #2 both indicated they did not conduct some care plan meetings when there was no social worker available in the facility. They indicated the facility SW was responsible for setting up care plan meetings with the residents and their family members. Both MDS Nurses stated when the facility did not have any SW, the unit managers were talking to families visiting the residents regarding their medication and any changes. They stated those unit managers were no longer worked for the facility. MDS Nurse #1 and Nurse #2 stated they could not confirm if any care plan meetings were conducted for Resident #91. During an interview on 6/21/23 at 1:15 PM, The Director of Nursing (DON) stated the facility's Social Workers had each quit their position in mid-January 2023. A new Social Worker was hired to this position in April 2023. The DON indicated the SW was working part-time for the facility prior to her hire as the facility's full time social worker. The facility did not have a social worker on a full-time basis from mid-January to March 2023 and some of the care plan conferences were not conducted at that time. During an interview on 6/22/23 at 10:34 AM, the Social Services Consultant (Corporate) stated, the facility had two qualified staff working as part time social workers and were assisting with the residents' MDS assessments. The MDS staff were supposed to arrange the care plan meetings in the absence of the social worker, and they had	F 657	The RAC nurse will monitor the care plan meetings being conducted weekly for 8 residents for 4 weeks, then 5 residents for weekly for 4 weeks, and then 3 residents weekly for 4 weeks. The identified issues or trends will be discussed during the morning QI meeting weekly, and then further recommendations reviewed with the QA committee. The RAC nurses and SSD are responsible for the ongoing compliance of F657. Compliance date is 07/21/23.	

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F 657	Continued From page 10 not been conducting them. The Social Services Consultant stated this impacted some of the care plan conferences during that time. 2. Resident #34 was admitted on 9/21/20. A record review of the quarterly Minimum Data Set (MDS) assessment dated 6/6/23 revealed Resident #34 was assessed as cognitively impaired. Review of Resident #34's care plan revealed the care plan was reviewed and revised on 3/14/23, but there was no indication that resident representative participated in the care plan meeting or development of the care plan. During an interview on 6/19/23 at 2:45 PM, Resident #34' representative indicated she had not been participating in the care plan meeting. She stated she did receive a letter regarding the date for when the meeting was scheduled to be held, but on that date, there was no one to conduct the care plan meeting. She further stated the staff member who regularly conducted care plan meetings had quit her job and hence no one was conducting the care plan meetings. During an interview on 6/21/23 at 10:15 AM, the Social Worker (SW), indicated she was hired in April 2023. She further indicated the MDS nurses would send out a monthly schedule for care plan meetings. A letter was sent out to the families and residents regarding the care plan meetings based on the schedule provided. The SW stated Resident #34's was scheduled for a care plan meeting in June and an invitation letter to the resident's representative would be mailed out soon. The Social Worker indicated there was no documentation regarding other care plan	F 657		

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F 657	Continued From page 11	F 657		

meetings and she was unable to confirm if there was one conducted in past few months for Resident #34. She stated she was unsure if there was any social worker available in the facility to complete the previous care plan meeting.

During an interview on 6/22/23 at 9:42 AM, MDS Nurse #1 and MDS Nurse #2 both indicated they did not conduct some care plan meetings when there was no social worker available in the facility. They indicated the facility SW was responsible for setting up care plan meetings with the residents and their family members. Both MDS Nurses stated when the facility did not have any SW, the unit managers were talking to families visiting the residents regarding their medication and any changes. They stated those unit managers no longer worked for the facility. MDS Nurse #1 and Nurse #2 stated they could not confirm if any care plan meetings were conducted for Resident #34.

During an interview on 6/21/23 at 1:15 PM, The Director of Nursing (DON) stated the facility's Social Workers had each quit their position in mid-January 2023. A new Social Worker was hired to this position in April 2023. The DON indicated the SW was working parttime for the facility prior to her hire as the facility's full time social worker. The facility did not have a social worker on a full-time basis from mid-January to March 2023 and some of the care plan conferences were not conducted at that time.

During an interview on 6/22/23 at 10:34 AM, the Social Services Consultant (Corporate) stated, the facility had 2 qualified staff working as part time social workers and were assisting with the residents' MDS assessments. The MDS staff were supposed to arrange the care plan meetings

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F 657	Continued From page 12 in the absence of the social worker, and they had not been conducting them. The Social Services Consultant stated this impacted some of the care plan conferences during that time.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to safely transfer a resident from his bed to the wheelchair, failed to immediately notify the nurse of a fall when the resident was lowered to the floor by a staff member during the transfer and failed to investigate the cause of the fall by not interviewing the staff member who was present during the fall. This affected 1 of 11 residents (Resident #60) reviewed for accidents. Findings included: Resident #60 was re-admitted to the facility on 1/12/23. Diagnoses included, in part, hemiplegia and cerebrovascular accident. The quarterly Minimum Data Set (MDS) assessment dated 4/19/23 revealed Resident #60 was cognitively intact. He required extensive assistance with the help of two people for	F 689	White Oak of Burlington ensures the resident's environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. Resident #60 was was transferred from the bed to wheelchair which resulted in the resident in the resident being lowered to the floor by a Hospice staff member. The staff member did not immediately notify the nurse of the fall, and the investigation was not complete by not interviewing the Hospice staff member involved. Resident #60 continues to be care planned for risk for falls and was not injured during the identified incident. Resident #60 lift status was reassessed by the Safety Nurse on 7/12/23 for appropriate status to prevent further	7/21/23

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F 689

Continued From page 13
transfers.

The care plan included a focus area of risk for falls. A care plan intervention dated 1/13/23 stated, "Two person pivot transfers."

An Occurrence Report dated 5/4/23 and completed by Nurse #7 stated the following: Date of occurrence 5/3/23. The resident stated to the writer that yesterday around 9:00 AM the agency Nursing Assistant (NA) dropped the resident on the floor. The resident stated that the NA did not use a lift to get resident out of the bed. The resident stated that the wheelchair was not locked. The resident stated that he was on the floor waiting for help. There was no apparent injury. Additional information included in the report indicated the agency NA had not assisted with the transfer; rather, a Hospice NA had assisted Resident #60.

The falls care plan was updated 5/8/23 and included an intervention of "transfer resident out of bed as per facility protocol."

The Safe Resident Handling Data Collection form, located in Resident #60's paper chart, was reviewed (not dated) and indicated a total lift was required when transferring Resident #60.

On 6/21/23 at 1:00 PM an observation of Resident #60's room door revealed a sticker on the wall next to his name that had a picture of a mechanical lift and indicated two staff were needed to operate the lift to transfer the resident.

During an interview with Resident #60 on 6/21/23 at 1:08 PM, he shared normally there were two staff members who assisted him with transfers

F 689

accidents during transfers.

An audit of residents with falls for June 2023 was completed by the Safety Nurse on 7/12/23 to assure no other residents were transferred by contracted staff members, and whether a fall resulted from not following lift status. Another audit of residents' lift status was also completed to assure the current residents have proper lift status for the Nursing staff to follow. This audit will be completed on 7/17/23 by the Safety Nurse.

Newly admitted residents will be assessed for proper lift status for the Nursing staff to follow.

When investigated by the DON during survey and confirmed again on 7/13/23 with the Hospice Service, their CNAs denied being involved in the incident, and the Hospice CNA allegedly involved could not be identified. The contracted Hospice staff was educated by the Hospice Supervisor to not transfer facility's residents. This re-education was initially started on 6/26/23 and will be completed by 7/17/23 by the DON and SDC.

The current Nursing staff were re-educated on appropriate use of mechanical lifts, residents' lift status and no contracted staff members, such as Hospice, to transfer facility's residents. This re-education was initially started on 6/26/23 and will be completed by 7/17/23 by the DON and SDC.

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F 689	Continued From page 14 and they used a mechanical lift. He recalled on 5/3/23 there was one NA who helped with his transfer from the bed to his wheelchair. The NA had not used the mechanical lift during the transfer. He stated during the transfer, the wheelchair slid away and the NA assisted him to the floor. Resident #60 said the NA left the room and got another staff member to help. He added the NA "called a man to help her" put him back in the bed. He stated he was not injured when he was assisted to the floor and didn't think the NA told the nurse about the fall. NA #10 was interviewed on 6/21/23 at 11:15 AM. She said she worked on the day Resident #60 fell but had not worked with the resident that day. She recalled Hospice NA #1 was in the building and did not want to work with her assigned Hospice resident since the Hospice resident's roommate had COVID. NA #10 stated she thought Hospice NA #1 and NA #11 (an agency NA who was assigned to Resident #60) switched residents and Hospice NA #1 assisted Resident #60 with his care. When NA #10 came to work on 5/4/23 she heard Resident #60 had fallen during a transfer. She said she didn't think anyone reported the fall until Resident #60 said something to staff on 5/4/23. NA #10 explained that typically, if a resident fell or was assisted to the ground, staff immediately notified the nurse before the resident was moved back into bed. Attempts to interview NA #11 and Hospice NA #1 were unsuccessful. On 6/21/23 at 1:59 PM an interview was conducted with Floor Technician #1. He confirmed he worked at the facility on 5/3/23. He recalled the NA came out of Resident #60's room	F 689	Newly hired Nursing staff will receive this education during the job specific orientation by the SDC. The DON and Nursing Administration will monitor 6 residents with falls for 4 weeks, then 4 residents for 4 weeks, and then 2 residents for 4 weeks. The identified issues or trends will be discussed during the morning QI meeting weekly, and then further recommendations reviewed with the QA Committee. The Director of Nursing is responsible for the ongoing compliance of F689. Compliance date is 7/21/23.	

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F 689	Continued From page 15 and asked him if there was anyone at the nurse's station that could help her. Floor Technician #1 said there wasn't anyone at the nurse's station and the NA asked if he could help her. He informed the NA he wasn't permitted to lift any resident. He entered Resident #60's room and observed the resident seated on the floor next to the bed and was leaned up against the side of the bed. The wheelchair was next to the bed. Floor Technician #1 explained he locked the wheels on the wheelchair and then held on to the handles at the back of the wheelchair while the NA attempted to lift Resident #60 up into the wheelchair. He said the NA "still had problems lifting him up to the chair." Floor Technician #1 said he then left the room and added the next time he saw Resident #60 was about 5-10 minutes later and he was seated in the wheelchair. A telephone interview was conducted with Nurse #8 on 6/21/23 at 2:22 PM. She verified she was Resident #60's nurse on 5/3/23. She was unable to recall the events of the day but added she didn't think anyone notified her of Resident #60's fall. She explained when a resident fell, she immediately went to the resident's room and completed an assessment before the resident was moved. In a telephone interview with Nurse #7 on 6/20/23 at 4:03 PM, she said when she worked with Resident #60 on 5/4/23, he told her about the fall that occurred on 5/3/23. She began an incident report when the resident informed her about the fall. Nurse #7 said she was told by other staff that a Hospice NA had been in Resident #60's room helping another NA. She then stated she mistakenly put Hospice NA on the report instead	F 689		

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F 689	Continued From page 16	F 689		

of an agency NA. She added the NAs went to transfer Resident #60 into a wheelchair but had not used the mechanical lift; the wheelchair was not locked and Resident #60 was lowered down to the floor.

Unit Manager #1 was interviewed on 6/20/23 at 12:07 PM, 6/21/23 at 9:24 AM, and 6/21/23 at 1:38 PM. She explained staff identified a resident's transfer status when they looked at the picture on the sticker to the side of the resident's door. She said on 5/3/23 Hospice NA #1 was in Resident #60's room and tried to assist him with a transfer but didn't know his "lift status." She said Hospice NA #1 tried to transfer the resident by herself and when she put him in the wheelchair, it was not locked, rolled away and she assisted Resident #60 to the floor. She stated the resident was not injured. Unit Manager #1 further added she worked the day he fell and recalled during shift change in the afternoon she overheard a NA comment about Resident #60's fall. She heard that NA #11 and Hospice NA #1 had switched a resident assignment and that Hospice NA #1 assisted Resident #60 with the transfer. After she heard about his fall, Unit Manager #1 said she got busy with her work and forgot to check on Resident #60, then was off work for two days. She recalled Nurse #7 called her on 5/4/23 and asked about the fall.

On 6/22/23 at 8:56 AM an interview was conducted with the Safety Nurse. She explained when a resident was admitted to the facility, the admission nurse assessed the resident and determined how much help was required to safely transfer a resident. Once the transfer status was identified, a sticker was put on the resident's door. Information about the transfer status was

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F 689	Continued From page 17 also included in the resident's paper chart. The Safety Nurse shared that Resident #60 had been identified as needing a mechanical lift for "quite a while" and staff utilized a mechanical lift in May 2023, prior to the fall. She stated when a resident fell, the nurse on duty started documentation on the incident/occurrence report. Unit Coordinators then reported the fall in the morning meeting and the interdisciplinary team discussed fall prevention interventions. An investigation was completed and information from the investigation went to the care plan nurse and then was forwarded to the Director of Nursing (DON) and Administrator who signed off on the investigations. The DON and Unit Manager #1 were interviewed on 6/21/23 at 1:46 PM. Unit Manager #1 stated any time a resident fell, the nurse assessed the resident prior to the resident being moved back into bed. The assessment included vital signs, neurological checks, range of motion evaluation and resident interview about what happened. The DON added, "We are a no lift facility," and explained, after a fall, a resident was to be transferred back into bed with a mechanical lift. During an interview with the DON, Administrator and Corporate Nurse on 6/22/23 at 1:19 PM, the DON revealed at the time of the survey she learned Hospice NA#1 and NA #11 had switched part of their assigned duties and Hospice NA #1 assisted Resident #60 with the transfer. She shared other staff informed her that Hospice NA #1 hadn't assisted her assigned Hospice resident because the Hospice resident's roommate had COVID and Hospice NA #1 didn't want to enter the room and so she switched room assignments with NA #11. The DON thought at the time of the	F 689		

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F 689	Continued From page 18 fall, Resident #60 was a two person stand and pivot assist, and not a mechanical lift. She explained when a resident fell, the nurse initiated an incident report which was brought to the interdisciplinary team for review and discussion. Part of the discussions included implementing a new intervention for fall prevention. The DON said she thought two nurse aides had assisted with the transfer but had not interviewed the NAs as part of the facility's investigation of the fall. She added the facility completed education with all nursing staff regarding identifying transfer status, use of mechanical lifts for transfers and notifying the charge nurse immediately after a resident fell.	F 689		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to use the service of a registered nurse (RN) for at least 8 consecutive hours (hrs.) a day for 4 of 52 days reviewed (5/6/23, 5/7/23,	F 727	White Oak of Burlington will ensure the services of Registered Nurse (RN) for the least 8 consecutive hours a day, 7 days a week.	7/21/23

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F 727	Continued From page 19 5/13/23 and 5/14/23). Findings included: Review of staffing sheets from 5/1/23 through 6/21/23 revealed the following: On 5/6/23 the staffing sheets indicated "0" (zero) RN on duty. On 5/7/23 the staffing sheets indicated "0" (zero) RN on duty. On 5/13/23 the staffing sheets indicated "0" (zero) RN on duty. On 5/14/23 the staffing sheets indicated "0" (zero) RN on duty. During an interview on 6/22/23 at 9:04 AM, the Staff Development Coordinator (SDC) stated that she was handling the scheduler position since 6/9/23 The SDC further stated the facility had 3 RNs and all efforts were made to ensure there was at least one RN working 8 hours per day. The SDC indicated the facility had contract with 4 staffing agencies and these agencies were contacted when there was no RN available working at least 8 consecutive hours a day. She acknowledged that based on the staffing schedule on 5/6/23, 5/7/23, 5/13/23 and 5/14/23 there was no RN on duty. During an interview on 6/22/23 at 9:13 AM, the Director of Nursing (DON) stated the facility had contracts with 4 staffing agencies. The DON indicated the previous scheduler was not making efforts to staff RNs. On days when there was no RN on the schedule, the DON stated she would come to the facility to provide supervision over Licensed Practice Nurse (LPNs) and Med Aides. She stated she did not work on the medication cart when she had come in when there was no	F 727	The facility will continue utilize agency staff, and making efforts to hire new registered Nurses for openings that are available. An audit was completed by the Human Resources Director, from 6/22/23 to 7/12/23 to ensure RN coverage for 8 consecutive hours a day was achieved. The DON re-educated the current Licensed Nursing staff and Staffing Coordinator on the requirements for of RN coverage for at least 8 consecutive hours a day, 7 days a week. This re-education will be completed by 6/27/23. Newly hired Licensed Nursing staff and Staff Coordinators will receive this education during their job specific orientation by the SDC. The Human Resources Director will monitor the number of RN hours worked per day for 12 weeks. The identified issues or trends will will be discussed during the morning QI meeting weekly, and then further recommendations reviewed with the QA Committee. The DON is responsible for the ongoing compliance of F727. Compliance date is 7/21/23.	

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F 727	Continued From page 20 RN. She explained she was covering the RN requirement for 8 hours as needed. The DON stated the facility was making every effort to ensure there was a Registered nurse for 8 hrs. a day. The previous scheduler was no longer employed by the facility and was unavailable for interview.	F 727		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out	F 849		7/21/23

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F 849	Continued From page 21 at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical	F 849		

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F 849	Continued From page 22	F 849		

supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the

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WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 23 resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff	F 849		

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F 849	Continued From page 24 furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and family interview, the facility failed to notify a hospice agency when a resident enrolled in hospice had a change in his medical condition and was transferred to the hospital for 1 of 2 residents (Resident #423) reviewed for hospice. Findings included: Resident #423 was admitted to the facility on 12/9/23 with diagnoses that included chronic kidney disease, benign prostatic hyperplasia (enlarged prostrate), and urinary retention. Review of the comprehensive Minimum Data Set (MDS) dated 12/15/22 showed Resident #423 was cognitively moderately impaired. The MDS further showed Resident #423 had an indwelling foley catheter. Physician order dated 3/2/23 read admit to hospice services provided by (hospice agency name). Progress note dated 3/12/23 at 3:21 P.M. read in part "noted blood from indwelling catheter. Patient had increased diaphoresis (sweating to an	F 849	White Oak of Burlington will ensure hospice agencies are notified of Resident enrolled in hospice services are notified of change in condition and transferred to the hospital. Resident #423 expired on 3/14/23 at a hospice house. An audit was completed by the SSD on 7/23/23 to ensure the hospice agencies were notified of any changes in condition and transfers to the hospital for the current Residents that are enrolled in hospice services. Newly admitted Residents enrolled in hospice services, Licensed Nursing staff will notify the hospice agencies of any changes in condition and transfers to the hospital. The DON and SDC re-educated the current Licensed Nursing staff to ensure the hospice agencies are notified of any changes in condition and transfers to the hospital for the Residents that are	

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F 849 Continued From page 25

unusual degree), and emesis (vomiting) x 2 of food content. Nurse Practitioner (NP) notified; Responsible Party notified. Emergency Medical Services (EMS) called. Patient exited Skilled Nursing Facility (SNF) with EMS. Waiting patient return."

Progress note dated 3/12/23 at 7:57 P.M. read in part "Writer notified (responsible party's name) of patient's change in condition during shift. (Responsible party) stated send my dad to hospital due to change in condition. Writer then called EMS, NP notified of patient change, writer received order to send patient to hospital per family request. EMS arrived. PT exited SNF via EMS. Hospice call(ed) writer updated (on) patient condition."

An interview was conducted on 6/21/23 at 12:37 P.M. with Nurse #7. Nurse #7 indicated during her shift on 3/12/23, a nurse aide reported Resident #423 had blood in his urinary catheter bag. Nurse #7 assessed Resident #423 and called his responsible party, who wanted Resident #423 sent to the hospital for evaluation. Nurse #7 indicated she called the nursing home's on-call physician and received an order to send Resident #423 to the hospital. During the interview, Nurse #7 indicated she was unaware Resident #423 had been accepted into hospice services and she did not contact the hospice agency when Resident #423 had a change in his medical condition and was transferred to the hospital. Nurse #423 further indicated she remained unaware Resident #423 was in the hospice program until a nurse from Resident #423's hospice agency called and spoke with her on 3/12/23 after she had sent Resident #423 to the hospital. Nurse #7 indicated she would have

F 849

enrolled in hospice services. This re-education was completed on 6/27/23.

newly hired Licensed Nursing staff will receive this education during their job specific orientation by SDC.

The DON and Nursing Administration will monitor 7 residents enrolled in hospice services for 4 weeks regarding notification to the hospice agencies for change in condition or transfer to the hospital, then 4 residents for 4 weeks, and then 2 residents for 4 weeks.

The identified issues or trends will be discussed during the morning QI meeting weekly, and then further recommendations reviewed with the QA Committee.

The DON is responsible for the ongoing compliance of F849.

Compliance date is 7/21/23.

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called the hospice agency about the change in Resident #423's condition if she had known he was a hospice patient.

An interview was conducted on 6/20/23 at 10:12 A.M. with Resident #423's family member. During the interview, the family member indicated herself and Resident #423's responsible party went to the hospital on 3/12/23 when Resident #423 was transferred following a change in his medical condition. She indicated when they arrived, the hospital staff were unaware Resident #423's received services from a hospice agency. The family member stated she contacted Resident #423's hospice agency and made them aware Resident #423 was transferred to the hospital.

An interview was conducted on 6/22/23 at 12:00 P.M. with the Unit Manager. During the interview, the Unit Manager indicated on 3/12/23 when Resident #423 had a change in his medical condition and was taken to the hospital, his assigned nurse was responsible to contact his hospice agency at the time the change in condition occurred. The Unit Manager further indicated when a resident was on hospice, a label placed on the outside spine of the resident's paper medical chart kept at the nurse's station with the hospice agency's phone number, a sticker was placed on the inside cover of the resident's medical chart with the hospice agency information, and the resident's electronic medical records included the hospice agency's contact information. The Unit Manager was unsure why the nurse assigned Resident #423 on 3/12/23 was unaware Resident #423 was enrolled in hospice and had not provided the hospice agency with an update on Resident #423's condition.

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F 849	Continued From page 27 An interview was conducted on 6/22/23 at 1:07 P.M. with the Director of Nursing (DON). During the interview, the DON indicated when Resident #423 had a change in his medical condition and was taken to the hospital, his assigned nurse was responsible for immediately calling the hospice agency with an update on his condition. The DON indicated staff should first contact the hospice provider with any change in a hospice resident's condition and only if the hospice provider was unable to be reached, the next step was to contact the nursing home's physician for orders.	F 849		
F 850 SS=B	Qualifications of Social Worker >120 Beds CFR(s): 483.70(p)(1)(2) §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to employ a qualified Social Worker on a full-time basis from 1/12/23 to 4/2/23. Review of the daily census report revealed the census was greater than 120 for 56 of the 82 days reviewed.	F 850	White Oak of Burlington ensures a Social Worker is employed on a full-time basis. Full-time SSD started employment at the facility on 4/7/23, and received education on Care Plan Meetings on 6/15/23 by the	7/21/23

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F 850	Continued From page 28 Finding include: The facility's daily census report from January 2023 to April 2023 was reviewed. The report indicated the facility's census was greater than 120 from January 15th to January 30th, 2023. In February 2023 the facility census was greater than 120 from February 1st to February 23rd. The Census was greater than 120 from March 22nd to April 2nd, 2023. During an interview on 6/21/23 at 10:15 AM, the Social Worker (SW) stated she was hired by the facility on full time basis on 4/4/23. The SW further stated she was working part time since end of February 2023 and was assisting the facility's Minimum Data Set (MDS) Nurses complete the resident's MDS assessments. Review of the Social Worker's timecard revealed she worked. 11.25 hours from 2/1/23 to 2/9/23. 32.50 hours from 2/10/23 to 2/23/23 (2 weeks.) 25.25 hours from 2/24/23 to 3/9/23 (2 weeks). 30.50 hours from 3/10/23 to 3/23/23 (2 weeks). 51.25 hours from 3/24/23 to 4/6/23 (2 weeks). During an interview on 6/22/23 at 8:30 AM, the Admission Assistant stated she was assisting in social work role during the time when the facility did not have a full time Social Worker. She stated she held a degree in Bachelor of Science (Health system and Minor in Gerontology) and had previously worked as a Social Worker at their sister facility. She stated she was working few	F 850	Corporate Social Services Consultant during orientation, and then started conducting Care Plan meetings consistently. A Social Services Assistant (SSA) started full-time employment with in-house transfer to the Social Services Department in the facility on 6/27/23. newly hired Social Services staff will receive their education during their job specific orientation by the SDC and Corporate Social Services Consultant. The Human Resource Director will monitor the number of Social Work hours worked per day for 12 weeks. The identified issues or trends will be discussed during the morning QI meeting weekly, and then further recommendations reviewed with the QA Committee. The DON is responsible for the ongoing compliance of F850. Compliance date is 7/21/23.	

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F 850	Continued From page 29	F 850		

hours as a Social Worker for this facility.

Review of the Admission Assistant timecard revealed, she worked:
6.25 hours 12/30/22 to 1/12/13 (2 weeks period).
10 hours 1/13/23 to 1/26/23 (2 weeks).
13.50 hours overtime from 1/27/23 to 2/9/23 (2 weeks).
15.00 hours from 2/10/23 to 2/23/23 (2 weeks).
14.25 hours from 2/24/23 to 3/9/23 (2 weeks).
3.00 hours from 3/10/23 to 3/23/23 (2 weeks).
5.75 hours from 3/24/23 to 4/6/23 (2 weeks).

During an interview on 6/22/23 at 10:34 AM, Social Services Consultant (Corporate) stated she was available on phone as needed for any issues related to grievances/ concerns and other social services questions. She further stated the Admission Assistant was working as a part time Social Worker and was assisting with MDS assessments, discharge planning, ensuring safe discharges, and assisting with grievances. She added there was another Social Worker who was also working parttime and was assisting with the resident's MDS assessments. The Social Services Consultant stated some of the care plan conferences were not done at that time. She indicated the combined working time between these two staff members was less than 40 hours.

During an interview on 6/21/23 at 1:15 PM, The Director of Nursing (DON) stated the facility's Social Workers had quit their position in mid-January 2023. A new Social Worker was hired to this position in April 2023. The DON indicated the newly hired Social Worker was

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F 850	Continued From page 30 working parttime for the facility. She began full time Social Worker 4/3/23. The facility did not have a Social Worker on a full-time basis from mid-January to March 2023 and some of the care plan meeting did not occur at that time.	F 850		