STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 A unannounced recertification and complaint investigation survey was conducted 12/4/23 through 12/8/23. The facility was found in compliance with the requirements of CFR483.73 Emergency Preparedness. Event ID #7HUE11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 12/4/23 through 12/8/23. Event ID# 7HUE11. The following intakes were investigated: NC00197646, NC00198496, NC00199582, NC00199640, NC00200630, NC00200885, NC00202139, NC00202151, NC00202329, NC00204718, NC00205954, NC00207496, NC00208275, NC00208380, NC00208568, and NC00210185. 9 of the 41 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		1/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/29/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews and record review, the facility failed to provide a dignified dining experience when Nurse Aide (NA) #4 fed Resident #10 while 5 residents who were seated at the same table did not have their lunch. This failure occurred for 5 of 5 residents sampled for dignity (Residents #8, #39, #119, #70 and #100). The reasonable person concept was applied as individuals have the expectation of dining in a dignified environment. The findings included:	F 550	White Oak Manor - Charlotte will ensure each resident is treated with respect and dignity, and their rights are honored, including a dignified dining experience. Resident #10, #8, #39, #119, #70, #100, and current residents will be provided with a dignified dining experience and will have their meals provided at the same time when seated at the same table, whether it is set up for the resident or the resident is assisted with feeding their meal. Newly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	**4009 CRAIG AVENUE CHARLOTTE, NC 28211**

(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 550	Continued From page 2 1a. Resident #8 was re-admitted to the facility on 10/15/23. A quarterly Minimum Data Set (MDS) assessment dated 10/27/23 assessed Resident #8 with clear speech, adequate hearing/vision, no corrective lenses, or hearing aids, understood, able to understand, severely impaired cognition and fed herself after staff provided set up assistance. A care plan revised October 2023 recorded Resident #8 required assistance with setting up her meal tray, she fed herself and staff were to give her assistance to complete the task as needed. Resident #8 was observed on 12/4/23 at 12:45 PM seated in her wheelchair at a table in the 500/600 hall parlor with Residents #10, #39, #119, #70 and #100 while she waited for her lunch meal. During the observation, Resident #8, when asked how she was doing, replied to the surveyor, "I'm hungry." NA #4 was observed on 12/4/23 to assist Resident #10 to eat from 1:13 PM until 1:25 PM, Resident #100 fed himself from 1:17 PM until 1:31 PM, and NA #4 fed Resident #39 at 1:32 PM while Resident #8 waited. Resident #8 received her lunch meal from NA #5 at 1:41 PM, twenty-eight minutes after NA #4 began assisting Resident #10. At the time of the observation, NA #5 stated Resident #8's meal tray was not on the meal delivery cart, so she went to the kitchen to get it. During an interview on 12/07/23 at 2:21 PM NA #4 stated she was a Restorative Aide and a NA who assisted residents with their meals. NA #4	F 550	admitted residents will also have a dignified dining experience and will have their meals provided at the same time when seated at the same table. Re-education of the Nursing staff by Nursing Administration was started on 12/06/2023 when the meal observations were noted during the survey. The Nursing staff continued their re-education by the Staff development Coordinator (SDC) on the importance to provide the residents with a dignified dining experience by providing the residents their meals at the same time when seated at the same table whether it is set up for the resident or the resident is assisted with feeding their meal. This re-education will be completed by 01/05/2024. Newly hired Nursing Staff will be educated on the dignified dining experience for residents by the SDC during their job specific orientation. The Nursing Administration such as the Director of Nursing (DON), Assistant Director of Nursing (ADON), Clinical Coordinator, SDC or Nursing Supervisor will monitor 5 meals per week for 12 weeks to ensure residents" meals are served the same time when seated together whether it is set up or the resident is assisted with feeding their meals, and have dignified dining experiences. The identified trends or issues will be discussed weekly during the morning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 550 Continued From page 3

stated Resident #8 ate her meals well, but that she was not that familiar with the Resident's care needs. NA #4 stated she sat down to feed Resident #10 lunch on Monday, 12/4/23, but once she noticed the other Residents who were seated at the same time did not have their lunch, she knew the meal trays were not delivered to the unit at the same time, so she went ahead and fed Resident #10 so that her meal would not get cold.

NA #5 was interviewed on 12/06/23 at 12:06 PM. NA #5 stated she was the scheduler and a NA. She stated she was familiar with Resident #8 and described the Resident as able to make her needs known to staff. NA #5 stated she realized Resident #8 did not have a lunch meal when the last cart came on the unit around 1:20 PM, so she went to the kitchen to get her tray. NA #5 stated as it related to dignity she was trained that residents should not have to wait while others ate in front of them at the same table, but that was a frequent occurrence for residents who ate in the parlor on the 500/600 hall because their meal trays were delivered on different carts. NA #5 stated Residents who ate in the 500/600 hall parlor waited "15 minutes or so" before the next cart was delivered, so residents without a meal tray sat and waited.

A family interview occurred by phone for Resident #8 on 12/4/23 at 2:38 PM. When asked by the surveyor if Resident #8 would consider it undignified to wait at the dining table for her meal while other residents ate in front of her, the family member stated that he was not certain if Resident #8 would prefer to eat at the same time as her tablemates, but that he felt it was important for all residents seated at the same table to eat at the same time.

F 550

Quality Improvement (QI) meetings for 12 weeks, and then brought to the Quality Assurance (QA) Committee meetings for further recommendations as needed..

The Director of Nursing is responsible for the ongoing compliance F550.

The date of compliance is 01/05/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 550	Continued From page 4	F 550		

1b. Resident #39 was admitted to the facility on 1/16/21.

A quarterly MDS assessment dated 9/10/23 assessed Resident #39 with clear speech, adequate hearing, impaired vision, no corrective lenses, or hearing aids, understood, able to understand, severely impaired cognition and fed herself after staff provided set up assistance.

A care plan revised September 2023 recorded Resident #39 required assistance with setting up her meal tray, she fed herself and staff were to give her assistance to complete the task as needed.

Resident #39 was observed on 12/4/23 at 12:45 PM seated in her wheelchair at a table in the 500/600 hall parlor with Residents #10, #8, #119, #70 and #100 while she waited for her lunch meal. During the observation, Resident #39 asked Nurse #4 "Where is my lunch?" Nurse #4 replied, "It's coming we are waiting on it now." Resident #10 was assisted with her lunch meal by NA #4 from 1:13 PM until 1:25 PM and Resident #100 fed himself from 1:17 PM until 1:31 PM while Resident #39 waited. Resident #39 received her lunch meal at 1:32 PM, nineteen minutes after NA #4 began assisting Resident #10. NA #4 set up her lunch meal and assisted Resident #39 with eating.

During an interview on 12/07/23 at 2:24 PM NA #4 stated she was a Restorative Aide and a NA who assisted residents with their meals. NA #4 indicated over the last few months Resident #39 required more assistance with her meals. NA #4 stated she sat down to feed Resident #10 lunch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 550	Continued From page 5	F 550		

on Monday, 12/4/23, but once she noticed the other Residents who were seated at the same time did not have their lunch, she knew the meal trays were not delivered to the unit at the same time, so she went ahead and fed Resident #10 so that her meal would not get cold.

1c. Resident #119 was re-admitted to the facility on 10/31/23.

A quarterly MDS assessment dated 11/6/23 assessed Resident #119 with clear speech, impaired hearing with the use of hearing aids, moderately impaired vision, no corrective lenses, sometimes understood, sometimes able to understand, memory problems with moderately impaired decision-making, and fed herself after staff provided set up assistance.

A care plan revised November 2023 recorded Resident #119 required assistance with setting up her meal tray, she fed herself and staff were to give her assistance to complete the task as needed.

Resident #119 was observed on 12/4/23 at 12:45 PM seated in a chair at a table in the 500/600 hall parlor with Residents #10, #8, #39, #70 and #100 while she waited for her lunch meal. During the observation, NA #4 was observed on 12/4/23 to assist Resident #10 with eating from 1:13 PM until 1:25 PM, Resident #100 fed himself from 1:17 PM until 1:31 PM and Resident #70 received her lunch at 1:19 PM and fed herself while Resident #119 waited. Resident #119 received her lunch meal from NA #6 at 1:24 PM, eleven minutes after NA #4 began assisting Resident #10. Resident #119 fed herself after her meal was set up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 550	Continued From page 6	F 550		

A family interview occurred by phone for Resident #119 on 12/4/23 at 3:45 PM. The family member stated that Resident #119 was "very social" and that she would prefer to eat together with her tablemates.

1d. Resident #70 was admitted to the facility 4/16/18.

An annual MDS assessment dated 9/21/23 assessed Resident #70 with clear speech, adequate hearing, moderately impaired vision, no corrective lenses, understood, able to understand, severely impaired cognition, and required staff assistance with meal set up and feeding.

A care plan revised September 2023 recorded Resident #70 required assistance with setting up her meal tray, she could feed herself at times, but required staff to give her assistance to complete the task as needed.

Resident #70 was observed on 12/4/23 at 12:45 PM seated in her wheelchair at a table in the 500/600 hall parlor with Residents #10, #8, #119, #39 and #100 while she waited for her lunch meal. During the observation, NA #4 was observed on 12/4/23 to assist Resident #10 with eating from 1:13 PM until 1:25 PM while Resident #70 waited for her lunch meal. Resident #70 received her lunch meal from NA #6 at 1:19 PM, seven minutes after NA #4 began assisting Resident #10. Resident #70 fed herself after her meal was set up.

Attempts to interview family for Resident #70 were unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 550	Continued From page 7	F 550		

1e. Resident #100 was admitted to the facility 3/7/22.

A quarterly MDS assessment dated 9/15/23 assessed Resident #100 with clear speech, adequate hearing, moderately impaired vision, no corrective lenses, understood, able to understand, severely impaired cognition, and required staff assistance with meal set up and able to feed himself.

A care plan revised September 2023 recorded Resident #100 required assistance with setting up his meal tray and was able feed himself.

Resident #100 was observed on 12/4/23 at 12:45 PM seated in his wheelchair at a table in the 500/600 hall parlor with Residents #10, #8, #119, #70 and #39 while he waited for his lunch meal. During the observation, NA #4 was observed on 12/4/23 to assist Resident #10 with eating from 1:13 PM until 1:25 PM while Resident #100 waited for his lunch meal. Resident #100 received his lunch meal from NA #6 at 1:17 PM, four minutes after NA #4 began assisting Resident #10. Resident #100 fed himself after his meal was set up until 1:31 PM.

A family interview occurred by phone for Resident #100 on 12/4/23 at 3:30 PM. When asked by the surveyor if Resident #100 would consider it undignified to wait at the dining table for his meal while other residents ate in front of him, the family member stated that he was not certain if Resident #100 would prefer to eat at the same time as his tablemates, but that he felt it was important for all residents seated at the same table to eat at the same time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 550	Continued From page 8	F 550		

NA #6 was interviewed on 12/07/23 at 1:32 PM. NA #6 stated that the meal trays for residents who ate in the 500/600 hall parlor were delivered at different times on different carts. NA #6 stated that sometimes the Residents in the parlor sat there and waited for their meal while other Residents ate because the meal trays were on different carts. NA #6 stated that meal trays were given to residents who fed themselves first, and those Residents who needed assistance received their meal tray last so that staff could assist them with their meal.

During an interview on 12/07/23 at 2:39 PM, Nurse #4 stated she worked on the 7 AM - 3 PM shift since August 2023 and when asked by the surveyor about her training for dining she stated she was trained related to dignity not to feed a resident in front of residents who were not eating. Nurse #4 stated that since she had been a Nurse in the facility, the meal trays for residents who ate in the 500/600 hall parlor were delivered to the unit at different times which caused residents who ate in the parlor on that unit to wait for their meal tray while other residents ate. Nurse #4 stated that on 12/4/23, she recognized that Resident #10 received her lunch meal and was fed by NA #4 while Residents #8, #39, #70, #100 and #119 remained in the parlor but did not have their lunch tray. Nurse #4 stated she advised NA #4 that Residents were still waiting for their lunch tray while she fed Resident #10, but NA #4 stated that since she had already started feeding Resident #10, she did not want to take her tray away from her. Nurse #4 stated she did not think about asking NA #4 to ask Resident #10 if NA #4 could feed her in her room until the other Resident's trays came on the unit. Nurse #4 also stated staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 550	Continued From page 9	F 550		

did not want the meal trays to get cold, so staff served the meal as the trays came onto the unit. Nurse #4 stated Resident #8 was the last Resident to be fed because her meal tray was not delivered to the unit and staff had to go to the kitchen to get her tray. Nurse #4 stated Resident meal trays were delivered to the unit by room number and Residents who required assistance with meals ate in the parlor, but their trays were not delivered together.

An interview with the Dietary Manager (DM) on 12/06/23 at 5:01 PM revealed she was the DM for the past 4 months. The DM stated residents were asked on admission where they preferred to eat their meals. She stated that the meal carts were delivered to the units and the meal trays were ordered by room number for residents who preferred to eat in their rooms. The DM stated the dietary staff were not aware of which residents ate meals in the parlors on the units, that was nursing staff's responsibility to distribute meal trays to residents who ate meals in their rooms or in the parlor on the unit. The DM stated that as it related to dignity, she was aware that residents who ate together at the same table should receive their meals at the same.

The Assistant Director of Nursing (ADON) stated in an interview on 12/06/23 at 2:27 PM that it was brought to her attention when she and a surveyor observed Residents on the South unit that day (12/6/23) who ate in the parlor on that unit receive lunch meals at different times. The ADON stated staff were re-educated on 12/06/23 to provide a dignified dining experience by not giving a resident a meal tray if the rest of the trays were not available to provide to residents who ate together.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 550	Continued From page 10 The Administrator stated in an interview on 12/08/23 at 1:06 PM that she was the Administrator in the facility since July 2023. When asked by the surveyor her expectation for a dignified dining experience, the Administrator stated that she expected all residents eating in the same area or table would be served together and she was not aware this was an ongoing concern.	F 550		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585		1/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585	Continued From page 11 provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585	Continued From page 12 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, resident and staff interviews, the facility failed to provide a written decision/resolution regarding a grievance related to missing bras belonging to Resident #52 and failed to submit a grievance per the facility's grievance policy for 3 of 3 residents (Resident #52's missing supply of salad dressing, Resident #446's missing property and Resident #141's concerns related to a disrespectful staff). Findings included:	F 585	White Oak Manor - Charlotte will ensure efforts are made to complete, provide and submit grievances per facility's grievance policy. The facility's Administrator ordered 2 of the 5 missing front snap bras for Resident #52 on 12/07/2023 when noted during the survey, and delivered on 12/13/23. 3 more front snap bras and the missing supply of salad dressing was ordered on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	**4009 CRAIG AVENUE CHARLOTTE, NC 28211**

(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 585

Continued From page 13

A review of the facility Grievances Policy dated 2/2018 revealed in part The facility recognizes two levels of communication: 1. Concern- A concern is defined as an oral communication that can be resolved immediately. 2. Grievance- A grievance is a written statement, which implies a breach of care or service. A follow-up telephone call or on-site conference shall be held within 5 working days from receipt of a grievance with a complainant outlining corrective action taken. A written decision regarding grievance issued to the resident and/or representative.

A review of the facility's Lost or Missing Articles Grievance Policy (undated) revealed in part If the lost article is a piece of clothing, the Nurse or Social Service staff will notify the laundry department. If the article is a personal supply item or an article that would not be going to the laundry, the article may be considered misplaced, and the resident will be provided assistance in searching for the lost item/ article. All attempts will be made to locate the missing article. A Lost or Missing Articles Report will be completed and submitted to the Administration. The Administrator or his/ her designee will notify the Resident and/ or Family of the findings.

1 a. Resident # 52 was admitted to the facility on 6/13/2017.

A quarterly Minimum Data Set assessment dated 9/11/23 indicated Resident #52 was cognitively intact.

A review of the grievance log dated August 2023 revealed grievances for Resident #52, including a Lost/ Missing Articles Grievance dated 8/10/23.

F 585

12/29/2023.

In response to the events that occurred with Resident #446's missing items, the facility will initiate a grievance even if the residents are discharged from the facility, and family members will be able to retrieve a resident's personal items even if it's needed to be supervised by Administration due to previous conflicts with the family. The Administration staff and Social Services Department received this education on 12/29/2023 by the Corporate Consultant.

In response to Resident #141 grievance regarding disrespectful staff, the facility initiated a Dignity and Respect in-service to nursing staff by the SDC with the emphasis on staff tone, personal hygiene and not speaking to residents 'like a child.' This in-service is to be completed by 01/05/2024.

Current and newly admitted residents will be provided and submitted a written decision and resolution regarding grievances that are shared to the facility's staff and investigated.

The facility staff will receive re-education on the grievance policy and how to complete a grievance form by the Social Services Department, which also includes providing and submitting a written decision and resolution regarding the resident's grievances when the investigation is completed. This re-education will be completed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585	Continued From page 14 The grievance indicated Resident #52 had 3 bras missing (1 bra had been gone for 3 weeks and 2 bras had been missing for 3 months) and one bra was found. The findings section of the report indicated the article was "not located". The report further indicated the facility was still looking for 2 more missing bras. The follow-up section of the report indicated the resident was notified on 8/17/23 that they were still looking for the other bras. The report was signed by the Social Worker and Administrator that the issue was resolved on 8/17/23 although 2 of the bras were still missing. During an interview on 12/5/23 at 10:43 AM Resident #52 revealed she was missing 5 (front snap) bras since July 2023. She stated she completed a grievance for 6 missing bras around that time and one bra was recovered from the laundry in August 2023. However, she was still missing 5 (front snap) bras that were labeled with her name. However, she continued to ask for the remaining missing bras and was told the facility was still looking for them. She last asked the Social Service Director (SSD) #1 about the remaining missing bras in November 2023. She further revealed she believed there was only one staff member working in the laundry room at that time. The resident explained that other than receiving the one found bra from in August, she had received no communication regarding the outcome of the grievance which was filed. During an interview on 12/6/23 at 5:34 PM, the Laundry Supervisor indicated the laundry department was short staffed until October 2023 and she was the only laundry staff person during the summer and fall months. She further indicated the laundry department labeled resident items with a quick press label device and if the	F 585	01/05/2024. Newly hired facility staff will be educated on the grievance policy during their job specific orientation by the Staff Development Coordinator or Social Services Director. The Social Services Department will monitor by interviewing 5 residents weekly for 12 weeks and ask them if they had a grievance filed with a staff member in the past week to determine if a grievance was submitted and investigated, and then to ensure a written decision/resolution was provided. Results from the monitoring and filed grievances will be discussed during the QI morning meetings for 12 weeks. Any identified trends or issues will be further discussed at the QA Committee meetings for recommendations as indicated. The Administrator, Director of Nursing and Social Services Director are responsible for the ongoing compliance F585. The date of compliance is 1/05/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585	Continued From page 15 label came off, the items may end up in lost/ found pile and held for 90 days before being donated or discarded. The Laundry Supervisor stated Resident #52 informed her about two weeks prior (mid- late November 2023) she was missing 3-4 bras. The Laundry Supervisor looked for the missing items, could not locate them, then told the SSD #1 that she would continue to look for them. The Laundry supervisor stated she had not filed a grievance regarding the missing bras because there was already a grievance in place from August regarding the missing bras. The Laundry supervisor further stated the resident continued to ask about the lost bras from August to November 2023. During an interview on 12/6/23 at 5:24 PM SSD #1 revealed she began working at the facility in July 2023 and Resident #52 reported she was missing 3 bras on 7/28/23 and one bra was found on 8/10/23. She further revealed she and the Laundry Supervisor looked for the bras and they were continuing to look for the bras. SSD #1 stated the laundry department had been short staffed until October 2023 and there was only one staff person working prior to being fully staffed. However, she had not followed up with a written resolution for the grievance regarding the outcome of the remaining missing bras. During a follow-up interview on 12/8/23 at 11:43 AM SSD #1 indicated she ordered 2 bras on 12/7/23 per Resident #52's selection. She further indicated there was no excuse why the grievance that was submitted in August 2023 was not resolved in a timely manner. She stated the facility should have come to a decision to reimburse or replace the bras long before 12/7/23 and she planned to reimplement the resident	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	**4009 CRAIG AVENUE CHARLOTTE, NC 28211**

(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 585	Continued From page 16	F 585		

inventory log, which would include clothing.

During an interview on 12/7/23 at 6:07 PM the Administrator revealed SSD #1 was the Grievance Official who wrote up the grievance, assigned it to the appropriate department supervisor for an investigation/ resolution, and provided the resident or family member with the resolution before the Administrator would sign off on it. The Administrator further revealed it was her understanding that her staff was still looking for Resident #52's bras. However, if items were misplaced or damaged by the facility, it would be replaced, or the resident would be reimbursed. She further stated SSD #1 had since ordered replacement bras for Resident #52 on 12/7/23 and the remaining missing bras from August 2023 should have been replaced long before 12/7/23. The Administrator clarified the follow-up to the resident was the facility staff continued to tell the resident they were still looking for the bras.

b. During an interview on 12/6/23 at 2:55 PM Resident #52 revealed she ordered a box of salad dressing, and she discovered it was missing from her room when she was returned from recently being hospitalized in October 2023. She further revealed she reported it to the SSD #1 on multiple occasions and was told the salad dressing was locked in storage along with some of her other belongings that were packed up and stored while she was hospitalized. Resident #52 stated she asked the SSD #1 about the status of the salad dressing for over a month. She further stated that she was unaware if the SSD #1 completed a written grievance regarding Resident # 52's missing salad dressing.

During an interview on 12/6/23 at 5:24 PM the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	**4009 CRAIG AVENUE CHARLOTTE, NC 28211**

(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 585	Continued From page 17 SSD #1 indicated she was the Grievance Official and had mentioned on four occasions during morning meetings with clinical staff that Resident #52 made several requests for her salad dressing to be returned from the storage and the Administrator directed the Maintenance Director to obtain the salad dressing from the storage. SSD #1 further indicated Resident #52 continued to inquire about the return of her salad dressing long after the Maintenance Director was to retrieve it from the onsite storage. SSD #1 stated she was unaware why the salad dressing had not been returned to Resident #52 and she did not feel the need to submit a grievance on the Resident's behalf. During an interview on 12/7/23 at 12:40 PM the Maintenance Director revealed he placed 5-6 storage boxes of Resident #52's belongings in an onsite storage unit between the end of October and the beginning of November 2023. He further revealed he was asked during that time to retrieve the salad dressing from storage. After he searched Resident #52's belongings in the storage, he did not locate the salad dressing and did not follow-up with the Administrator, staff member or Resident #52 with the outcome of his search. During an interview on 12/7/23 at 12:22 PM the Assistant Director of Nursing (ADON) indicated she was made aware in morning meetings (which included the Maintenance Director) that Resident #52's salad dressing was supposed to be returned to her. During an interview on 12/7/23 at 6:00 PM the Administrator revealed it was her understanding Resident #52's salad dressing was in storage and	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585		F 585		

Continued From page 18

upon her request, would receive a box at a time. She further revealed she had the Maintenance Director go to the storage and check Resident #52's storage boxes the same day as the interview (12/7/23) and no salad dressing was found. The Administrator stated a grievance was not completed and probably should have been.

2. Resident #446 was admitted to the facility on 2/1/22 and discharged on 10/9/23.

A quarterly MDS assessment indicated Resident #446 had moderate cognitive impairment.

During a phone interview on 12/5/23 at 8:50 AM Resident #446's family member revealed when they came back to the facility after the Resident was hospitalized in October 2023 and was not expected to return to the facility, they were unable to go to the Resident's room to collect his belongings. Instead, the family member waited in the front lobby while the SSD #1 packed Resident #446's belongings and brought them to her, in the lobby. The family member further stated the SSD #1 reassured her that the Resident's dentures and eyeglasses were in his packed belongings that consisted of two boxes and a duffle bag. The family member stated when they returned home and checked Resident #446's belongings, there were clothing items that did not belong to the Resident and the dentures, eyeglasses, and hall of fame certificate were missing. The family member stated they sent 2 emails to the Administrator and received a voice mail from the SSD#1 instead of the Administrator. The family member stated they did not have a good interaction with SSD #1 previously and preferred to speak to the Administrator, since she was in charge. However, the Administrator never replied

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585	Continued From page 19 to family member's emails. The family member further stated the facility lost Resident #446's wheelchair that was issued by the Veterans Administration and offered to replace the wheelchair with another wheelchair, but the family member refused it because it belonged to another resident. The family member preferred to have the personal wheelchair that was admitted with the Resident. The family member stated the Resident did have an appointment to get assessed for a new wheelchair from the Veterans Administration but was hospitalized the day before the appointment. Further, the family member was unaware if the facility initiated a grievance investigation regarding the missing items. During an interview on 12/8/23 at 11:24 AM the SSD #1 indicated the facility had not implemented inventory sheets for resident belongings until July 2023. She further indicated she and (former) SSD #2 packed Resident #446's belongings and she could only recall packing clothing items, eyeglasses, framed pictures, and items from the nightstand into 2 boxes and a duffle bag that was already packed with clothing items. She brought the belongings to Resident #446's family member who was in the lobby and the facility offered to replace the lost wheelchair with a high back wheelchair. However, the spouse refused it. The SSD #1 stated she assisted Resident #446's family member pack the Resident's belongings into the family member's vehicle. SSD #1 stated she called and left a voice mail message for the family member after the family member sent emails to the Administrator regarding the missing items. SSD #1 further stated she did not feel the need to complete a grievance or missing/ lost grievance because Resident #446 was not	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585	Continued From page 20	F 585		

returning to the facility and the family had been restricted from visiting beyond the lobby and visitations needed to be scheduled due to the family member's conflict with facility staff.

During an interview on 12/8/23 at 12:42 PM the Administrator revealed she received 2 emails from the family member of Resident #446, after the family member came to the facility to retrieve the Resident's belongings. The emails indicated requests to have missing and damaged items (dentures, eyeglasses, cell phone, clothing, damaged picture frames). She further stated she had the SSD #1 contact the family member after the first email was received. The Administrator stated SSD #1 left a voice mail message for Resident #446's family member and there was no further communication from the family member. The Administrator stated a grievance report was not submitted and it would have been a good idea to submit one due to the previous conflicts with the Resident's family member.

3. The facility Grievance Policy, reviewed 2018, recorded in part, "Residents may express a grievance and may expect prompt efforts from the facility to resolve voiced concerns or grievances."

Resident #141 was admitted to the facility on 10/9/23 from the hospital and discharged home on 10/20/23.

An admission nursing assessment dated 10/10/23 recorded Resident #141 was alert and oriented and required staff assistance with toileting.

A social services admission progress note dated

F 585 Continued From page 21 F 585

10/10/23 written by Social Services Director #2 (SSD #2), recorded Resident #141 admitted to the facility for a short-term rehab stay with plans to return home. SSD #2 documented she introduced herself to Resident #141 in her room after the Resident had just returned from a therapy session. The SSD documented Resident #141 was "very alert and oriented to surroundings and situations."

A Minimum Data Set assessment, dated 10/20/23, assessed Resident #141 with intact cognition, required supervision of one staff with toileting, occasional bladder incontinence, independent with toilet transfers and active discharge plans for a return to the community.

An interview with Nurse #2 occurred on 12/07/23 at 3:25 PM. Nurse #2 stated she was the assigned Nurse for Resident #141 on the 7AM - 3PM shift and she remembered Resident #141 stated to her that some of the nursing staff on the 11 PM - 7AM shift was disrespectful to her. Nurse #2 stated she did not recall if Resident #141 gave her the names of staff, but the Resident stated that she did not like the tone of some of the staff and it made her feel "like she was being spoken to like a child." Nurse #2 stated she reported this to the Nurse Supervisor, SSD #2 and either the Director of Nursing (DON) or the Assistant Director of Nursing (ADON). Nurse #2 stated she did not record this in the Resident's medical record because she expected the SSD to write the concern as a grievance.

Resident #141 was interviewed by phone on 12/08/23 at 11:02 AM. Resident #141 stated that the staff were disrespectful, she stated "They didn't say ugly things but ignored me, the first

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585	Continued From page 22	F 585		

night I was there I rang the bell, and they didn't come, I needed to get to bathroom, but it was locked, and somebody had to come unlock it." She stated that the Nurse Aide (NA) from that evening "Came in after I peed on the floor, and talked loudly to me, I guess it was just the way she talked." Resident #141 stated she reported this to Nurse #2 and stated, "It made me feel like what's coming up next, that was my first night there." Resident #141 stated no one came to talk to her about her concern after she expressed it to the Nurse, so she just learned to manage and care for herself.

Review of the October 2023 grievances revealed there was no grievance documented regarding Resident #141.

NA #3 was interviewed by phone on 12/07/23 at 6:09 PM. NA #3 stated she worked at the facility for the past three years on the 11 PM - 7AM shift during the week and the 7 AM to 3 PM shift on the weekends. NA #3 stated she did not recall being assigned to Resident #141, but when she met residents for the first time, she introduced herself, responded to the call bell, assisted the resident with anything they needed and if she was made aware that a resident felt disrespected, she would tell the Nurse. NA #3 stated if a resident said she was yelling, she would apologize and try to lower her voice. NA #3 stated she had not been advised that a resident felt like she talked to them like a child.

An interview with Nurse #3 occurred on 12/07/23 at 6:02 PM. Nurse #3 stated she worked the 11 PM - 7 AM shift since May 2023. Nurse #3 stated she did not remember Resident #141, but if she were made aware of a resident grievance, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585	Continued From page 23	F 585		

would talk to the resident to find out what happened, then talk to the Nurse Supervisor or the ADON. Nurse #3 stated she did not recall being informed of a resident expressing they were disrespected.

The Nurse Supervisor was interviewed on 12/07/23 at 5:48 PM. She stated that she was the 3 PM - 11 PM shift supervisor, but that she did not recall Resident #141 or being told by Nurse #2 the Resident expressed that she was disrespected by staff. The Nurse Supervisor stated if the Nurse had notified her of this Resident's grievance, the Nurse Supervisor stated she would have talked to the Resident and staff, re-educated staff, left a note for the SSD to file a grievance, and removed the staff involved from the Resident's assignment.

The ADON was interviewed on 12/07/23 at 4:59 PM. The ADON stated she did not remember Resident #141, but if a Resident filed a grievance with the Nurse, the ADON stated she expected the Nurse to notify the Nurse Supervisor, the Nurse Supervisor would notify the SSD, the SSD would follow the facility's grievance policy, record the concern as a grievance and notify either the ADON/DON. The ADON stated staff would follow the grievance policy.

A phone interview with SSD #2 occurred on 12/07/23 at 4:44 PM. SSD #2 stated that she was the SSD in the facility from May 2023 to November 2023. SSD #2 stated she did not recall Resident #141 or being informed by Nurse #2 of a grievance. SSD #2 stated if she was notified, she would talk to the Resident, obtain a statement, write the concern as a grievance, and notify the Administrator. SSD #2 stated she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 585	Continued From page 24 also check the nursing schedule to make sure the staff member involved was not assigned to care for the Resident again. SSD #2 stated after the grievance was documented, she would follow up with the Nurse and the Administrator or DON within the next 24 hours to see if the grievance was resolved. An interview with the DON occurred on 12/06/23 at 11:19 AM, the DON stated she did not recall Resident #141 or being advised that this Resident filed a grievance with a Nurse. The Administrator was interviewed on 12/08/23 at 1:06 PM. The Administrator stated she was the Administrator since July 2023. She stated if a resident expressed to the Nurse, they felt disrespected by staff, she would expect the Nurse who was informed to notify the Nursing Supervisor and the SSD so that the facility could implement the grievance policy. The Administrator stated she was not made aware of the concern voiced by Resident #141.	F 585		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the	F 626		1/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 626	Continued From page 25 resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review interviews with the Hospital Case Manager, Veterans Affairs (VA) Case Manager and staff, the facility failed to allow a resident to return the facility after a facility-initiated transfer to the hospital for 1 of 1 (Resident #445) resident reviewed for readmission from the hospital. The findings included: Resident #445 was admitted to the facility on 6/16/23. His diagnoses included epilepsy, acute respiratory failure with hypoxia, schizophrenia, delirium. The face sheet of Resident #445 stated	F 626	White Oak Manor -Charlotte ensures residents are permitted to return to the facility after a facility initiated transfer when they are hospitalized or placed on therapeutic leave per policy. During review of Resident #445's return to the facility, there appeared to be confusion of when the allotted amount of Veteran Administration (VA) residents that the VA will allow the facility to admit came into effect and the facility indicating Resident #445 was not admitted because the resident was not appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ____ B. WING ____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 626	Continued From page 26 that his discharge status was anticipated to return to the community from his short term stay at the facility. He had VA benefits that paid for the 32 day stay through the Corporate Nursing Home contract. A nurses note dated 6/20/23 at 10:56 PM read in part, Resident #445 was noted to be in bed with wet/clammy skin, drooling, and body jerking. Resident #445 was able to respond to name being called. Medical Doctor (MD) notified, and orders were to send Resident #445 to the hospital with a diagnosis of seizure activity. Resident #445 was transported to hospital. Resident #445 had a discharge Minimum data Set assessment dated 6/20/23 that was coded for discharge returned anticipated. A review of an email thread from the Admission Director and VA case manager on 7/3/23 at 12:23 PM stated that the Admission Director updated the VA case manager that Resident #445 was ready to discharge from the hospital to the facility on 7/5/23. The Admission Director requested the VA case manager send a new authorization for respite stay at the facility due to the length of stay at the hospital. A review of hospital referral to the facility dated 7/3/23 revealed that Resident #445 was ready to return to the facility. The referral showed that the facility accepted Resident #445's referral for readmission on 7/3/23 at 3:08PM per Admission Director. A review of Pre-Admission Snapshot dated 7/11/23 at 12:34 PM stated that Resident #445 was not admitted because Resident #445 was not	F 626	financially, but still had a contract with the facility. As a result, the facility is requesting a notification through email from the VA to indicate if or when a re-admission of a VA residents is not allowed by the VA. Residents within the facility including VA residents have the potential of being affected. An audit of residents discharged to the hospital for the last 3 months were reviewed to ensure residents returned to the facility from the hospital as required. The audit was completed 12/29/23 by the Corporate Social Services Consultant. Newly admitted resident, including VA residents, will be permitted to return to the facility after being hospitalized. The facility Admission Department, Business Office Department, Social Services Department and Nursing Administration will receive re-education on permitting residents, including VA residents, to return to the facility after a facility initiated transfer to the hospital. This re-education was completed on 12/29/2023 by the Corporate Social Services Consultant. Newly hired facility admissions, Business Office, Social Services and Nursing Administration Department staff members will be educated on permitting residents, including VA resident, to return to the facility after a facility initiated transfer to the hospital during their job specific orientation by Administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 626	Continued From page 27 appropriate financially. The pre-admission snapshot was communicated from the hospital case manager and the admissions person at the facility. An interview with Resident #445's family member was conducted on 12/8/23 at 10:13 AM and revealed that Resident #445 did not return to the facility and was discharged home from the hospital with home health care. The family member further stated that Resident #445 had returned to the hospital two weeks later due to seizure activity and was readmitted to the hospital. Resident #445 was currently at another facility in a different town. The family member confirmed that the VA was paying for Resident #445's stay at the new facility. The family member stated that they wanted Resident #445 to return however they were upset about the back and forth with the hospital and the facility. An interview with the VA Case Manager on 12/8/23 at 1:48 PM revealed that the VA can authorize short term rehab care or respite stay at the facility. They further explained that the start date of benefits for the nursing facility stay for Resident #445 was 6/16/23 with an approved end date of benefits on 7/18/23. They stated that Resident #445 was discharged to the hospital on 6/20/23. If the VA veteran was out of the facility for more than 3 midnights, the VA would discharge them which meant that the authorization ends for the short-term rehab stay. The VA Case Manager stated that Resident #445 was expected to return to the facility after the hospital stay once medically stable. They stated that Resident #445 was re-evaluated on 7/7/23 and approved for a new authorization with a 32-day Corporate Nursing Home contract from	F 626	The Social Services Director (SSD) will monitor by reviewing 5 discharged residents to the hospital weekly for 12 weeks to ensure residents, including VA residents, returned to the facility as required. Results from the monitoring will be discussed during the QI morning meetings for 12 weeks. Any identified trends or issues will be further discussed at the AQ committee meetings for recommendations as indicated. The Administrator, Director of Nursing, Admissions Coordinator, Business Office Manger, and SSD are responsible for the ongoing compliance of F626. The date of compliance is 01/05/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 626	Continued From page 28 the date that they would re-admit from the hospital. The VA Case Manager noted that Resident #445 was discharged from the hospital on 7/18/23 with home health care in place due to the facility's refusal to readmit. The VA Case Manager stated that all conversations were with the Admission Director. The authorization form would have been sent to the facility on his re-admission date to the facility. A phone interview with the Admission Director was conducted on 12/7/23 at 10:50 AM who stated that Resident #445 was eligible for short term stay benefits. The Admission Director further stated if the resident had been accepted for readmission to the facility the VA authorization would have been approved. The interview further revealed if anyone had asked or contacted her, she would have informed them that the VA authorization was valid. A phone interview with the Hospital Case Manager was conducted on 12/7/23 at 10:45 AM and revealed that Resident #445 had been discharged home from the hospital with home health care on 7/18/23. The Hospital Case Manager stated that the family ended up taking the resident home due to the back and forth between the facility and hospital. They further stated that the facility declined to readmit Resident #445 back to the facility due to no financial source for Resident #445. The Hospital Case Manager stated that the authorization was approved and that the finances were covered for the facility stay after readmission from the hospital. The Hospital Case Manager stated that she spoke with the VA Case Manager around 7/5/23 and was informed of the approval for Resident #445's return to the facility. The Hospital	F 626		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 626	Continued From page 29 Case Manager stated that she informed the Admission Director of all of this in an email which included the pre-admission snap shot. She further stated that the authorization was approved on 7/7/23 and she informed the Admission Director through the pre-admission snap shot information. An interview with the Director of Nursing (DON) was conducted on 12/6/23 at 11:18 AM and revealed that the DON did not recall any denials of readmission for residents from the hospital. The DON further stated that the Admission Director followed up with the hospital around 7/7/23. The DON stated that the Business Office Manager would have verified that the VA authorization had been approved for readmission. The DON stated that the VA made the decision to deny Resident #445 to return to facility and was not made aware of any issues. The DON stated that Resident #445 did not come back and was not denied readmission. A phone interview with the Business Office Manager on 12/7/23 at 10:40 AM revealed that Resident #445 had short term VA benefits. The Business Office Manager did not recall any issues with the VA authorization and did not recall asking the VA for the authorization form for Resident #445. The Business Office Manager stated that the Admission Director handled that. An interview with Corporate Business Office Consultant was conducted on 12/8/23 at 10:37 AM and revealed that the Admission Director gave information to the business office regarding payor sources that would come from the hospital. The Corporate Business Office Consultant confirmed that they did have a contract with the	F 626		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 626	Continued From page 30	F 626		

VA. They stated that the VA authorization would be re-authorized for a 32-day Corporate Nursing Home contract with the current authorization on file for Resident #445. The Corporate Business Office Consultant stated that with the re-authorization for Resident #445 from the VA, they would have been able to re-admit from the hospital.

An interview with the Administrator was conducted on 12/8/23 at 1:07 PM and revealed that they had been the administrator since 7/10/23 and was not the administrator at the time of Resident #445's re-admission discussion. The Administrator stated that the VA veteran would have been eligible for re-admission if the facility was able to care for them and if the restriction did not limit the number of admissions for VA veterans in the facility. The administrator further explained that the facility had a limitation on how many VA Veterans were able to be admitted to the facility with a cut off of 30 at a time. However, upon review of the census with the number of Veterans for this time frame, they would have been allowed to re-admit him if the limitation was in effect because they did not have 30 veterans in the facility during the proposed readmission time frame. The Administrator explained that the facility was limited to 30 residents with VA benefits. They further stated that the facility has around 28 to 30 residents that are veterans that used VA benefits monthly.

During an interview with the VA Case Manager on 12/8/23 at 1:48 PM she stated that there was no cap for VA veterans' admission to facilities until October 2023 and would not have been in effect for Resident #445 during this specific time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 657	Continued From page 31	F 657		
F 657 SS=E	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: Based on record review, resident/ family and staff interviews, the facility failed to schedule, invite residents/representatives, and hold care plan meetings for 3 of 3 residents (#52, #28, #4) reviewed for care planning. Findings included:	F 657	White Oak Manor - CHarlotte will ensure care plan meetings are scheduled, resdients and resident representatives are invited, and care plan meetings are held. Resident #52 and their representative were invited to a scheduled care plan	1/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 657	Continued From page 32 A. Resident # 52 was admitted to the facility on 6/13/2017 with diagnoses inclusive of respiratory failure. A review of the medical record indicated the last care plan meeting for Resident #52 took place on 3/15/22. A quarterly Minimum Data Set (MDS) assessment dated 9/11/23 indicated Resident #52 was cognitively intact. During an interview on 12/5/23 at 10:43 AM Resident #52 revealed she had not been invited to a care plan meeting since 2022. B. Resident #28 was admitted to the facility on 4/22/18 with diagnoses inclusive of anxiety and acid reflux. A review of the medical record indicated the last care plan meeting for Resident #28 took place on 7/19/22. A quarterly MDS assessment dated 11/24/23 indicated Resident #28 had moderate cognitive impairment. During an interview on 12/4/23 at 10:15 AM the family member of Resident #28 revealed the Resident had not been invited to a care plan meeting since July 2022. During an interview on 12/6/2023 at 5:08 PM the Social Service Director #1 (SSD) indicated Resident #52 had not had a care plan meeting since 3/15/22 and Resident #28 had not received a care plan meeting since 7/19/22. She stated	F 657	meeting on 12/29/2023 and will be held on 01/03/2024. Residents #28 and their representative were invited to a scheduled care plan meeting on 12/29/2023 and will be held on 01/04/2024. Residents #4 and their representative were invited to a scheduled care plan meeting on 12/07/2023 and it was held on 12/12/2023. Current and newly admitted residents and resident representatives will be invited to scheduled care plan meetings and held for the residents. An audit of the current residents was completed on 12/06/2023 by the Corporate Social Services Consultant to prioritize the next care plan meeting for the residents/ resident representatives. The facility interdisciplinary care plan team was re-educated on inviting residents and resident representatives to scheduled care plan meetings that will be held with them. This re-education was completed on 12/11/2023 by the Corporate Social Services Consultant. Newly hired facility interdisciplinary care plan team staff members will receive this education during their job specific orientation by the Social services Director (SSD). The SSD will monitor by reviewing 5 residents weekly for 12 weeks to ensure the residents and resident representatives are invited to scheduled care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 657	Continued From page 33 she had only been in her position a few weeks and was working on a new process for care plan meetings. She further stated she expected care plan meetings to be scheduled quarterly with a phone call invite or an invitation letter mailed which would include the resident and/ or resident representative. She further indicated she had had only been in the SSD #1 position since July 2023 and was aware that care plan meetings were behind. She also stated it would be the SSD #1's responsibility to create and maintain the care plan meeting calendar, send out the care plan meeting invitations, and hold the care plan meeting. During a phone interview on 12/7/23 at 5:06 PM the (former) SSD #2 as of July 2023 revealed there were several barriers to completing the care plan meetings to include time constraints, training the current SSD #1 replacement, discharge planning and over all resident case load. She further indicated she was able to complete some care plans and some residents and families did complain about not having a care plan meeting. She also stated care plan meetings were to be scheduled one week after the MDS was completed. During an interview on 12/7/23 at 5:52 PM the Corporate Social Work Consultant indicated she was recently made aware that the facility was falling behind on care plan meetings. Her expectation was for care plan meetings to be scheduled within 1-1 and a half weeks after the MDS was completed. She further indicated prioritizing, increased census and staffing turnover contributed to missed care plan meetings. During an interview on 12/7/23 at 5:57 PM the	F 657	meetings and that the scheduled care plan meetings are being held. Results from the monitoring will be discussed during the QI morning meetings for 12 weeks. Any identified trends or issues will be further discussed at the QA committee meetings for recommendations as indicated. The SSD is responsible for the ongoing compliance of F657. The date of compliance is 01/05/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 657	Continued From page 34	F 657		

Administrator revealed she started role at the facility in July 2023 and in September she was made aware that care plan meetings were not being conducted. She further revealed the SSD #1 had been working on creating a care plan meeting schedule. The Administrator's expectation was for care plan meetings to be scheduled, care plan invitations to be sent to residents/ representatives and care plan meetings to be conducted.
C. Resident #4 was admitted to the facility on 01/25/2016 with diagnoses that includes dementia, cerebral vascular accident (CVA), diabetes mellites, and high blood pressure (HTN).

Review of Resident #4's medical record revealed the last documented care plan meeting occurred on 11/30/2022.

Review of the quarterly Minimum Data Set (MDS) assessment dated 11/20/2023 revealed Resident #4 had severe cognitive impairment.

A phone interview was conducted with Resident #4's responsible party (RP) on 12/05/2023 at 9:01 AM. The RP revealed she had not been invited or attended a care plan meeting for Resident #4 in many months. She further stated she does not know the exact length of time since the last care plan meeting was held but it was quite a long time ago.

The Social Service Director #1 (SSD) was interviewed on 12/6/2023 at 12:37 PM. The SSD confirmed Resident #4 had not had a care plan meeting since 11/30/2022. She stated she had only been in her position a few weeks and was working on a new process for care plan meetings. She further stated she expected care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 657	Continued From page 35 meetings to be scheduled quarterly with a phone call invite or an invitation letter mailed which would include the resident's RP. She also indicated she had been working on developing a care plan meeting calendar for all residents. She also stated it would be the SSD #1's responsibility to create and maintain the care plan meeting calendar, send out the care plan meeting invitations, and hold the care plan meeting. An interview was completed on 12/07/2023 at 10:06 AM with the Administrator. The Administrator stated that she realized the care plan meeting process was behind schedule and the SSD was currently working on a new process to ensure care plan meetings were being held.	F 657		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to honor food preferences for 2 of 2 residents reviewed for food preferences (Resident #19 and #52). The findings included:	F 806	White Oak Manor - Charlotte will ensure residents' food preferences are honored. Dietary aides and nursing staff were re-educated on Resident #19's meal tray care to familiarize themselves of the resident's dislikes such as white chicken	1/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 806

Continued From page 36

1. Resident #19 was admitted to the facility on 5/17/19. Diagnoses included hypertension, gastroesophageal reflux disease, and renal insufficiency.

Review of a Physician (MD) Orders diet list revealed a MD order dated 3/19/20 for a regular diet for Resident #19.

An annual Minimum Data Set assessment dated 10/2/23 assessed Resident #19 with clear speech, adequate hearing, impaired vision without corrective lenses, understood, able to understand, moderately impaired cognition and fed herself after staff provided set up assistance.

A care plan revised October 2023 recorded that Resident #19 was at risk for nutritional decline due to her diagnoses and a history of weight loss. Interventions included providing food preferences when possible.

Resident #19 was observed in her room and interviewed on 12/04/23 at 1:54 PM. During the observation, Resident #19 fed herself her lunch meal which included chicken breast (white meat). The tray card on her lunch meal tray recorded "Dislikes: Chicken White Meat." Resident #19 ate her remaining food but did not eat the chicken. Resident #19 stated "I don't like white meat, they serve it to me all the time, I will ask for a peanut butter and jelly sandwich instead."

Nurse #4 was interviewed on 12/07/23 at 2:54 PM. Nurse #4 stated that she was the 7 AM - 3 PM Nurse for Resident #19 and often observed her with breakfast and lunch meals. Nurse #4 stated that if Resident #19 received food she did

F 806

meat. resident #19's meal trays have been noted by the Dietary Manager with no dislikes on their meal trays.

Plant-based meats was added to Resident #52's preference on their meal tray card. Dietary and Nursing Staff were re-educated on Resident #52's meal tray care to familiarize themselves of the resident's dislikes and/or allergies such as an allergy to tomatoes, and preference for plant-based meats. Resident #52's meal trays have been noted by the Dietary Manager with no dislikes or allergic food items on their meal trays, and preferred plant-based meats.

The Dietary department will audit current residents' foo preferences, dislikes and food allergies are updated on the residents' meal tray cards. This audit will be completed by 01/05/2024.

Current and newly admitted residents will receive their food preferences, and will not receive their dislikes and allergic food items.

The Dietary staff were re-educated by the Dietary Manager or designee regarding the responsibility to review the meal tray cards and provide foods according to the residents' dislikes, allergies and preferences. This re-education will be completed by 01/05/2024. Newly hired Dietary Staff will receive this education during their job specific orientation with Dietary Manager or designee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 806	Continued From page 37 not like, she went to the kitchen to get something else. Nurse #4 stated she observed Resident #19 receive white meat chicken before, but that she did not like white meat chicken and that she did not eat it. Nurse #4 stated that if a resident received food, they did not like the staff should offer the resident a substitute. An interview with the Dietary Manager (DM) on 12/06/23 at 5:01 PM revealed she was the DM for the past 4 months. The DM stated that meal preferences were obtained on admission, updated during care plan meetings, and the DM entered the preferences into the facility's tray card system. The DM stated that sometimes a resident received food that was listed on the tray card they disliked, but that the dietary aides were responsible to review the tray card and provide foods according to the resident's preferences. The DM stated that sometimes dietary staff did not always identify preferences correctly that were listed on the tray card and when that occurred the DM provided education. The DM stated that it was possible that the dietary aides did not know the difference between white/dark meat chicken and therefore did not tell the cook not to plate white meat chicken for Resident #19 during the meal tray line service. The DM stated that at times she checked meal trays for accuracy, her focus was to check for allergies and consistency, but during her checks, she did not lift the lid to look at the resident's plate. The Administrator stated in an interview on 12/08/23 at 1:06 PM that she was the Administrator in the facility since July 2023. The Administrator stated that she expected dietary staff to review tray cards when meals were plated and for nursing staff to review tray cards when	F 806	The Nursing Staff were re-educated by the Staff Development Coordinator (SDC) regarding their responsibility to review meal tray cards when delivering residents' meal tray to ensure dislikes, allergies and preferences is honored. This re-education will be completed by 01/05/2024. Newly hired Nursing Staff will receive this education during their job specific orientation with the SDC. The Dietary Manager or designee will monitor by checking 5 meals per week for 12 weeks to ensure the residents' preferences are honored and dislikes and allergic food items are not on the residents' trays as indicated. Results from the monitoring will be discussed during the morning QI meetings for 12 weeks. Any identified trends or issues will be further discussed at the QA committee meetings for recommendations as indicated. The Dietary Manager and Director of Nutrition are responsible for the ongoing compliance of F806. The date of compliance is 01/05/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 806	Continued From page 38	F 806		

they assisted a resident to set up their meal. The Administrator stated that resident meal preferences should be honored.

2a. Resident # 52 was admitted to the facility on 6/13/2017 with diagnoses inclusive of hypertension, malnutrition, and colitis.

A quarterly Minimum Data Set assessment dated 9/11/23 indicated Resident #52 was cognitively intact and required set up or cleanup with food.

A review of Resident #52's lunch menu ticket dated 12/7/23 indicated "no tomatoes" as a preference.

A review of a grievance report dated 4/3/23 indicated Resident #52 continued to receive tomatoes on her salad meal although she had an allergy to tomatoes and did not eat meat. Action taken included making dietary staff aware of Resident #52's allergy to tomatoes and that she did not eat meat. The grievance was investigated and signed by the Registered Dietician.

An interview on 12/6/23 2:55 PM Resident #52 revealed she was served tomatoes on her lunch tray on 12/6/23 and tomatoes were listed on her meal ticket as "dislikes." She further revealed tomatoes had been placed on her food tray in the past, despite being listed as "dislikes" on her meal ticket. She stated she submitted a grievance dated 4/3/23 related to receiving tomatoes on her salad and that she had an allergy to tomatoes. Resident #52 stated when she discovered the tomatoes on her salad on 12/6/23, she went to the kitchen and was given another salad without tomatoes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 806	Continued From page 39 An interview on 12/6/23 at 3:37 PM the Dietary Director stated she and her dietary staff were very familiar with Resident #52's preferences. However, a new dietary aide, who was not familiar with the Resident's preferences, did not call out to the cook that the Resident should not receive tomatoes on her salad. The Dietary Director revealed she was aware Resident #52 received tomatoes on her salad on 12/6/23 although her meal ticket indicated "no tomatoes." She stated it was the responsibility of the dietary aide to communicate resident preferences while building food trays. She further revealed she would have to re-train the dietary aides on communication with the cook. An interview on 12/7/23 at 6:35 PM the Administrator indicated she expected dietary staff to review and honor meal tray tickets before they leave the kitchen and for nurse aides to review the tray tickets upon delivery to residents. She further indicated, Resident #52's preferences should have been honored as indicated on her meal ticket. 2b. A review of Resident #52's breakfast and lunch menu tickets dated 12/7/23 indicated no options for plant-based meats and was not indicated as a preference. During an interview on 12/5/23 at 10:43 AM Resident #52 revealed she became a vegetarian in 2022 and during a recent Resident Council meeting, she requested alternative plant-based meat options. Resident #52 further revealed the Dietary Director attended that meeting and agreed to offer plant-based meat options as a menu item. The Resident received plant-based meat once or twice in October 2023 and had not been offered plant-based meat since then. The	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 806	Continued From page 40	F 806		

Resident also stated it was never added to the printed menu as a preference, although the Dietary Director was made aware of the Resident's preferences.

During an interview on 12/6/23 at 3:37 PM the Dietary Director indicated the facility had been offering plant-based options to residents since August 2023 when residents requested the options during a Resident Council meeting. She further indicated plant-based options had not been added to the printed menu and would be written on the menus or discussed during the admission process. The Dietary Director stated although she was aware Resident #52 preferred plant-based options, she did not update Resident #52's preferences to include plant-based options because she assumed the Resident would write it on her menu when she wanted it. She stated there were only two vegetarians in the facility and did not think other residents were interested in plant-based options.

During an interview on 12/6/23 at 2:34 PM the RD revealed she assessed residents at admission, significant weight loss, and at the request of residents and families. She further revealed she met with Resident #52 in September 2023 and plant-based options were never discussed. Further, she was not aware the Resident wanted plant-based options.

During a follow-up interview on 12/7/23 at 1:39 PM Resident #52 indicated plant-based options were never placed on her preference list, although she recommended it during a Resident Council meeting during July or August 2023. She further indicated the Dietary Director told her it would be written on the menu ticket, but it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 806	Continued From page 41 not written or offered since October 2023. Resident #52 stated if plant-based options were offered/ listed on the menu as promised, she would certainly choose those options, since she became vegan in 2022. During an interview on 12/7/23 at 1:53 PM Nurse Aide #1 (NA) revealed she never discussed plant-based options with Resident #52. She further revealed the Resident often complained about her food and periodically requested meat. During an interview on 12/7/23 at 11:56 AM Nurse #1 indicated Resident #52 said she was not getting plant- based options but Nurse #1 was unsure if the Resident was offered the plant-based options after she first received them in September or October 2023. During an interview on 12/7/23 at 6:25 PM the Administrator revealed the facility attempted to accommodate plant-based options requested by Resident #52 although it was not part of their menu. She further revealed she was aware the facility started ordering plant-based items in late summer 2023 but was not aware the plant-based items were not regularly offered to the Resident or any other resident via the menu. She expected the plant-based options to be added to Resident #52's menu and preferences honored.	F 806		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may	F 808		1/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 808	Continued From page 42 delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to provide Resident #95 a renal diet per physician order for 1 of 1 sampled resident reviewed for therapeutic diets. The findings included: Resident #95 was admitted to the facility on 7/19/23. Diagnoses included hypertensive chronic kidney disease stage 5, end stage renal disease, and dependence on renal dialysis. Review of the medical record revealed a physician (MD) order dated 7/24/23 for a liberalized renal diet. An annual Minimum Data Set assessment dated 10/17/23 assessed Resident #95 with clear speech, adequate hearing/vision, understood, able to understand, intact cognition and fed herself after staff provided set up assistance. A care plan revised October 2023 recorded that Resident #95 was at risk for nutritional decline due to end stage renal disease, hemodialysis, and a therapeutic diet. Interventions included providing a diet as ordered. Resident #95 was observed in her room and interviewed on 12/04/23 at 12:54 PM. During the observation, Resident #95 fed herself lunch. She received a salad with diced tomatoes. A meal tray	F 808	White Oak Manor - Charlotte will ensure resident's are provided with their therapeutic diets prescribed by the physician. Resident #95, other current residents and newly admitted residents will correctly receive their therapeutic diets as ordered by the physician. For Resident #95 and other residents on a liberalized renal diet, they will not receive tomatoes and potatoes on their meal trays. The current residents on a liberalized renal diet including Resident #95 will have their meal tray cards updated indicating no tomatoes and potatoes for an additional reminder to the Dietary and Nursing staff. Newly admitted residents on a liberalized renal diet will also have the indications on their meal tray card for no tomatoes and potatoes. The Dietary staff were re-educated by the Dietary Manager or designee regarding the responsibility to review meal tray cards and provide foods according to the residents' therapeutic diet, such as a liberalized renal diet and no tomatoes and potatoes. This re-education will be completed by 01/05/2024. Newly hired Dietary Staff will receive this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 808 Continued From page 43

card on her lunch meal tray recorded "Dislikes: tomatoes, potatoes." Resident #95 stated she received potatoes and tomatoes often, and stated, "But I am not supposed to." Resident #95 explained potatoes and tomatoes were not foods she disliked, but foods she could not have on her renal diet.

Review of the weekly menu therapeutic diet spreadsheet revealed a resident with a diet order for a renal diet should receive a salad without tomatoes and rice instead of potatoes.

Nurse #4 was interviewed on 12/07/23 at 2:39 PM. Nurse #4 stated that she was the 7 AM - 3 PM Nurse for Resident #95. Nurse #4 stated she knew that residents with a diet order for a renal diet should not receive tomatoes or potatoes. Nurse #4 stated that she often saw Resident #95 receive meals that included tomatoes, tomato soup, and potatoes, but she did not report this to the dietary staff because she did not know if the diet rules were different in this facility.

An interview with the Dietary Manager (DM) on 12/06/23 at 5:01 PM revealed she was the DM for the past 4 months. The DM stated that residents with a diet order for a renal diet should not receive foods high in phosphorus like tomatoes or foods high in potassium like tomatoes and potatoes. The DM stated the "disliked" section of the meal tray card included food preferences and foods not allowed on the therapeutic diet. The DM stated sometimes dietary staff did not always identify "disliked" foods correctly that were listed on the tray card and when that occurred the DM provided education. The DM stated that at times she checked meal trays for accuracy, her focus was to check for allergies and consistency, but

F 808

education during their job specific orientation by the Dietary Manager.

The Nursing staff were re-educated by the Staff Development Coordinator (SDC) regarding their responsibility to review meal tray cards when delivering residents" meal tray to ensure residents are receiving their therapeutic diet as ordered by a physician, such as a liberalized renal diet and no tomatoes and potatoes. This re-education will be completed by 01/05/2024. Newly hired Nursing Staff will receive this education during their job specific orientation by the SDC.

The Dietary Manager or designee will monitor by checking 5 therapeutic meals, including residents on liberalized renal diets as ordered by the physician, per week for 12 weeks to ensure the residents are receiving their therapeutic diets.

Results form the monitoring will be discussed during the QI morning meetings for 12 weeks. Any identified trends or issues will be further discussed at the QA committee meetings for recommendations as indicated.

The Dietary Manager and Director of Nursing are responsible for the ongoing compliance of F808.

The date of compliance is 01/05/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 808	Continued From page 44 during her checks, she did not lift the lid to look at the resident's plate. In an interview with the registered dietitian (RD) #1 on 12/06/23 at 5:10 PM she stated Resident #95 had a diet order for a liberalized renal diet which restricted foods high in potassium and phosphorus. A phone interview with RD #2 on 12/07/23 at 4:13 PM, revealed she was the RD at the dialysis facility where Resident #95 was a patient. She stated Resident #95 should receive a renal diet with foods low in potassium, low in phosphorus and low in sodium. RD #2 stated she would be more concerned about Resident #95 receiving foods high in potassium like potatoes and tomatoes because her potassium levels in October 2023 and November 2023 were on the upper limit. The Assistant Director of Nursing (ADON) stated in an interview on 12/06/23 at 1:44 PM that the dietary staff were responsible to send foods from the kitchen per the diet order and if something was missing or wrong, nursing staff should address it if they saw it. The Administrator stated in an interview on 12/08/23 at 1:06 PM that she was the Administrator in the facility since July 2023. The Administrator stated that she expected dietary staff to review tray cards when meals were plated and for nursing staff to review tray cards when they assisted a resident to set up their meal. The Administrator stated residents should receive food per diet order.	F 808		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345238	A. BUILDING: ______ B. WING ______	12/8/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	**4009 CRAIG AVENUE CHARLOTTE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 638	Qrtly Assessment at Least Every 3 Months

CFR(s): 483.20(c)

§483.20(c) Quarterly Review Assessment
A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and medical record reviews, the facility failed to complete and submit a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date (ARD) of the previous MDS assessment for 1 of 1 resident reviewed for timely submission of quarterly MDS assessments (Residents #53).

Findings included:

Resident #53 was admitted to the facility on 10/24/22.

Review of Resident #53's medical records revealed his most recent quarterly MDS assessment was with an ARD of 08/02/23. No subsequent submission of MDS assessment was found in his electrical health records as of 12/05/23. It had been 125 days since the last MDS assessment submitted on 08/02/23.

During a joint interview conducted on 12/05/23 at 3:54 PM, MDS Coordinator #1 and MDS Coordinator #2 stated they were responsible for the completion and submission of Resident #53's quarterly MDS. Both MDS Coordinators explained the facility had a software update a few months ago. They had to delete the MDS assessment schedule in the system and upload it back after the system upgrade was completed. Due to a computer glitch, the MDS assessment for Resident #53 was dropped out from the schedule during the process. Both MDS Coordinator confirmed that the last quarterly MDS assessment completed and submitted for Resident #53 was on 08/02/23, and the scheduled 11/02/23 MDS assessment had not been completed and submitted.

An interview was conducted with the Director of Nursing (DON) on 12/05/23 at 5:07 PM. She was aware of staffing issues in the MDS Department and had hired an additional MDS Coordinator recently. It was her expectation for the MDS Coordinators to follow the regulations to complete and submit Resident #53's quarterly MDS assessment at least once every 92 days.

During an interview conducted on 12/08/23 at 1:04 PM, the Administrator expected the MDS Coordinator to complete and submit Resident #53's quarterly MDS according to the regulations in a timely manner.

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

The above isolated deficiencies pose no actual harm to the residents