STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The surveyor was on site at the facility to conduct a complaint investigation survey from 3/20/25 through 3/21/25. Additional information was obtained off site from 3/24/25 through 3/27/25. The surveyor returned to the facility on 3/31/25 to obtain additional information, validate the credible allegations of immediate jeopardy removal, and conduct an exit conference. Therefore the exit date was changed to 3/31/25. Event ID# XL4L11. The following intakes were investigated: NC00221185, NC00224672, NC00224716, NC00225347, NC00226841, NC00227524, NC00228117, and NC00228729. Intakes NC00228117, NC00227524, NC00225347, and NC00228729 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity K CFR 483.12 at tag F600 at a scope and severity J CFR 483.12 at tag F607 at a scope and severity K CFR 483.25 at tag F684 at a scope and severity K CFR 483.35 at tag F726 at a scope and severity K Substandard Quality of Care was identified at: CFR 483.12 at tag F600 at a scope and severity J CFR 483.12 at tag F607 at a scope and severity K CFR 483.25 at tag F684 at a scope and severity K	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Immediate Jeopardy began on 11/5/24 and was removed on 3/28/25. A partial extended survey was conducted. Five of the twelve complaint allegations resulted in deficiency.	F 000		
F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		4/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, Physician, and Nurse Practitioner, the facility failed to ensure the physician was notified when Resident # 3 was initially identified by Nurse Aide # 5 to have discomfort with positioning, swelling, and bruises on his arm and chest with no known cause and while the resident was not receiving an anticoagulant. The physician was not notified until the following shift. When Resident # 3's physician was notified and a complete assessment was conducted, multiple bruises were found on both arms and the resident's chest which was a broader area than had been reported by Nurse Aide # 5 when she identified bruising. The bruising was irregular in shape and included both red and purple bruising. Two days following the initial identification of the bruises, the resident was transferred to the hospital ED	F 580	White Oak Manor Burlington will ensure that all residents that experience an accident resulting in an injury, have a significant change in condition, have a change in orders or treatment or treatment plan, or are being transferred or discharged from the facility will receive timely notification to the resident, their representative, and the provider. 1.Resident # 3 was noted with discomfort with positioning, swelling, and upper arm and chest bruising initially by the Nurse Aide # 5 (NA # 5) on 12/17/24. NA # 5 failed to notify a nurse and delayed assessment and treatment of Resident # 3 by the physician during the following shift. When evaluated by the physician on 12/18/24, Resident # 3 had multiple	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 (Emergency Department) where A CT (computerized tomography) of the chest abdomen and pelvis with contrast was completed. The CT "impression" read, "1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip." Unexplained bruises could be a sign of abuse or neglect and require an investigation. According to an interview with Resident # 3's physician, the provider should have been notified on the shift the bruises, discomfort, and swelling were identified because of the extent of the unexplained bruises. Additionally, for another resident (Resident #9), the facility failed to notify the physician on multiple occurrences when Resident # 9's documented elevated FSBS (finger stick blood sugar) readings exceeded 400 and both the Nurse Practitioner and Physician reported they should have been notified so that orders could be given. (Normal blood sugar values for nondiabetic individuals typically do not exceed 125). On the evening of 1/24/25 after Resident # 9's last documented finger stick blood sugar (FSBS) reading registered 524 the resident fell after becoming dizzy. The resident was transferred to the hospital where he was diagnosed with a small subdural hematoma (type of bleeding near your brain that can happen after a head injury). For a third resident (Resident # 11), the facility also failed to ensure the physician was notified following falls while the resident was receiving anticoagulant medication which placed him at greater risk of bleeding. This was for three of five sampled residents reviewed for physician notification. Immediate Jeopardy began on 12/18/24 for	F 580	bruises on both arms and a broader area on the chest than initially found. The area was irregular in shape with red and purple bruising. Resident # 3 was transferred to the Emergency Department on 12/20/24 for an evaluation and CT findings included a large left subpectoral hematoma underlying the pacer control box measuring 9.5cm X 5.2cm and a superficial soft tissue contusion of the left flank and hip. On 3/26/25, an audit of current residents was completed by the Unit Coordinators to ensure no other residents were identified with bruising, discomfort and swelling, and if so to ensure proper notification and/or investigation was completed. Current and newly admitted residents with identified areas of bruising, discomfort and swelling will be reported for further investigation if they have unexplained areas and notification to the provider will be completed when noted. The Licensed Nurses, Medication Aides, Nursing Assistants, Activities Department, Social Services Department, and Therapy staff were re-educated on reporting unexplained bruises at the time it is noted because it could be a sign of abuse or neglect and require further investigation. The re-education also included the notification to the provider as soon as an extensive and/or unexplained bruising, swelling and discomfort is identified. Staff to recognize and report significant changes in condition and proper chain of communication to the provider for reporting bruising or other changes in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

Resident # 3 when Nurse Aide # 5 identified during her shift that Resident # 3 had unexplained bruises, swelling, and discomfort and there was no physician notification. Immediate Jeopardy began for Resident # 9 on 1/8/25 when his FSBS registered 409 and there was no physician notification. Immediate Jeopardy was removed on 3/28/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E to ensure education is completed and monitoring systems put in place are effective. Example # 3 was cited at a scope and severity level of "D."

The findings included:

1. Resident # 3 was admitted to the facility on 10/19/23. The resident's diagnoses in part included dementia, congestive heart failure, Parkinson's, atrial fibrillation, anxiety, and dysphagia.

Resident # 3's annual Minimum Data Set (MDS) assessment, dated 10/14/24, coded the resident as severely cognitively impaired and as needing total staff assistance for bathing, dressing, and hygiene needs. Resident # 3 was coded as needing partial to moderate assistance to roll from side to side in bed and as needing substantial to maximum assistance to transfer.

Review of Resident # 3's medication regimen for December 2024 revealed Resident # 3 was not on an anticoagulant.

Review of staffing sheets revealed on the night shift which began at 11:00 PM on 12/17/24 and

condition. This re-education was completed by the Director of Nursing (DON) and Staff Development Coordinator (SDC) from 3/26/25 to 3/27/25. Newly hired Licensed Nurses, Medication Aides, Nursing Assistants, Activity, Social Services and Therapy staff will receive this education during their job specific orientation by the SDC.
The DON or designated management nurse will monitor 5 residents weekly for 12 weeks to ensure any significant change in condition such as identified bruises, discomfort and swelling is reported for further investigation and the provider is notified at the time of the significant change of condition.
2.Resident # 9 is a diabetic and was noted with multiple occurrences (1/8/25 with a finger stick blood sugar (FSBS) of 409, 1/10/25 with a FSBSs of 433 and 423, 1/18/25 with a FSBS of 413, 1/22/25 with a FSBSs of 453 and 456, 1/23/25 with FSBSs of 419 and 403, 1/24/25 with FSBSs of high and 524) of seriously elevated blood sugars (greater than 400) and the provider was not notified to provide orders to address the elevated blood sugars. During this time period, Resident # 9 did not have orders for sliding scale insulin or parameters for notifying the physician of elevated blood sugars. On 1/24/25 after Resident # 9's last documented FSBS reading of 524, the resident fell after becoming dizzy. Resident # 9 was transferred to the hospital and diagnosed with a small subdural hematoma. In January, several nurses and nurses on subsequent shifts

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 ended at 7:00 AM on 12/18/24, Employee # 1 was assigned to care for Resident # 3 as a nurse. Review of Employee # 1's statement revealed it was dated on 12/19/24 and read, "I was collecting [Resident # 3's] routine 02 when I notice he had some bruising to his right shoulder as well as some to his left. No fall or bruising was reported from the previous shift to me in report so my next thought was to bring it to our unit coordinators attn. that he had bruising on him. Before I could bring it to [Unit Coordinator's] attention it was brought to my attention once more by the next shift and when the unit coordinator got here I immediately let her know my findings so it could be documented properly." Employee # 1 was interviewed on 3/25/25 at 2:57 PM. This interview revealed Employee # 1 was not a nurse, she did not know how the bruises had occurred, and she had not notified the physician about Resident # 3's bruises. According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, "When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However I notice some bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I notice while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I	F 580	failed to notify the provider of the elevated blood sugars resulting in delayed assessments, treatments and monitoring. On 1/24/25, Resident # 9 readmitted with orders for sliding scale insulin and FSBS parameters of greater than 400 to contact the provider. On 3/25/25, an audit was completed by the DON of current residents with FSBS readings was reviewed to ensure any noted elevated blood sugars (greater than 400) from 3/19/25 to 3/25/25 were reported to the provider and obtained orders to address the elevated blood sugars. Identified elevations without proper physician notifications were communicated by the DON to the provider on 3/25/25 and no further orders were given for the identified residents. Current and newly admitted residents with FSBS readings will be monitored and notifications will be made to the provider when blood sugars are significantly elevated. On 3/26/25, the Quality Information Manager (QIM) audited and entered the verbiage to each blood sugar on the Medication Administration Record (MAR) with the following, blood sugar greater than 400 call the provider. The Licensed Nurses and Medication Aides were re-educated by the DON on notifying the provider when elevated FSBS readings that exceed 400 and the provider can provide orders to address the elevated blood sugars to prevent further issues such as dizziness or a fall. The re-education also included that normal blood sugar values for nondiabetic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6	F 580		

came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aid to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON."

NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been "washed up" by the 2nd shift. He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was a golf ball sized bruise on his arm which appeared light reddish and turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise, and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift and staff were already aware it was there. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse.

A review of nursing notes revealed the first entry documenting the resident's bruising and that the physician was notified was on 12/18/24 at 7:32 AM by Nurse # 1. The entry was entered into the record as a late entry on the date of 12/19/24 at 8:08 AM. The entry read, "Resident able to make needs writer made aware during report that resident had bruising to left side of chest, armpits, and arms. VS 128/77 (blood pressure), 97 % on

individuals typically do not exceed 125.
This re-education was completed on 3/26/25. Newly hired Licensed Nurses and Medication Aides will receive this education during their job specific orientation by the SDC.
On 3/25/25, the DON educated the Licensed Nurses to add blood sugar greater than 400 call the provider to newly admitted residents or new orders for current residents with FSBS orders for proper notification to the provider. Newly hired Licensed Nurses will receive this education during their job specific orientation.
The QIM will monitor by reviewing all new blood sugar orders entered in the residents electronic medical record (EMR) to ensure that the verbiage blood sugar greater than 400 call the provider. The monitoring will be completed 3 times a week for 4 weeks and then weekly for 8 weeks.
The DON or designated management nurse will monitor all recorded blood sugars from the previous day beginning on 3/26/25 to ensure all blood sugar elevations above 400 are addressed and reported to the provider 5 days a week for 4 weeks and then 3 days a week for 8 weeks.
3.Resident # 11 experienced a fall on 1/9/25 and nursing failed to ensure the physician was notified following the fall while the resident was receiving anticoagulant medication which increased their risk for bleeding.
On 4/9/25, an audit of current residents with falls including residents on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 RA (room air), 18 (respirations), 97.9 (temperature), 63 (pulse.) No s/s (signs and symptoms) of SOB (shortness of breath), wheezing or labored breathing. Facial grimacing noted when resident move his left arm. Resident refused to be repositioned ..." Nurse # 1 further noted Resident # 3 had an order for Tylenol 325 mg (milligrams) 2 tabs every 6 hours. Nurse # 1 also noted the physician was notified and orders were obtained for a stat x-ray on the chest, right arm and left arm. The Director of Nursing (DON), Unit Coordinator, and Social Worker were also notified. Review of physician progress notes revealed the resident's physician, who served as the facility medical director, assessed Resident # 3 on 12/18/24. The physician noted, "He (Resident # 3) was noted this morning to have bruising on his upper body. Patient has cognitive impairment and is not able to tell us what happened. Last BIMS (brief interview for mental status) 2/15. He seems to only have pain when moving the left shoulder. No documented falls. He was given Tylenol for pain." The physician further documented measurements of the bruising as follows: "Note Bruises were irregular shaped and were measured at largest diameter. Right anterior chest upper near midline, about 5.5 X 3.5 cm (centimeters) reddish with some faint purplish area inferior to it. Right shoulder near AC joint circular reddish abrasion. Right shoulder lateral clavicle about 7 x 6 cm irregular shaped reddish bruise with faint deeper purple underneath it extending further down about 5 X 8 cm at largest diameter. Right arm-3 circular bruises about 1 cm each-2 inner bicep mid to distal and 1 lateral inferior. Left chest wall- Pacemaker scar with 6 small irregular shaped purplish red bruises.	F 580	anticoagulant medications was reviewed to ensure the provider and resident representatives were notified. No failure of notification was noted in the audit. This audit was completed by the DON and the Safety Licensed Nurse. Current and newly admitted residents that experience a fall including residents on anticoagulant medications, will have their occurrence reported to their provider for evaluation, treatment and monitoring. The Licensed Nurses were re-educated by the DON, SDC, and nursing supervisor on notifying the provider following a fall, including residents receiving anticoagulant medication which places them at a greater risk of bleeding. This re-education was completed on 4/14/25. Newly hired Licensed Nurses will receive this education during their job specific orientation by the SDC. The DON or Safety Licensed Nurse will monitor all fall events beginning on 4/10/25 weekly for 4 weeks and then up to 5 falls a week for 8 weeks to ensure the provider is notified following a fall. The results from the monitoring tools will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks. Identified issues or trends will be further discussed at the monthly Quality Assurance (QA) meeting with the team and recommendations made as indicated. The DON is responsible for the ongoing compliance of F580. Compliance date is 4/25/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8	F 580		

Pacemaker appears more lateral and turned/sticking out. Left side -about 7 X 3 cm reddish bruise with faint edges in shoulder near clavicle. Large reddish purple about 10 X 4 cm inferior to tattoo on lateral upper arm. Left arm-irregular shaped bruise going down bicep with varying colors-reddish to darker purple inferior, 12 X 4 cm around to lateral aspect of arm. 8 X 3 cm circular bruise purplish inferior and medial to elbow. Large left chest wall bruise light purplish edges wraps around chest lateral to nipple, darker purple on posterior chest. No ecchymosis (discoloration of the skin, typically caused by bruising) neck, facial area, or body below waist." Within the progress note, the physician noted a chest x-ray and complete blood count would be obtained. The physician further noted that she was unsure when the pacemaker had been placed or last tested. She further noted the pacemaker appeared to be "turned/sticking out more."

Resident # 3's Physician, who serves as the facility's medical director, was interviewed on 3/21/25 at 3:13 PM and reported the following information. When she evaluated Resident # 3 on 12/18/24 the bruising was all on his upper body which included areas on his arms and chest wall which wrapped around some on his trunk. According to the Physician the provider should have been called during the night when the bruising was found due to the extent of the bruising. She learned of the bruising when she arrived at the facility during the dayshift of 12/18/24.

2. Record review revealed Resident # 9 was admitted to the facility on 11/7/24 and had diagnoses which in part included diabetes and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9	F 580		

Alzheimer's dementia.

Review of Resident # 9's admission Minimum Data Set assessment, dated 11/13/24, coded Resident #9 as severely cognitively impaired and as receiving Insulin.

Review of physician orders revealed Resident # 9 was ordered to receive Eliquis 5 mg (milligrams) every 12 hours for atrial flutter. This order began on 11/8/24. (Eliquis is an anticoagulant and increases the chances of bleeding).

Resident # 9's care plan included the information that Resident # 9 was a diabetic. This was added to the care plan on 11/8/24 and remained part of the resident's active care plan. Staff were directed on the care plan to monitor blood sugar levels as ordered and both observe and report any signs and symptoms of hyperglycemia or hypoglycemia.

Review of physician orders and Resident # 9's January 2025 MAR (medication administration record) revealed the following information.

Resident # 9 had an order for FSBS (fingerstick blood sugars) twice per day. This order had originated on 11/8/24 and was in effect until discontinuation on 1/27/25. There were no physician orders regarding what parameters the physician should be notified when the FSBSs were obtained.

According to the January 2025 MAR, the FSBS were scheduled for 6:30 AM and 4:30 PM. There were no orders for parameters to call the provider regarding results and there was no order for sliding scale insulin coverage based on FSBS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10	F 580		

results.

Review of physician orders revealed between the dates of 1/1/25 and 1/24/25, the only type of insulin Resident # 3 was prescribed was a long acting insulin given at night and there was one order change in Resident # 9's diabetic medication dosages. Specific medications and the dosage order change were as follows:

Jardiance 25 mg (milligram tablet once per day. This order was in effect from 12/7/24 until its discontinuation on 1/27/25.

Metformin 500 mg tablet twice per day. This order was in effect from 12/13/24 until discontinuation on 1/27/25.

Ozempic pen injector; 0.5 mg; subcutaneous once per week on Monday. This order was in effect from 11/11/24 until discontinuation on 1/27/25.

Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); Administer 15 units subcutaneous at bedtime. This order was in effect from 12/31/2024 until the discontinuation on 01/06/2025. (Lantus is a long- acting insulin which can last up to 24 hours but does not have a rapid onset of action).

Insulin glargine-yfgn insulin pen; 100 unit/mL (3 mL); Administer 15 units subcutaneous at bedtime. This order was in effect from 1/6/25 until discontinuation on 1/18/25. (Insulin glargine-yfgn is a biosimilar interchangeable insulin product to insulin glargine which the resident was already receiving. There were no dosage changes).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11	F 580		

The date of 1/18/25 was the only date where an increase in insulin dosage order was noted in the chart from 1/1/25 to 1/24/25. The order was for insulin glargine-yfgn insulin pen; 100 unit/mL (3 mL); Administer 18 units subcutaneous at bedtime. This order was in effect until discontinuation on 1/27/25.

According to the record, the physician entered a progress note on 1/18/25 and noted his hemoglobin HgbA1c on 12/24/24 had been 9.2 and she would increase the resident's long-acting insulin from 15 to 18 units. (Hemoglobin A1c is a blood test that measures the average blood sugar result in the last two to three months. A result of 6.5% and above reflects diabetes.)

Review of Resident # 9's MAR revealed multiple times Resident # 9's FSBS exceeded 400 from 1/1/25 to 1/24/25 without any documentation the physician was notified in the record. Specifics are as follows

On 1/8/25 at 6:30 AM Employee # 1 documented 409 on the MAR.
On 1/10/25 at 6:30 AM Nurse # 6 documented 433 on the MAR.
On 1/10/25 at 4:30 PM Nurse # 7 documented 423 on the MAR.
On 1/18/25 at 4:30 PM Nurse # 8 documented 413 on the MAR.
On 1/22/5 at 6:30 AM Medication Aide (MA) # 1 documented 453 on the MAR.
On 1/22/25 at 4:30 PM MA # 2 documented 456 on the MAR.
On 1/23/25 at 6:30 AM Nurse # 9 documented 419 on the MAR.
On 1/23/25 at 4:30 PM MA # 3 documented 403 on the MAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12	F 580		

On 1/24/25 at 6:30 AM MA # 4 documented "high" on the MAR.
On 1/24/25 at 4:30 PM Nurse # 5 documented 524 on the MAR.

Nurse # 6 was interviewed on 3/25/25 at 1:45 PM and reported she did not recall details of the date of 1/10/25 but she would normally call the physician and make a note she had done so for elevated blood sugars.

Nurse # 7 was interviewed on 3/26/25 at 9:48 AM and reported she wasn't aware she was to call for blood sugars over 400 but would have done so if the blood sugars went over 500.

An attempt was made to talk to Nurse # 8 on 3/25/25 at 1:21 PM and the nurse could not be reached by phone.

MA # 1 was interviewed on 3/25/25 at 6:30 AM and reported she would have reported to a nurse the FSBS on 1/22/25 but did not recall who the nurse was. MA # 1 reported she always did so, and that Resident # 9 would often eat sugary items brought in by the family.

MA # 2 was interviewed on 3/25/25 at 12:38 PM and reported she could not recall specific details of 1/22/25 but she would have told a nurse about an elevated blood sugar over 400, rechecked it in an hour and put it on the 24-hour nursing report.

Nurse # 9 was interviewed on 3/25/25 at 12:10 PM and reported she had not worked on the night shift on 1/23/25 at 6:30 AM to have obtained a FSBS of 419 and did not know why her initials were signed off on the MAR as obtaining the result. The nurse reported she was a day shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13	F 580		

nurse.

An attempt was made to interview MA # 3 on 3/25/25 at 11:29 AM and she could not be reached.

MA # 4 was interviewed on 3/25/25 at 10:28 PM and reported the following information. She recalled Resident #9's blood sugar registering "high" on the morning of 1/24/25. At the time she was to be reporting to Employee # 1, who she thought was a nurse at the time. She told Employee # 1 about the "high" blood sugar and Employee # 1 stated she would check the record for sliding scale orders and call the physician. She saw Employee # 1 make a phone call and talk to someone, but she did not know to whom she was talking to. Afterwards Employee # 1 asked to look in her (MA # 4's) medication cart, obtain an insulin pen, and go into Resident # 9's room. She did not know what insulin pen Employee # 1 had obtained or what she had done when she went into the room. When she had checked the FSBS, Resident # 9 had appeared okay.

Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She had applied and been accepted to work at the facility as a nurse. She had provided a false license to the facility and had no nursing education nor a license to perform job duties of a nurse. She had taken care of diabetic family members and had some partial training as a medication assistant in another state. On the morning of 1/24/25 when Resident # 9's blood sugar registered "high" she had called the doctor and gotten an order for some insulin. She had given the insulin. When interviewed about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14	F 580		

issue that Resident # 9 did not have any short acting insulin ordered and filled for her to access for him, Employee # 1 replied they kept some on the cart or in back up for times such as this.

Nurse # 5 was interviewed on 3/25/25 at 1:26 PM and reported the following information. She was new at the time on 1/24/25 when Resident # 9's FSBS registered 524. She was walking to the desk when she saw MA # 1. She asked MA # 1 if Resident # 9's FSBS usually ran high, and MA # 1 told her that Resident # 9 would get sugary things on his hands and recommended to clean his finger better and recheck it. There was not much time between Nurse # 5 talking to MA # 1 before she then went back to recheck the FSBS. She then obtained a result in the 300s but did not recall what it was. She thought she had documented the FSBS but had not done so. Nurse # 5 was interviewed regarding whether she had cleaned Resident # 9's finger well the first time and responded that she thought she had done so. She had not communicated with the physician following either FSBS check. Nurse #5 further stated during her shift Resident # 9 appeared to be okay.

Interview with Unit Coordinator # 1 on 3/25/25 at 12:46 PM revealed the facility kept a communication book that the provider could reference when they arrived at the facility. She had looked through the physician communication book and found no record of communication left for the provider between the dates of 1/1/25 to 1/24/25 about Resident # 9's elevated blood sugar readings.

Further review of nursing notes revealed the only note on 1/24/25 was dated 1/24/25 at 7:16 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 15	F 580		

and was written by Nurse # 10. Nurse # 10 documented at this time that Resident # 9 was in the shower with staff present and became dizzy and fell. Resident # 9 sustained a laceration to his head with minimal bleeding. Nurse # 10 further documented that given the resident was on an anticoagulant the resident was transferred by EMS services to the hospital.

Interview with Nurse # 10 on 3/25/25 at 10:44 AM revealed she had not been caring for Resident # 9 at the time of the fall, but was closet to the shower room when the resident fell.

Review of EMS records dated 1/24/25 revealed the EMS paramedics arrived at 7:23 PM on 1/24/25 and Resident # 9 did not complain of blurred vision or dizziness at the time of their arrival.

Review of the hospital records for the date of 1/24/25 to 1/30/25 revealed the following information. Resident # 9 was diagnosed with a small subdural hematoma. His blood sugar was 305 at 8:40 PM on 1/24/25 when drawn by the lab. The hospital physician noted Resident # 9's last HgbA1C was 10.2. The hospital physician noted the resident should receive both long acting and short acting insulin upon discharge back to the facility. Also, the hospital discharge summary included information that the resident had been hypotensive when he arrived to the hospital and his Toprol (used for heart failure) was held. Also, while hospitalized, neurosurgery was consulted and recommended holding the resident's anticoagulant medication. Prior to discharge, a repeat CT scan was performed to ensure the resident's subdural hematoma had not worsened. Discharge orders included that the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 16	F 580		

should be placed on sliding scale insulin coverage and in addition to the prescribed sliding scale insulin, when the FSBS was greater than 400, the primary physician should be contacted.

On 1/30/25 Resident # 9 returned to the facility with the new insulin orders and designated parameters to call the physician.

Interview with Resident # 9's NP (Nurse Practitioner) on 3/24/25 at 5:15 PM and again on 3/26/25 at 11:21 AM revealed the following information. She was at the facility three days per week. She also took call during the day. She had not been notified of blood sugar results greater than 400 from 1/1/25 to 1/24/25. If she had been, then she would have left orders for the resident. During the night if the resident's blood sugar registered over 400, the facility staff could call an on-call provider. She had reviewed the on-call provider log and found no documentation of calls that came into the on- call provider between the dates of 1/1/25 and 1/24/25 related to Resident # 9's blood sugars being above 400. The NP also validated that the change made on 1/6/25 in Resident # 9's long-acting insulin was a substitution and was probably due to insurance covering one form of insulin. The order change had not been due to notification of elevated blood sugar readings.

The facility's Medical Director, who also was Resident # 9's physician, was interviewed on 3/21/25 at 3:13 PM and again on 3/27/25 at 1:42 PM. The physician reported the following information. The staff should call the provider about blood sugars which were greater than 400 unless there are specific instructions in the orders and a different parameter is set for a specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 17	F 580		

resident based on their individual history. If she had been notified of a blood sugar greater than 400 then she would have given an order to address it. She did not typically answer her phone before 7:00 AM unless she was on call and did not know to whom Employee # 1 had talked to on 1/24/25. The Physician was further interviewed about whether residue on an individual's finger could affect a FSBS result and reported that it sounded strange that by just cleaning someone's finger that such a large difference in a result would occur as reported by Nurse # 5 unless something was wrong with the glucometer itself. The Physician reported even if the FSBS was in the 300s that also needed to be addressed.

On 3/25/25 at 8:55 PM the Administrator was notified of Immediate Jeopardy.

The Administrator presented the following Credible Allegation of Immediate Jeopardy Removal Plan.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and
Resident #3 was noted with significant Chest and upper arm bruising initially by a Certified Nursing Assistant (CNA) on 12/18/2024. The CNA failed to notify any nurse of the bruising. Her failure to report the bruising to the nurse delayed assessment and treatment of Resident # 9 by the provider.

In the month of January 2025 resident # 9 experienced multiple instances of seriously elevated blood sugars (greater than 400). During this time period resident # 9 did not have orders for sliding scale insulin or parameters for notifying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 18	F 580		

physician of blood sugar elevations. During January several nurses including employee #1 and nurse #5 failed to notify the provider or nurses on subsequent shifts of these seriously high blood sugars resulting in the delayed assessment, treatment, and monitoring. And as a result of the failure resident # 9 experienced hyperglycemia.

On 3/26/25 The DON conducted an audit of all nursing progress notes from 3/19/25-3/25/25 to ensure that the provider had been notified of any residents with a significant change in condition. The audit revealed that there were no changes in condition that were not communicated to the provider.

A complete audit from 3/19/2025-3/25/2025 of the Vital Signs (Blood Glucose Values) for elevated blood glucose levels over 400 with proper physician notification was completed by the DON on 3/25/2025. Identified elevations without proper physician notification were communicated by the DON to the provider on 3/25/2025. No further orders were given by the provider for identified residents.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 3/26/25 The Director of Nursing (DON) conducted education with all licensed nurses and Medication Aides on blood glucose parameters and the necessity of notifying the provider of any reading above 400. All nurses and Medication Aides were contacted either face to face or via

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 19	F 580		

phone communication on 3/26/25. Education was provided to prevent any further failures of nurses to notify providers and to prevent uncontrolled hyperglycemia in facility residents.

On 3/27/25 the Staff Development Coordinator was educated by the DON that all Newly hired nurses, medication aides and agency nurses will receive this training in orientation by the Staff Development Coordinator.

On 3/26/2025 the Quality information manager (QIM) audited and entered the verbiage to each blood sugar order on the MAR: "blood sugar greater than 400 call provider".

On 3/25/25 the Director of nursing educated licensed nurse to add "blood sugar greater than 400 call provider" to newly admitted resident with finger stick blood sugar orders for proper notification to the provider.

On 3/27/25 the QIM was educated by the Director of Nursing to include in the current QIM admission order review process to ensure "blood sugar greater than 400 call provider" has been added by the nurse to those residents with finger stick blood sugar orders for proper notification to the provider.

On 3/26 & 3/27/2025 the DON and Staff Development Coordinator (SDC) completed education with all nurses, CNAs, activities (life enrichment), social services and therapy staff on recognition and reporting of significant changes, and proper chain of communication to the provider for reporting bruising or other resident changes in condition. Education was completed either by face to face or phone communication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 20	F 580		

The SDC will also educate all newly hired nurses, CNAs, Activities (Life enrichment) staff, therapy and social services staff on the recognition and reporting of significant changes, and proper chain of communication to the provider for reporting bruising or other resident changes in condition as part of the facility orientation process.

Date of Immediate Jeopardy removal will be 3/28/25.

On 3/31/25 the facility's Credible Allegation of Immediate Jeopardy Removal Plan was validated by the following actions:

The facility presented an audit of all resident's records in which the Director of Nursing had reviewed progress notes and vital signs to identify changes in condition. Recent progress notes were printed by the DON. The DON had made written notations regarding the physician was aware on any progress note which indicated a resident was experiencing an acute medical condition.

The facility presented evidence of blood sugar checks to ensure the physician was being informed of elevated levels.

Review of a random diabetic resident's record revealed the information had been added to the resident's record that the physician should be contacted for blood sugars greater than 400.

Interview with nurses revealed they were aware they were to immediately call for blood sugars greater than 400 unless otherwise specified in the physician's orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 21	F 580		

The facility presented evidence of education as outlined in their removal plan.

The facility's date of immediate jeopardy removal was validated to be 3/28/25.

3. Resident # 11 was admitted to the facility on 12/10/24. Resident # 11's diagnoses in part included dementia and a history of pulmonary embolus.

Resident # 11's admission MDS (Minimum Data Set) assessment, dated 12/16/24 coded Resident # 11 as severely cognitively impaired. The resident was also coded as needing substantial to maximum assistance with his hygiene needs, requiring total staff assistance to turn in bed, not ambulatory during the assessment period, and as having no falls.

Review of orders revealed Resident # 11 was prescribed Eliquis 5 mg (milligrams) from 12/17/24 to 1/30/25. (Eliquis is an anticoagulant which places a resident at greater risk for bleeding).

On 12/28/24 12:30 AM Employee # 1 documented, "Resident slipped of the left side of the bed sitting on the floor, laid down on his left side, head propped up against the nightstand. No obvious injury or bruising. Head trauma protocol given and vitals record at the time of the fall. Temp-97.9, Pulse-71, Resp. 20 B/P (blood pressure) 115/64.

Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She was not a licensed nurse and had never completed any formal training program in health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 22	F 580		

care. She had taken care of bedridden family members, and she thought she knew what to do. Resident # 11 did not seem hurt to her on 12/28/24 and 1/9/25 and she had not called the physician.

There was no record the physician was called regarding the resident's fall he sustained while on Eliquis.

Review of nursing notes following 12/28/24 did not reveal any documented injury from the 12/28/24 fall.

NA # 8 had cared for Resident # 11 on the night shift which had begun on 12/27/24 at 11:00 PM. NA # 8 was interviewed on 3/25/25 at 6:45 AM and reported she did not recall taking care of Resident # 11 that night and did not know how he had fallen.

Interview with the Director of Nursing on 3/21/25 at 9:00 AM revealed Employee # 1 had worked at the facility from November 2024 until her termination in February 2025 under false pretenses as a nurse. She had not been a licensed nurse while caring for Resident # 11.

On 1/9/25 at 7:27 AM Employee # 1 documented, "[Resident # 11] was laying on the floor in the room beside his bed and neuro assessment to make sure he did not sustain any blows to the head. T-94.6 P 64 R 20 B/P 126/83. He was alert and oriented." (A temperature reading of 94.6 would indicate a hypothermic reading which is a lower than normal body temperature).

Review of the nursing notes revealed no notification to the physician was documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 23 Interview with Resident # 11's Physician on 3/21/25 at 3:13 PM revealed the provider should be contacted when a cognitively impaired resident, who was on Eliquis, falls and it is not known if the resident hit their head. In those cases, the resident would be sent out to the hospital to be checked.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview with residents, staff, Physician, and Nurse Practitioner the facility failed to protect Resident #3's right to be free of an injury of unknown source; and abuse/neglect. Resident # 3, who was a cognitively impaired resident, was identified to have significant bruises on his arm and chest which wrapped around his torso on 12/18/24. The bruises were also accompanied by swelling and discomfort with positioning when	F 600	White Oak Manor Burlington will ensure to protect the residents and their right to be free from abuse, neglect, exploitation, and injury of unknown source. While under the care of Employee # 1 (non-licensed employee), Resident # 3 was found to have an injury of unknown source on 12/17/24, but did not notify provider, resident representative or Administration. On 12/18/24 at 7:20AM,	4/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24 initially found. Staff reported they had not observed any incident which had caused the bruises. The resident could not provide detailed information about how the bruises occurred, and the extent of the bruising without a known cause indicated a suspicion of neglect or abuse. Also, Resident # 3 was under the care of a non-licensed employee (Employee # 1), who was working at the facility under the false pretense she was a nurse when the bruises were found. The bruises continued to spread and on 12/20/24 Resident # 3 was evaluated at the local hospital ED (Emergency Department) where it was noted Resident # 3 had extensive chest and abdominal wall ecchymosis (discoloration of the skin, typically caused by bruising). A CT (computerized tomography) of the chest abdomen and pelvis with contrast was completed. The CT "impression" read, "1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip." This was for one (Resident # 3) of three residents reviewed for abuse, neglect, and injuries of unknown origin. Immediate jeopardy began on 12/18/24 when Nurse Aide # 3 identified during her shift that Resident # 3 had unexplained bruises, swelling, and discomfort. Immediate Jeopardy was removed on 3/28/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D to ensure education is completed and monitoring systems put in place are effective.	F 600	the Unit Coordinator noted the bruising to Resident # 3s chest and arm area. Resident # 3 was noted with a significant bruising to chest and arms that were reddish with a faint deeper purple, located over the right clavicle extending to the upper chest over the pacemaker site. The bruising was noted to be an irregular shape measuring 7cm X 6cm. The Unit Coordinator then reported the bruising to the Director of Nursing (DON). The DON then instructed the Unit Coordinator to complete and send the initial report to the State for an injury of unknown source. Resident # 3 was observed having swelling and discomfort with positioning when the bruising was initially noted by Nurse Assistant # 5 (NA # 5). No documented incident was noted relating to the bruises and Resident # 3 was not cognitively able to explain how the bruises occurred. NA # 5 failed to notify any licensed nurses of the significant bruising, swelling and discomfort. This failure of notification resulted in a delay in notifying the provider, assessment, treatment and monitoring of Resident # 3s bruising, swelling and discomfort. On/12/20/25, the bruises continued to spread and the resident was transferred to the Emergency Department and diagnosed with extensive chest and abdominal wall ecchymosis, a large left subpectoral hematoma underlying the pacemaker measuring 9.5 X 5.2 cm, and a superficial soft tissue contusion of the left flank and hip. The DON began the investigation into Resident # 3s injury of unknown source.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25 The findings included: Resident # 3 was admitted to the facility on 10/19/23. The resident's diagnoses in part included dementia, congestive heart failure, Parkinson's, atrial fibrillation, anxiety, and dysphagia. Resident # 3's annual Minimum Data Set (MDS) assessment, dated 10/14/24, coded the resident as severely cognitively impaired and as needing total staff assistance for bathing, dressing, and hygiene needs. Resident # 3 was coded as needing partial to moderate assistance to roll from side to side in bed and as needing substantial to maximum assistance to transfer. The resident was coded as using a manual wheelchair to roll 50 feet after set-up assistance. The resident was not coded as having falls during the assessment period. Review of Resident # 3's care plan revealed the following information. On 10/19/23 staff added the resident was at risk for falls. This remained part of the resident's active care plan. On 10/27/23 staff added the resident picked at his skin causing skin tears and bruises at times. This also remained as part of the resident's active care plan. On 2/10/24 staff added that Resident # 3 could be combative with care. This remained as part of the resident's active care plan. Review of November 2024 nursing notes revealed Resident # 3 sustained one fall which was on the date of 11/2/24 at 6:15 PM. According to a nursing note, Resident # 3 had attempted to try to transfer himself from the chair to the bed before staff could assist him. His upper body had landed on the bed and then his body had slid to	F 600	The investigation revealed the resident had no documented injury that have contributed to the bruising and unable to substantiate abuse. The probable causes for the bruises could possibly be contributed to dislodgement of pacemaker. Resident # 3s body audits reveal no further areas with no swelling and discomfort. On 2/6/25 and 2/7/25, the Unit 300 Licensed Nurse and Wound Care Nurse conducted body audits on current residents to ensure no other residents were identified with bruising, discomfort and swelling, and if so to ensure proper notification and/or investigation was completed. No further signs or symptoms of injuries or new skin abnormalities were noted. Current and newly admitted residents with identified areas of bruising, discomfort and swelling will be reported to Administration for further investigation if they have unexplained areas. On 2/6/25 to 2/7/25, an audit of all resident hospital transfers and recorded incidents/events (events include reported falls, skin tears and infections) to ensure the completeness of the documentation, proper notification of the resident representative and provider, and follow-up interventions were implemented. The audit included the timeframes/shifts Employee # 1 worked from 11/5/24 to 2/6/25 and was conducted by the Nurse Consultant to identify any care concerns. The review of hospital transfers and reported falls, skin tears or infections did not reveal any obvious care concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 26 the floor. According to the nursing note at 6:15 PM on 11/2/24, the resident's range of motion was at his baseline. A later nursing note on 11/2/24 at 9:57 PM noted the resident had some discoloration but no swelling to his left knee, and orders were given for an x-ray. Review of x-ray results reported on 11/3/24 revealed Resident # 3 had sustained no fractures from the 11/2/24 fall. Review of Resident # 3's medical record revealed no falls in December 2024 were documented. Review of Resident # 3's medication regimen for December 2024 revealed Resident # 3 was not on an anticoagulant. Review of nursing progress notes revealed no entry for the date of 12/17/24, which was the date prior to Resident # 3's injury being identified. Review of staffing sheets revealed NA (Nurse Aide) # 1 had cared for Resident # 3 on the 12/17/24 dayshift (7:00 AM to 3:00 PM) prior to the bruising being identified on 12/18/24. A statement written by NA # 1 read, "I [Nurse Aide # 1] had [Resident # 3] from 7 AM 3 PM. No bruising or swelling at the time me and coworker [name of coworker] use [mechanical] lift to get resident up on 12/17/2024 and resident was dressed by me on 12/17/2024 around 11 AM." NA # 1 was interviewed on 3/21/25 at 12:25 PM and reported the following information. She routinely cared for Resident # 3. On 12/17/24 there had been no problems with his care or transfer and there had been no bruising on his body. She and another staff member used a lift to transfer the resident, and he was still up when she left at the end of her shift.	F 600	On 3/26/25 and 3/27/25, the DON, SDC and the Administrator completed re-education with current staff on the Abuse/Neglect Protocol including protecting the residents right to be free from injury of unknown source, and reporting protocols for suspicion of abuse or neglect. The re-education also included recognizing and reporting injuries or changes in residents condition, and the chain of reporting. Significant bruising without a known source indicates a suspicion of abuse or neglect and should be reported to Administration as soon as it is noted for further investigation and to report to the State Agency. Newly hired staff will receive this education during their job specific orientation by the SDC. The DON or designated management nurse will monitor all nursing progress notes weekly for 4 weeks, then 5 progress notes weekly for 8 weeks to ensure any indication of an injury of unknown source has been reported to Administration for further investigation and to report to the State Agency. The DON or designated management nurse will monitor 5 completed skin assessment sheets 3 days a week for 4 weeks then 5 completed skin assessment sheets weekly for 8 weeks to ensure there is no evidence of unreported injury of unknown source. The results from the monitoring tools will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks. Identified issues or trends will be further discussed at the monthly Quality Assurance (QA) meeting with the team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 27 Review of the investigative file revealed a statement by NA # 2 noting that she (NA # 2) had assisted NA # 1 on 12/17/24 with Resident # 3's transfer to the chair and there had been no incident or bruising on the resident. Review of the facility's investigative file revealed Nurse # 1 had been assigned to care for Resident # 3 on 12/17/24 during both the day shift and the evening shift (3:00 PM to 11:00 PM). Nurse # 1's statement within the facility's investigative file read, "On 12/17/24 I [Nurse # 1] worked 1st (7:00 AM to 3:00 PM) and 2nd shift (3:00 PM to 11:00 PM) as [Resident # 3's] nurse. I did not observe any bruising or swelling on resident body. No one reported any swelling or bruising. I [Nurse # 1] last seen [Resident # 3] approximately around 9:25 PM with no shirt on while giving him his night meds. No bruising or swelling noted." An attempt was made to interview Nurse # 1 on 3/21/25 at 12:01 PM and she could not be reached for an interview. Review of staffing sheets revealed NA # 3 had cared for Resident # 3 on the 12/17/24 evening shift. A review of the investigative file provided to the surveyor did not include a statement from NA # 3. NA # 3 was interviewed on 3/21/25 at 12:34 PM and reported the following information regarding the evening shift of 12/17/24. Resident # 3 had not fallen and there had been no incidents. He had no bruises. She (NA # 3) had placed Resident # 3 back in bed with the mechanical lift with the help of NA # 4. After she placed Resident # 3 back in bed on the evening shift, she had	F 600	and recommendations made as indicated. The DON and Administrator are responsible for the ongoing compliance of F600. Compliance date is 4/25/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 28	F 600		

checked on him every two hours and he had been fine. She had submitted a statement during the facility's investigation and did not know what had happened to it.

NA # 4 was interviewed on 3/24/25 at 3:21 PM and corroborated NA # 3's statement. NA # 4 reported she did assist NA # 3 with transferring Resident # 3 on the evening shift of 12/17/24. NA # 4 reported Resident # 3 was okay at the time, and she had not observed any injuries.

Review of the facility's investigative file for reportable incidents of injuries for which there was no known cause revealed the following information. On 12/18/24 the facility submitted an initial report, which was completed by Unit Coordinator # 1, to the state agency noting that at 7:20 AM on 12/18/24 Resident # 3 had been identified with a baseball size bruise on the front right shoulder, large hematoma to his left side under arm, swelling and bruising on his left upper chest and below clavicle. The report also noted the resident was unable to lift his left arm without pain and there was swelling.

Review of staffing sheets revealed on the night shift which began at 11:00 PM on 12/17/24 and ended at 7:00 AM on 12/18/24, Employee # 1 was assigned to care for Resident # 3 as a nurse.

Review of Employee # 1's personnel file revealed Employee # 1 was hired as a nurse but was not licensed as a nurse and her application prior to hire indicated no nursing education.

During an interview with the DON (Director of Nursing) on 3/21/25 at 9:00 AM, the DON confirmed that Employee # 1 had submitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 29	F 600		

someone else's nursing license upon hire in November 2024 and was terminated in February 2025 when this had been validated. At the time she had been caring for Resident # 3 on the night shift of 12/17/24, the facility had not noted she was impersonating a nurse and was not licensed.

A review of Resident # 3's vital sign log revealed Employee # 1 documented Resident # 3's oxygen level was checked at 12/18/24 at 12:56 AM. (According to Employee # 1's statement this was when she noticed the bruises.) The reading was 94%. There was no notation it was taken again on Employee # 1's shift. Employee # 1 also documented Resident # 3's weight was 127 pounds at 6:38 AM on 12/18/24.

Review of Employee # 1's statement read, "I was collecting [Resident # 3's] routine 02 (oxygen) when I notice he had some bruising to his right shoulder as well as some to his left. No fall or bruising was reported from the previous shift to me in report, so my next thought was to bring it to our unit coordinators attn. (attention) that he had bruising on him. Before I could bring it to [Unit Coordinator's] attention it was brought to my attention once more by the next shift and when the unit coordinator got here, I immediately let her know my findings so it could be documented properly."

According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, "When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However I notice some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 30	F 600		

bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I notice while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aide to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON."

NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been "washed up" by the 2nd shift. He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was a golf ball sized bruise on his arm which appeared light reddish and was turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise, and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift and therefore the nurses were already aware of it. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse. She thought Employee # 1 had been in Resident # 3's room before her (NA # 5) at some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 31	F 600		

time during the night shift but she did not see Employee # 1 go into Resident # 3's room.

During a follow up interview with NA # 5 on 3/24/25 at 1:02 PM, NA # 5 reported she had not obtained Resident # 5's weight that had been documented on 12/18/24 at 6:38 AM.

Review of the facility's investigative file revealed a statement from NA # 6 which showed discrepancies in what Employee # 1 had written in her statement. According to Employee # 1's statement she had seen the bruises when she checked Resident # 3's oxygen level and this had been recorded in Resident # 3's record by Employee # 1 at 12/18/24 at 12:56 AM. NA # 6's statement read, "On 12/18/24 I came to work passing the trays (breakfast trays). I got [Resident # 3's] tray. As soon I drop it off, I saw him with no shirt on. I saw bruises on his right shoulder, left upper quadrant. As soon I saw the bruises I talked to 3rd shift (11:00 PM to 7:00 AM) nurse [Employee # 1]. I saw her go to [Resident # 3's] room and showed her the bruises. She told me that this first time seeing this, that they had no falls last night."

Employee # 1 was interviewed on 3/25/25 at 2:57 PM and acknowledged she had given someone else's nursing certificate number who shared a similar name to the facility in order to work as a nurse. According to Employee # 1 she completed no type of Nursing Education or Nurse Aide training. She reported she had some medical assistant training from another state but had not completed that either. She was interviewed regarding Resident #3's bruises and reported she had called the DON at "12 something" when she saw them on the 11:00 PM to 7:00 AM shift which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 32	F 600		

began on 12/17/24 when she did the oxygen level and saw the bruises. Employee # 1 reported she did not know who obtained Resident # 3's weight which she had recorded. Employee # 1 did not know how the bruises occurred and reported she would never do anything to hurt a resident.

A review of nursing notes revealed the first entry documenting the resident's bruising was on 12/18/24 at 7:32 AM by Nurse # 1. The entry was entered into the record as a late entry on the date of 12/19/24 at 8:08 AM. The entry read, "Resident able to make needs writer made aware during report that resident had bruising to left side of chest, armpits, and arms. VS 128/77 (blood pressure), 97 % on RA (room air), 18 (respirations), 97.9 (temperature), 63 (pulse.) No s/s (signs and symptoms) of SOB (shortness of breath), wheezing or labored breathing. Facial grimacing noted when resident move his left arm. Resident refused to be repositioned ..." Nurse # 1 further noted Resident # 3 had an order for Tylenol 325 mg (milligrams) 2 tabs every 6 hours. Nurse # 1 also noted the physician was notified and orders were obtained for a stat x-ray on the chest, right arm and left arm. The DON, Unit Coordinator, and Social Worker were also notified.

An attempt was made to interview Nurse # 1 on 3/21/25 at 12:01 PM and she could not be reached for an interview.

The next nursing entry was dated 12/18/24 at 7:36 PM by Nurse # 2 and read, "Was informed from previous shift nurse that resident had discoloration noted to chest area. Resident has discoloration noted to chest, sides of chest, armpits and arms. Measurements obtained and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 33	F 600		

put in DON office Supervisor, MD, and DON aware."

Review of Nurse # 2's written statement which was located in the facility's investigative file read," Came into my shift and was made aware by [Nurse # 1] about [Resident # 3] having bruising. Went to go see [Resident # 3] and noted bruising to chest, arms, armpits, sides of chest. I asked [Resident # 3] what happened he just mumbled. I asked [Resident # 3] did he fall. He said yes the other night. I asked where did he fall. He then pointed to the closet area. I asked [Resident # 3] did anyone hurt him and he stated no. I then obtained measurements of bruising and placed them in DON office."

Nurse # 2 was interviewed on 3/21/25 at 10:28 AM and reported the following information. On the date of 12/18/24 she had reported to work at 11:00 AM because Nurse # 1 had to leave early that day. She had been told about Resident # 3's bruises in report at 11:00 AM and went to assess him and found bruises on his arms and chest. When he talked, he mumbled but if she asked him yes and no questions he would answer simple questions. When asked if he had fallen, Resident # 3 had replied, "yes." When asked where he had fallen, Resident # 3 had pointed to the closet area of the room. The resident was not able to convey more about the incident.

The facility Social Worker was interviewed on 3/24/25 at 10:56 AM and reported the following information. She had interviewed Resident # 3 on 12/18/24 after the bruises were brought to her attention. Resident # 3 was not able to convey what happened. She also interviewed Resident # 3's roommate (Resident # 12), who also had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 34	F 600		

cognitive impairment. Resident # 12 had reported someone pushed a machine into their room during the night and it was not used for his roommate. Resident # 12 did not report Resident # 3 had fallen. He was not able to say what the machine was that was pushed into the room.

Review of physician progress notes revealed Resident # 3's physician, who served as the facility medical director, assessed Resident # 3 on 12/18/24 and in addition to documenting the bruises also documented the resident had an "abrasion" to his skin. The physician noted, "He (Resident # 3) was noted this morning to have bruising on his upper body. Patient has cognitive impairment and is not able to tell us what happened. Last BIMS (brief interview for mental status) 2/15. He seems to only have pain when moving the left shoulder. No documented falls. He was given Tylenol for pain." The physician further documented measurements of the bruising as follows: "Note Bruises were irregular shaped and were measured at largest diameter. Right anterior chest upper near midline, about 5.5 X 3.5 cm (centimeters) reddish with some faint purplish area inferior to it. Right shoulder near AC joint (where the collar bone meets the shoulder blade) circular reddish abrasion. Right shoulder lateral clavicle about 7 x 6 cm irregular shaped reddish bruise with faint deeper purple underneath it extending further down about 5 X 8 cm at largest diameter. Right arm-3 circular bruises about 1 cm each-2 inner bicep mid to distal and 1 lateral inferior. Left chest wall-Pacemaker scar with 6 small irregular shaped purplish red bruises. Pacemaker appears more lateral and turned/sticking out. Left side about 7 X 3 cm reddish bruise with faint edges in shoulder near clavicle. Large reddish purple about 10 X 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 35	F 600		

cm inferior to tattoo on lateral upper arm. Left arm-irregular shaped bruise going down bicep with varying colors-reddish to darker purple inferior, 12 X 4 cm around to lateral aspect of arm. 8 X 3 cm circular bruise purplish inferior and medial to elbow. Large left chest wall bruise light purplish edges wraps around chest lateral to nipple, darker purple on posterior chest. No ecchymosis (discoloration of the skin, typically caused by bruising) neck, facial area, or body below waist." Within the progress note, the physician noted a chest x-ray and complete blood count would be obtained. The physician further noted that she was unsure when the pacemaker had been placed or last tested. She further noted the pacemaker appeared to be "turned/sticking out more."

On 12/18/24 at 7:38 PM Nurse # 2 noted Resident # 3's chest x-ray was normal.

Review of the 12/18/24 Chest x-ray result showed that the pacemaker was present but did not note any abnormalities with the pacemaker or with the resident's heart or lungs. The radiologist noted the report was "negative."

A review of Resident # 3's 12/18/24 CBC result revealed the resident's platelet count was normal. (Low platelets can increase the chance of bleeding.)

On 12/19/24 Resident # 3 was seen by the NP (Nurse Practitioner) who noted the following information. Resident # 3's CBC did not show thrombocytopenia (low platelets), and the chest x-ray had been normal. There had been a concern that the resident's pacemaker had been dislodged, and she had asked for a reread of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 36	F 600		

chest x-ray. Resident # 3 denied pain at the time.

Review of nursing notes revealed on 12/20/24 at 2:21 PM Unit Coordinator # 1 noted that Resident # 3's bruising was spreading from his bilateral shoulders down into his abdomen, left arm, and left side rib cage and he was being transferred to the hospital for further evaluation.

Review of 12/20/24 ED (Emergency Department) notes revealed the following information was documented. Resident # 3 had extensive chest and abdominal wall ecchymosis. A CT (computerized tomography) of the chest abdomen and pelvis with contrast was completed. The CT "impression" read, "1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip 3) No other CT evidence of acute traumatic injury to the chest, abdomen, or pelvis. 4) emphysema, 5) coronary artery disease." Upon preparing for discharge, the ED physician did not note any further comments about the hip contusion. The ED physician did note "CT scan obtained demonstrating hematoma around his pacemaker site but otherwise superficial contusion." There was no notation regarding how the hematoma could have formed around the pacemaker site. The resident was noted to be stable for discharge from the ED with a final diagnosis of "chest wall hematoma, left" and "superficial bruising of back, left." There were no ED discharge orders.

On 12/20/24 Nurse # 1 documented Resident # 3 returned from the hospital in no distress, no pain, and no new orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 37	F 600		

Interview with Resident # 3's Nurse Practitioner on 3/24/25 at 5:15 PM revealed she was not aware of how the bruising had occurred. The NP reported she attempted to see if the radiologist, who performed the chest x-ray at the facility, could determine if something occurred to the resident's pacemaker, but they were not able to determine. It had not been brought to her attention that the hospital's CT showed a contusion on the resident's hip.

Resident # 3's physician was interviewed on 3/21/25 at 3:13 PM and reported the following information. When she evaluated Resident # 3 on 12/18/24 the bruising was all on his upper body which included areas on his arms and chest wall which wrapped around some on his torso. She did not recall any bruising extending to his hip when she examined him on 12/18/24. He was also having some left shoulder pain. Prior to 12/18/24 there had been no history the resident had a pacemaker. The resident was thin and on the date of 12/18/24 the pacemaker was noticeable and appeared to be turned more to a lateral position and more towards the antecubital area. The resident had poor safety awareness and was not able to explain how the bruising occurred when she talked to him. If he had told the staff he had fallen, she was not sure the staff could go totally by what the resident had said because of his confusion. He was sent to the ED to be reviewed also, but the ED physician did not make mention of problems with the pacemaker itself. The ED physician also had not put anything in her notes about the contusion to the left hip which had shown up on the CT scan. It had not been brought to her attention that the CT in the ED showed a contusion to the left hip. She was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 38	F 600		

unsure if the contusion to the left hip was related to the 12/18/24 incident or a separate event. They had made a referral for a cardiologist, but the son had canceled the appointment. The physician was further interviewed regarding whether the pacemaker could have moved causing the resident's injuries. The physician reported the following information. She (the physician) was not a cardiologist and was not aware of what type of stitches had been placed when the pacemaker had originally been placed. She would think that over time scar tissue would help hold the pacemaker in place. She could not say 100 % for sure but would think that something would have had to happen to cause a pacemaker to move if it had done so. She did not know how far it could be moved. She would have to refer to a cardiologist's opinion.

Interview with the facility appointment scheduler on 3/21/25 at 2:55 PM revealed Resident # 3 had a cardiology appointment scheduled after the 12/18/24 incident but the son canceled the appointment. Due to the resident's payment sources, he was to be seen at a particular provider. They had talked to the son and arranged for the appointment to be rescheduled and it was rescheduled for 4/7/25.

Resident # 3 was interviewed on 3/20/25 at 2:45 PM. During the interview Resident # 3 mumbled and his words could not be understood. Following the interview, Resident # 3 was observed to roll himself out of his room and into the hallway independently. He was not observed to use his feet to propel the wheelchair, only his arms. Several times he would run his wheelchair into the wall or objects as he propelled himself and would readjust the wheelchair himself to continue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 39	F 600		

to move forward.

Resident # 3's roommate (Resident # 12) was interviewed on 3/20/25 at 3:00 PM. A review of Resident # 12's record revealed his BIMS (Brief Interview for Mental Status) score on a 2/18/25 MDS assessment was a "6," indicating severe cognitive impairment. Resident # 12 reported he had never witnessed anyone mistreat him or his roommate. Resident # 12, who was aware it was March during the interview, stated Resident # 3 had two falls he had recalled. One seemed to him (Resident # 12) about a month ago and then another one prior to that. One had happened in the hallway near the doorway and the other had happened in the room. The staff had helped the resident off the floor both times. Resident # 12 reported at times Resident # 3 had problems moving his wheelchair in the room.

Interview with Unit Coordinator # 1 on 3/21/25 at 11:10 AM revealed she first became aware of the bruising on the morning of 12/18/24. She had been stopped in the hallway but did not recall who told her about it. She knew that Employee # 1 had been aware of the bruising and had said she had "just seen it." When she (Unit Manager # 1) was made aware on the morning of 12/18/24, she notified the DON, and the DON informed her they needed to complete a reportable injury of unknown origin to the state agency.

During an interview on 3/20/25 at 3:20 PM with Nurse # 3, who oversaw safety reports in the facility, Nurse # 3 reported Resident # 3's last recorded fall was 11/2/24. Nurse # 3 also reported that Resident # 3's roommate (Resident # 12) was confused and was not a reliable source to report falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 40	F 600		

On 3/24/25 at 11:12 AM during a follow up interview, Nurse # 3 reported Resident # 3's 11/2/24 fall was the only time the facility had on record that the resident had fallen since he had resided at the facility.

Interview with the DON and Administrator on 3/21/25 at 5:30 PM revealed the following information. They had conducted their investigation following the identification of the bruising on 12/18/24. Employee # 1 had never called on her shift to report any injury. It was not reported until the dayshift on 12/18/24 and at that time they did an investigation and reported the incident to the state. None of the staff had reported they witnessed Resident # 3 to fall or have an accident for them to conclude a particular cause of the bruising. They thought something had happened to the pacemaker spontaneously, which had caused bleeding under the skin and had spread downwards. According to the DON, she had read of this occurring for other individuals. They had not been aware that the hospital CT showed there was a contusion of the hip also and had not included that in their investigation. The ED report had been sent to them and scanned into their computer without this being drawn to their attention.

A "Device Nurse" at the cardiology clinic, where Resident # 3 had been historically seen, was interviewed on 3/24/25 at 11:55 AM and reported the following information. She had been a "device nurse" for 30 years and had never known a pacemaker to spontaneously move. The pacemakers are sutured in place and then scar tissue formed around them to hold them in place. Resident # 3 had not been seen by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 41	F 600		

cardiologist since 2021. Their records showed he had a pacemaker and not an implanted defibrillator.

The hospital ED (emergency department) physician, who evaluated Resident # 3 on 12/20/24, was interviewed on 3/31/25 at 10:11 AM. Prior to the interview the ED physician had been sent a message that one of the questions which the surveyor would like to discuss was whether a pacemaker could spontaneously move. During the interview, the ED physician reported the following information. She had never heard of a pacemaker moving. After receiving the surveyor's question, she had reviewed studies and case reports and found one case in which an individual with an implanted defibrillator had an electrode lead to migrate causing some external bruising on the patient's left side. This had been a very "rare" case. She did not recall anything being wrong with Resident # 3's pacemaker when she saw him on 12/20/24. A chest CT would have shown a problem with any lead or displacement. She also did not think a problem with a pacemaker could lead to a hip contusion as well. It was her medical opinion that Resident # 3's injuries were more consistent with some sort of trauma that had occurred to him.

On 3/24/25 at 8:55 PM the Administrator was notified of Immediate Jeopardy. The Administrator submitted the following Credible Allegation of Immediate Jeopardy Removal Plan.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

While under the care of employee #1 (non-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 42	F 600		

licensed employee) resident # 3 was found to have an injury of unknown origin. Resident #3 was noted with significant bruising to his chest and arms. The bruises were reddish with faint deeper purple, located over the right clavicle extending to the upper chest over the pacemaker site. The bruising was noted to be an irregular shape measuring 7cmx 6cm in the largest area. In addition to the bruising to the chest, a night shift NA (NA #5) wrote in her statement in the facility's investigative file that she saw that the resident had swelling and appeared uncomfortable with positioning. NA #5 failed to notify any nurse of the significant bruising and the resident's discomfort. This failure of notification resulted in a delay in assessment and treatment of Resident #3's bruising and discomfort by the provider.

On 12/18/24 at 7:20am the unit coordinator noted the bruising to resident #3's chest and arm area. The unit coordinator then reported the bruising to the DON. The DON then instructed the unit coordinator to complete and send two-hour initial report of injury of unknown origin to North Carolina Department of Health and Human Services (NCDHHS). The DON began the investigation into Resident #3's injury of unknown origin. The investigation revealed that the resident had not had any injury that would have contributed to the bruising.

On 2/6/2025 the unit 300 nurse coordinator and wound care nurse conducted body audits on all residents who received care from employee #1 on unit 300. No signs or symptoms of injuries or new skin abnormalities were noted in any resident on the 300 unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 43	F 600		

On 2/6/25-2/7/25 a review of all resident hospital transfers and recorded incidents/events (events include reported falls, skin tears, and infections) to ensure completeness of the documentation, proper notification of the resident representative and provider, and follow-up interventions were implemented. Audit included the timeframes/shifts employee #1 worked from 11/5/24 to 2/6/25 was conducted by the nurse consultant to identify any care concerns. The review of hospital transfers and reported falls, skin tears, or infections did not reveal any obvious care concerns.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 3/26/25 and 3/27/25 The Director of Nursing, SDC, and Administrator completed education with all staff on recognizing and reporting injuries or changes in resident condition; including the chain of reporting. All staff were educated at the same time on abuse or neglect recognition and reporting protocols for suspicion of abuse or neglect. The education was either face to face or via phone. We currently do not utilize any agency staff. Any hired agency staff will be educated on recognizing and reporting injuries or changes in resident condition; including the chain of reporting, abuse or neglect recognition, and reporting protocols for suspicion of abuse or neglect.

The SDC was notified by the assistant nurse regional on 3/26/25 that all newly hired staff will receive education on recognizing and reporting injuries or changes in resident condition, including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 44 the chain of reporting, education on abuse or neglect recognition, and reporting protocols for suspicion of abuse or neglect during the facility orientation process. Date of Immediate Jeopardy removal will be 3/28/25. On 3/31/25 the facility's Credible Allegation of Immediate Jeopardy Removal Plan was validated by the following actions: Different staff members from different departments were interviewed and validated they had undergone training per the facility's action plan. Staff members were able to verbalize points that were covered in the training. Staff members reported no instances of abuse, neglect or instances of injuries of unknown cause of which they were aware. The facility presented documentation of in-service records as outlined in their plan. The facility's date of immediate jeopardy removal was validated to be 3/28/25.	F 600		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		4/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 45 §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy for employees who worked in the capacity of a licensed nurse by not screening and verifying Employee #1's credentials prior to hiring her as a licensed nurse and allowing her to perform licensed nurse duties for which she had no documented education or nursing license. Employee #1 provided the facility nurse license information for an individual she found online with a name that was similar to her own and she worked at the facility in the role of a licensed nurse from 11/5/24 until her termination on 2/6/25. During this timeframe, Employee #1 had resident assignments and performed licensed nurse responsibilities that she was not qualified to provide. On the shift that started on 11:00 PM on	F 607	White Oak Manor Burlington has developed and implemented written policies and procedures that prohibit and prevent abuse, neglect and exploitation of residents, and misappropriation of resident property, including screening and verifying credentials and reporting injuries of unknown source. 1.The facility failed to implement their abuse and neglect policy to screen, conduct reference checks, and thoroughly evaluate Employee #1 when hired in November 2024. As a result, Employee # 1 was hired as a licensed nurse, despite not being licensed as a nurse and provided care to multiple residents during her employment at the facility which lasted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 46 12/17/24 Employee #1 was assigned to Resident #3, who was not on an anticoagulant (blood thinner) when she identified bruising to the resident's shoulders with no known cause. Employee #1 was responsible for assessing the resident and notifying the physician of significant changes. Employee #1 did not notify the physician and there was no evidence of an assessment or interventions implemented for Resident #3 until he was assessed the following shift by the physician. The bruises continued to spread and on 12/20/24 Resident #3 was seen in the Emergency Department (ED) where a Computed Tomography (CT) scan revealed a large (9.5 centimeters [cm] by 5.2 cm) left subpectoral (situated under the chest muscles) hematoma (a collection of blood, usually clotted, outside of a blood vessel) and a superficial soft tissue contusion (bruising) of the left flank and hip. On 1/24/25 Medication Aide (MA) #4 reported to Employee #1, who she believed to be a nurse, that Resident #9's finger stick blood sugar (FSBS) registered outside of the meter's highest measurable range indicating a dangerously high blood sugar reading (normal blood sugar levels are between 70 and 100). There was no evidence Resident #9 was provided with treatment to address the high blood sugar level, and the physician was not notified. On 12/8/24 and 1/9/25 Employee #1 was assigned to Resident #11, who had severe cognitive impairment and was on an anticoagulant, in the role of a licensed nurse when he experienced falls. The assigned nurse was responsible for completing a comprehensive assessment and utilizing nursing judgment regarding whether to call the physician. Employee #1 was not qualified to complete a comprehensive assessment of Resident #11 nor	F 607	from 11/5/24 until her termination on 2/6/25. During this time period, unlicensed Employee #1 performed multiple job duties which required education and training to perform correctly to ensure the residents were safe and not neglected. This includes, but not limited to, blood sugar checks, neurological checks following falls and implementing interventions, insulin administration, physical assessments, and notification to provider of significant change in conditions for residents. On 2/6/25, the current Human Resources Manager (HRM) conducted a complete audit of all nursing licenses and nursing assistant certifications to ensure no discrepancies in name spelling or state of residence. There were no discrepancies, except for Employee #1 in regard to the spelling of Employee #1s name on her identification (ID) and the name on the presented Georgia LPN (Licensed Practical Nurse) license. It was also noted that Employee #1 had a Burlington, North Carolina address on her ID and was practicing with a Georgia LPN license. Employee #1 was questioned by the HMR and the Director of Nursing (DON) related to the discrepancies and was immediately removed from resident care duties and terminated on 2/6/25. On 2/6/25, the DON submitted a complaint to the North Carolina Borad of Nursing (NCBON) related to unlicensed Employee #1 and the suspicion that she had falsified her credentials as a LPN. On 3/18/25, the NCBON contacted the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 47 was she qualified to use nursing judgement to make decisions. Additionally, Nurse Aide (NA) #5 did not implement the abuse policy related to reporting injuries of unknown source when she identified that Resident #3 had discomfort with positioning, swelling, and bruises on his arm and chest with no known cause. These deficient practices affected Resident #3, Resident #9, and Resident #11 in addition to placing all residents Employee #1 was assigned to care for in the capacity of licensed nurse for the high likelihood of a serious adverse outcome or harm. This occurred for 1 of 3 employes whose personnel records were reviewed for credentials (Employee #1) and 1 of 3 nurse aides reviewed for reporting an injury of unknown source or allegation of abuse (Nurse Aide # 5). Immediate jeopardy began on 11/5/24 when the facility failed to screen and verify credentials for Employee #1, who fraudulently presented herself to the facility as a licensed nurse, prior to hiring her and allowing her to perform licensed nurse duties. Immediate Jeopardy was removed on 3/28/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E to ensure education is completed and monitoring systems put in place are effective. Example 2 is being cited at a scope and severity level severity of "E." The findings included: Review of the facility's "Plan for the Prevention of Elder Abuse," which was undated and provided to the surveyor as the facility's current policy, included the following information. "A thorough	F 607	DON to inform them that they had completed their investigation and unlicensed Employee #1 had falsified their LPN credentials. The NCBON advised the DON to contact law enforcement. On 3/18/25, the DON contacted the Burlington Police Department and filed a report with the findings from the facility's internal investigation and the NCBONs investigation. Since 2/6/25, the HRM has continued to evaluate licenses and certifications for any potential nurse and nursing assistant seeking employment to ensure there are no discrepancies, validate credentials with the NCBON and North Carolina Health Care Registry (NCHCR), and reference checks. This is to prevent any unlicensed or uncertified staff from working in the facility. On 2/6/25, the HRM received re-education the abuse and neglect protocol including the screening process for hiring to ensure credentials and reference checks are validated. This re-education was conducted by the Corporate Human Resources Manager (HRM). The re-education included implementation of the abuse and neglect policies for employees who work as licensed nurses or nursing assistants by screening and verifying their credentials prior to being hired and allowing them to perform licensed nurse duties and nursing assistant duties with the proper education and credentials. Licensed nurse education will be confirmed prior to hire. Newly hired Human Resources Managers will receive this education during their job	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 48	F 607		

preemployment screening" would be conducted in efforts to prevent negligence or abuse. This included a pre-employment interview, reference checks, and licensure verification.

1. Review of Employee # 1's personnel file records provided to the state surveyor revealed the following information. Employee # 1's application for employment was signed as submitted on 10/21/24 for a position as a licensed practical nurse/registered nurse on third shift from 11:00 PM to 7:00 AM. The only employment history included on the application noted Employee # 1 had attended an out-of-state high school. No further education experience was listed. There was one record of employment history listed. This was from the dates of 2/1/2016 until 5/1/2017 for an employer located in the "USA." Employee # 1 listed "chat support agent" as her job duty for this employer. There was one person listed as a reference whose relationship to Employee # 1 was noted to be her "employer." This individual, who was listed as Employee # 1's work reference, was noted to share the same last name as Employee # 1. Under "Reference Entry # 2" on the application form, Employee # 1 had submitted, "I do not have a # 2 Reference Entry." Under the question, "Please indicate education or skills training which you believe qualifies you for the position you are applying," Employee # 1's typed response was, "CNA (Certified Nurse Aide) and 5 years of home health." At the bottom of the application there were some scribbled notes which read, "In home care currently dementia 2 yrs-Nurse for 4 ½ years 3rd shifts M-F FT." There was no documentation of who had made the notes on the application. There was no documentation in the personnel file showing Employee # 1's one reference was checked and

specific orientation by the Corporate HRM.
On 3/27/25, the decision was made by the Corporate HRM to review and revise the current hiring policy for the facility to state the HRM will obtain 2 professional references prior to employment.
The HRM will monitor weekly for 12 weeks of newly hired licensed nurses and nursing assistants credentials by indicating that it has been checked for validation and for discrepancies to ensure that they are in good standing.
The HRM will also monitor weekly for 12 weeks by providing copies of 2 professional reference checks for newly hired employees to Administration.
2. The facility failed to implement their abuse and neglect policy including injury of unknown source protocol when Nurse Aide #5 (NA #5) failed to report unexplained injuries (bruises) found on Resident #3 during night shift of 12/17/24 to the charge licensed nurse on the shift.
On 2/20/25, the DON identified during the investigation of Resident #3s injury of unknown source that NA #5 had noted bruising, swelling and discomfort, but failed to report it to any licensed nurse.
The DON then implemented education with all licensed nurses and nursing assistants on Unit 300 about reporting bruising or injuries of unknown source.
This education was completed on 2/27/25.
On 2/6/25 and 2/7/25, the Unit 300 Licensed Nurse and Wound Care Nurse conducted body audits on current residents to ensure no other residents were identified with bruising, discomfort

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 49 there was no resume. Also located in the personnel file, there was an "employment notice" record for Employee # 1 which did not note for which employment position she was being hired. It did note the hours would be from 11 PM to 7:00 AM as a full-time employee. It was signed by a corporate Human Resources Consultant on the date of 11/5/24. There was no evidence of nursing license verification prior to 11/5/24 in the personnel records provided to the surveyor. Within the personnel file were different records provided by the Staff Development Coordinator and signed by Employee # 1 on dates which included 11/7/24 and 11/8/24 indicating she had reported to work for training on those days. The first license verification in Employee # 1's personnel file was a copy of an email from Employee # 1 to the DON (Director of Nursing). The email, dated 11/19/24, only contained a picture of a "QuickConfirm License Verification Report" from "QNursys." ("QNursys" is an online national nurse licensure and disciplinary database.) The picture within the email noted that the individual on the license was licensed in the compact state of Georgia with a multistate license as a practical nurse. Within the personnel file were copies of Employee # 1's social security card and driver's license. The name on the nursing license in the 11/19/24 email varied from the name on Employee # 1's copies of her social security card and her driver's license. They varied in the following ways. The first name of Employee # 1 had an extra "a" letter in it than the first name on the nursing license. The middle	F 607	and swelling, and if so to ensure proper notification and/or investigation was completed. No further signs or symptoms of injuries or new skin abnormalities were noted. Current and newly admitted residents with identified areas of bruising, discomfort and swelling will be reported to Administration for further investigation if they have unexplained areas and be reported as injury of unknown source as indicated in the abuse and neglect policy. On 3/26/25 and 3/27/25, the DON, SDC and the Administrator completed re-education with current staff on the abuse and neglect policy regarding immediately reporting any injury of unknown source to the DON or Administrator. The re-education included recognizing and reporting injuries of unknown source or changes in residents condition, and the chain of reporting. Significant bruising without a known source indicates a suspicion of abuse or neglect and should be reported to Administration as soon as it is noted for further investigation and to report to the State Agency. Newly hired staff will receive this education during their job specific orientation by the Staff Development Coordinator (SDC) or Corporate Consultant. The DON or designated management nurse will monitor all nursing progress notes weekly for 4 weeks and then 5 progress notes a week for 8 weeks to ensure there is no indication of an injury of unknown source that has not been reported to Administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 50 name was totally different. The last name was the same. According to Employee # 1's driver's license, she was born in 1996. The original nursing license issue date was 4/5/2006 on the license provided in the email to the DON, which indicated that Employee # 1 would have been nine years old when she was licensed. The Administrator and DON (Director of Nursing) were interviewed together on 3/21/25 at 9:00 AM and a follow up interview was conducted with the DON again on 3/21/25 at 9:45 AM revealing the following information. During the interviews the Administrator reported Employee # 1 "would have been" interviewed by the DON and the former Human Resources Manager (HRM #1). HRM # 1 would have been responsible for checking the nursing license of Employee # 1. The DON reported the following information during the interviews. Employee # 1's original hire date was 11/5/24. The DON did not recall any details of the interview or what was discussed. The DON recalled that it was called to her attention after hire, that Employee # 1's license was single state in Georgia only and therefore there was no reciprocity on the license for her to practice in North Carolina. She had contacted Employee # 1 and explained she needed to verify her license was for multi-state. After doing so, Employee # 1 sent the email (which was in the personnel file) with the license information to her (the DON) noting the license was multistate. At the time the license was submitted by email on 11/19/24 there had been no red flags that Employee # 1 was not really a nurse. Therefore, the DON looked at the license that Employee # 1 emailed her, noted that it did document she had a "multistate" license from Georgia, and it was placed in the personnel file without further questions. Employee # 1	F 607	The DON or designated management nurse will also monitor 5 completed skin assessment sheets 3 days a week for 4 weeks then 5 completed skin assessment sheets weekly for 8 weeks to ensure there is no evidence of unreported injury of unknown source. The results from the monitoring tools will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks. Identified issues or trends will be further discussed at the monthly Quality Assurance (QA) meeting with the team and recommendations made as indicated. The DON and Administrator are responsible for the ongoing compliance of F607. Compliance date is 4/25/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 51	F 607		

continued to work through 2/6/25 as a licensed nurse on third shift until her termination. At some point prior to 2/6/25 it had been brought to the DON's attention that Employee # 1's documentation skills were not professional. Therefore, she looked at Employee # 1's notes and started to question things. On 2/6/25 she (the DON) pulled Employee # 1's license again herself. At that time the license came up in Georgia as a single state again and she (the DON) noted during that check that the nursing license issue date was in 2006, which would have meant that Employee # 1 would have been nine years old when licensed. She (the DON) then noted Employee # 1's first name varied very slightly and that the middle name was not the same. Employee # 1 was confronted by her and terminated. When confronted, Employee # 1 maintained she did have a nursing license and would get it to the DON, which she never did. The State Board of Nursing was contacted on 2/6/25 and a report was filed with them. After the State Board of Nursing's investigation, they were also unable to verify any nursing license for Employee # 1 and directed the facility to call the police which they did.

A review of a police report revealed the Administrator called the police on 3/18/25 to notify them of Employee # 1 impersonating a nurse. The responding officer noted in the 3/18/25 police report that there was evidence of fraudulent documentation provided by Employee # 1 to the facility and the case would be forwarded for review and possible charges related to identity fraud.

HRM # 1 was interviewed on 3/21/25 at 10:45 AM and reported the following information. She left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 52	F 607		

employment at the facility in the middle of October 2024. She had nothing to do with Employee # 1 being hired and knew nothing about her.

The corporate Human Resources Consultant was interviewed on 3/24/25 at 11:32 AM and reported the following information. He had signed the Employment notification form on 11/5/24 in order to help get Employee # 1 in the payroll system and her start date was considered 11/5/24. He was assisting the facility in the interim when the facility was without a human resource manager. HRM # 1 had already done all the hiring paperwork before leaving on 10/25/24. It would have been HRM #1's or the DON's responsibility to have checked to see if Employee # 1 had a nursing license. This task would have fallen to whoever did her interview. He had never personally met Employee # 1. When he was helping in November 2024, during the interim when there was no human resources manager, he had noted that Employee # 1 had initially provided a nursing license that said single state licensure for Georgia only. When he noted the single state licensure, he mentioned to the DON that Employee # 1 would need to be pulled off the floor until they could verify her nursing license. He did not know what had happened to this initial nursing license she had submitted and why it was not on file in the personnel record given to the surveyor. According to human resource records, which the Corporate Human Resources Consultant referenced during the interview with the surveyor, Employee # 1 did not work from 11/14/24 through 11/18/24 because of this. Employee # 1 sent a copy of a license on 11/19/24 and he also looked at her nursing license online. At the time, he (the Corporate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 53	F 607		

Human Resources Consultant) looked up her nursing license, he did not note anything suspicious. He never suspected that she was not really the person she was presenting to be. His thought was that if she had the capability to get the nursing license changed from single state to multi state, then she must be the person on the nursing license. The corporate Human Resource Consultant was interviewed regarding the lack of education and nursing experience on Employee # 1's application and reported the following information. It was not uncommon for employees to initially apply through a third-party website to their organization and then the application fed into their corporate system. At times the application might not be complete, but the applicant would then provide some sort of resume to fill in the gaps.

Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She knew it was a "shot in the dark" when she applied for a nurse job at the facility. She had been homeless, living in a car, and had a child to support. She never thought that the facility would reach out to her after she submitted the application, but they did. She went to an interview. She did not know anybody by the name of HR# 1. She was interviewed by a male person and someone else, who was not the DON. Although she had never finished any type of formal health care training, she attended a medical assistant school in another state, and she did know about health care to some degree. She also had taken care of family members who were "bedridden" or diabetics and reported herself to be a fast learner. She told the facility during the interview she had health care experience. They never asked her for a license.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 54	F 607		

She was surprised when the facility called her and offered her a job. They called and texted her to come to training which had already started. There was supposed to be four days of training, and she attended the last two days only. Then they put her with a nurse on night shift for about two or three days and she went to work. She had been working for about two weeks before they even asked her about a nursing license. She looked up her name on a website and found someone with a similar name to hers that had a nursing license and she decided to give that to the facility. She did not think the facility would accept it and reported she was "baffled myself" when they did, but they never questioned it and let her come back to work. Her intent was never to hurt anyone, and it was her perception that she did as well as the other nurses who had a nursing license. She was trying to go back to school to actually get a nursing license while she was working at the facility.

Interview with the Administrator on 3/21/25 at 5:50 PM revealed HRM # 1 had been responsible for hiring Employee # 1 and no longer worked at the facility. HRM # 1 had been terminated out of the system on 10/25/24. Applicants for positions at the facility can provide an application for employment through a third-party system on the internet. That is how Employee # 1's application came through to them. He did not know everything HRM # 1 had done in hiring Employee # 1 but did know she had sent some "on boarding documents" through to get her hired. The Administrator stated Employee # 1's nursing license should have been verified before hire. He could find no reference checks in the personnel file.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 55	F 607		

The records of three residents, who were cared for by Employee # 1 while she worked as a Nurse, were reviewed. Although not all inclusive of all the nursing task performed and judgements made by Employee # 1 while she was impersonating a licensed nurse and employed at the facility, these three records revealed some of the following examples of nursing duties performed or required of Employee # 1 to be done safely.

Employee # 1 had been the responsible assigned Nurse for Resident # 3 on the night shift which began on 12/17/24 at 11:00 PM. Review of a facility investigative report revealed during this shift, Resident # 3 was identified by Resident # 3's Nurse Aide to have unexplained bruises to his chest and arm which were accompanied by swelling and discomfort with positioning. Employee # 1 would have been responsible for the assessment and notification of the physician during the night shift, and per her statement in the facility's investigative file she was aware of the bruises during the night shift. Employee # 1 noted in her statement she had seen the bruises on the resident's shoulders. Interview with the physician on 3/21/25 at 3:13 PM revealed she or another provider had not been notified by Employee # 1, and this should have been done. During the interview with the physician, the physician reported the bruising was all on the resident's upper body which included areas on his arms and chest wall which wrapped around some on his torso. He was also having some left shoulder pain. The physician further reported that Resident # 3 was a cognitively impaired resident and could not report what had happened. Further review of Resident # 3's nursing notes and 12/20/24 hospital ED (Emergency Department) records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 56	F 607		

revealed Resident # 3's bruising continued to spread, and a CT (computerized tomography) scan performed on 12/20/24 at the hospital showed the resident had a large left subpectoral hematoma underlying his pacer control box measuring 9.5 X 5.2 cm. (centimeters) and superficial soft tissue contusion (bruising) of the left flank and hip.

Per record review Employee # 1 was responsible for performing FSBS (Finger Stick Blood Sugar Checks) for Resident # 9 and making judgements about when to call the physician for blood sugar readings. There was documentation in Resident # 9's record that Employee # 1 administered Insulin to Resident # 9 according to Resident # 9's MAR (Medication Administrator Record). On 1/8/25 when Employee # 1 documented on the MAR Resident # 9's FSBS was 409, there was no documentation the physician was notified and orders received although the resident had no sliding scale insulin coverage ordered at the time. Furthermore, per a 3/25/25 interview at 10:28 AM with Medication Aide (MA) #4, MA # 4 reported the following information. She (MA # 4) had taken Resident # 9's FSBS on 1/24/25 when it was due to be checked at 6:30 AM. The result was "high" and did not register on the glucometer. She reported the result to Employee # 1, who at the time MA # 4 believed to be a nurse. She (MA # 4) observed Employee # 1 call someone. She did not know who Employee # 1 called and did not know what she said to them. Later Employee # 1 received a notice that someone was on the phone line for her. She (MA # 4) again saw Employee # 1 talk to someone but did not hear the conversation. After the conversation, Employee # 1 went through the insulin pens on the medication cart, removed one, and walked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 57	F 607		

into Resident #9's room. MA # 4 did not know what type of insulin pen was removed or to whom it belonged. A review of the chart revealed no documentation or orders for any insulin administration to address Resident # 9's 1/24/25 6:30 AM FSBS reading of "high." Resident # 4's next blood sugar check was next performed when it was scheduled to be completed at 4:30 PM, and the result was documented as 524. During an interview with Resident # 9's NP (Nurse Practitioner) on 3/25/25 at 9:00 AM, the NP validated she had not been called on the morning of 1/24/25. The NP further reported she had checked the on-call log for that date, and there was no record of a call being placed to the on-call provider on the morning of 1/24/25 regarding Resident #9. The NP did not know to whom Employee # 1 had spoken before Employee # 1 went into Resident # 9's room with an insulin pen. The interview with Resident # 9's physician revealed she only had given her personal number to the Unit Managers and therefore she did not know how the employee could have reached her. She did not usually answer her phone before 7:00 AM when she was not on call for the medical practice, and she did not know to whom Employee # 1 had spoken on 1/24/25 before going into Resident # 9's room with an insulin pen.

According to Resident # 11's record, the resident's 12/16/24 Minimum Data Set assessment coded the resident as severely cognitively impaired, and a review of physician orders revealed he received an anticoagulant. According to nursing notes, Employee # 1 documented Resident # 1 was on the floor on the dates of 12/28/24 and 1/9/25. Within her nursing note of 1/9/25, Employee # 1 documented she did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 58	F 607		

a neurological assessment to make sure the resident did not sustain any "blows" to the head. Employee # 1 was responsible for making a nursing judgment regarding whether to call the physician that night and there was no documentation she did so although a review of Resident # 11's orders revealed he was receiving Eliquis (an anticoagulant) when the falls were sustained.

On 3/24/25 at 8:55 PM the Administrator was notified of Immediate Jeopardy and provided the following Credible Allegation of Immediate Jeopardy Removal Plan

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to implement their abuse and neglect policy to screen, conduct reference checks, and thoroughly evaluate Employee # 1 when she was hired in November 2024. As a result, Employee #1 was hired as a nurse, despite not being licensed as a nurse and provided care to multiple residents during her employment period at the facility which lasted from her hire date in November 2024 until her termination on 2/6/2025.

During this time, unlicensed Employee # 1 performed multiple job duties which require education and training to perform correctly to ensure residents are safe and not neglected. This includes but is not limited to blood sugar checks, neurological checks following falls, insulin administration and other medication administration, and oxygen saturation level assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 59	F 607		

Furthermore, the facility failed to implement their abuse/neglect/ and injury of unknown origin policy when Nursing aide # 5 failed to report unexplained injuries- bruises she found on Resident #3 during night shift of 12/17/25 11pm to 12/18/25 7am to the charge nurse on the shift.

On 2/6/25 The Human Resource (HR) manager conducted a complete audit of all nursing licenses and CNA certifications to ensure no discrepancies in name spelling or state of residence. There were no discrepancies noted in the audit.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 2/6/25 the Human Resources (HR) manager was performing an audit of nursing licenses and noted a slight discrepancy in the spelling of Employee #1's name on her identification (ID) and the name on the presented Georgia LPN license. It was also noted that employee #1 had a Burlington North Carolina address on her ID and was practicing with a GA LPN license. Employee #1 was questioned by the HR manager and the DON related to the discrepancies and was immediately removed from resident care duties and terminated.

On 2/6/25 the Director of Nursing submitted a complaint to the North Carolina Board of Nursing (NCBON) related to unlicensed employee #1 and the suspicion that she had falsified her credentials as an LPN.

On 3/18/25 the NCBON contacted the Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 60	F 607		

Nursing and informed her that they had completed their investigation and unlicensed employee #1 had falsified her LPN credentials and advised the DON to contact law enforcement.

On 3/18/25 The DON contacted the Burlington NC Police and filed a report with the findings from the facility internal investigation and the NCBON investigation.

Since 2/6/25 the HR manager has continued to evaluate licenses and certifications for any potential nurse or CNA seeking employment to ensure there are no discrepancies with the spelling of names or state of residence. The HR manager also ensures that any potential nurse seeking employment has a valid license and is in good standing with the Board of Nursing (BON). The HR manager also checks the North Carolina Nurse Aide Registry for any potential CNA seeking employment to ensure that they have an active certification and are in good standing. This will prevent any unlicensed or uncertified staff from working in the facility.

On 2/6/2024 the HR manager received verbal and written re-education on the hiring policy and all of the above-mentioned steps from the Corporate Human Resources Manager. Any newly hired HR managers will receive this education from the Corporate Human Resources Manager as part of their orientation process.

On 3/27/25 the decision was made by the Corporate HR Manager to review and revise the current hiring policy for this center to state that the HR Manager will obtain two professional references prior to employment. The HR Manager will also ensure that all employees

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 61	F 607		

undergo background checks prior to employment.

On 2/20/25 the DON identified in her investigation of Resident #3's injury of unknown origin that NA #5 had noted bruising and discomfort but had failed to report it to any nurse. The DON then implemented education with all nurses and CNAs on unit 300 about reporting bruising or injuries of unknown origin. The education was face to face and was completed on 2/27/25.

On 3/26/25 through 3/27/25 The DON, SDC, and Administrator completed education with all staff on immediately reporting any injury of unknown origin to the DON or administrator. Education was presented face to face or via telephone. There are no Agency nurses currently contracted. Newly hired agency staff will be educated during orientation by the Staff Development Coordinator to immediately report an injury of unknown origin to the DON or administrator.

Date of Immediate Jeopardy removal will be 3/28/25.

On 3/31/25 the facility's Credible Allegation of Immediate Jeopardy Removal Plan was validated by the following actions:

The facility presented evidence of license verification audits per their plan.

The facility presented evidence they had reviewed and revised their hiring process per their plan of action to ensure employees were screened to prevent abuse and neglect.

The facility presented evidence of inservice records per their removal plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 62	F 607		

Interviews were conducted and validated that staff had been trained regarding abuse, neglect, and injuries of unknown origin and were aware they were immediately report instances when identified.

The facility's date of immediate jeopardy removal was validated to be 3/28/25.

2. Review of the facility's "Plan for the Prevention of Elder Abuse," which was undated and provided to the surveyor as the facility's current policy, included information that it was the responsibility of employees to promptly report any instances of injuries of unknown origin.

Review of the facility's investigative file for reportable incidents of injuries for which there was no known cause revealed the following information. On 12/18/24 the facility submitted an initial report, which was completed by Unit Coordinator # 1, to the state agency noting that at 7:20 AM on 12/18/24 Resident # 3 had been identified with a baseball size bruise on the front right shoulder, large hematoma to his left side under arm, swelling and bruising on his left upper chest and below clavicle. The report also noted the resident was unable to lift his left arm without pain and there was swelling.

According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, "When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However I notice some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 63	F 607		

bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I notice while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aid to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON."

NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been "washed up" by the 2nd shift. He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was a golf sized bruise on his arm which appeared light reddish and turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise, and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift and staff were already aware and therefore she did not report it. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse. She did not immediately report the bruises to anyone. Employee # 1 further reported that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 64 after her shift had ended, she later received a phone call from the Director of Nursing and the DON (Director of Nursing) informed her that she was supposed to report bruises immediately to the nurse on duty and not to wait to report.	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview and Physician Interview the facility failed to complete a thorough investigation related to unexplained swelling, discomfort, and bruising Resident # 3 experienced although there had been no reported accident and the resident was not on an anticoagulant. Review of the facility's completed investigation revealed the facility 1) failed to identify a hospital CT (computerized tomography) showed the resident's bruising	F 610	White Oak Manor Burlington will ensure to identify, investigate, clarify, prevent and correct alleged violation of abuse, neglect, or mistreatment. The facility failed to complete a thorough investigation related to Resident #3s unexplained swelling, discomfort, and bruising, and had no reported incident and the resident was not on an anticoagulant, resulting in an injury of unknown source.	4/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 65 extended to his hip area which they had not identified in their investigation 2) failed to investigate discrepancies further which were noted by reviewing Employee # 1's statements with other employees' statements and the resident's record and 3) failed to further question and clarify who had obtained a weight on the resident during the shift when the injuries were first identified in order to determine if something had happened while the resident was weighed. The findings included: Resident # 3 was admitted to the facility on 10/19/23. The resident's diagnoses in part included dementia, congestive heart failure, Parkinsons, atrial fibrillation, anxiety, and dysphagia. Resident # 3's annual Minimum Data Set (MDS) assessment, dated 10/14/24, coded the resident as severely cognitively impaired and as needing total staff assistance for bathing, dressing, and hygiene needs. Resident # 3 was coded as needing partial to moderate assistance to roll from side to side in bed and as needing substantial to maximum assistance to transfer. The resident was coded as using a manual wheelchair to roll 50 feet after set-up assistance. The resident was not coded as having falls during the assessment period. Review of Resident # 3's medical record revealed no falls in December 2024 were documented. Review of Resident # 3's medication regimen for December 2024 revealed Resident # 3 was not on an anticoagulant.	F 610	Further the investigation revealed the facility failed to identify a hospital CT (computerized tomography) that showed the resident's bruising extended to the hip area; failed to investigate discrepancies which were noted in staff statements and the resident's medical record; and failed to further clarify and question who had obtained a weight on Resident #3 during the shift when the injuries were first identified in order to determine if something had happened while the resident was weighed. Resident # 3 was noted with discomfort with positioning, swelling, and upper arm and chest bruising initially by the Nurse Aide # 5 (NA # 5) on 12/17/24, and did not report the areas to nursing or administration. Employee #1 never contacted a unit coordinator or administration on 3rd shift to report any injury. It was not reported until the dayshift on 12/18/24 and at that time they did an investigation and reported the incident to the State. There was no report that Resident #3 had a fall or an incident that would have caused the injury. Resident #3 has poor safety awareness and confusion and was not able to explain how the bruising occurred. On 12/18/24, the facility submitted an initial report by Unit Coordinator #1 to the State Agency noting that at 7:20 AM on 12/18/24 Resident #3 had been identified with a baseball size bruise on the front right shoulder, large hematoma to his left side under arm, swelling and bruising on his left upper chest and below clavicle. The report also noted the resident was unable to lift his	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 66 Review of the facility's investigative file for reportable incidents of injuries for which there was no known cause revealed the following information. On 12/18/24 the facility submitted an initial report, which was completed by Unit Coordinator # 1, to the state agency noting that at 7:20 AM on 12/18/24 Resident # 3 had been identified with a baseball size bruise on the front right shoulder, large hematoma to his left side under arm, swelling and bruising on his left upper chest and below clavicle. The report also noted the resident was unable to lift his left arm without pain and there was swelling. Review of Employee # 1's statement, which was located in the facility's investigative file read, "I was collecting [Resident # 3's] routine 02 (oxygen) when I notice he had some bruising to his right shoulder as well as some to his left. No fall or bruising was reported from the previous shift to me in report so my next thought was to bring it to our unit coordinators attn. (attention) that he had bruising on him. Before I could bring it to [Unit Coordinator's] attention it was brought to my attention once more by the next shift and when the unit coordinator got here I immediately let her know my findings so it could be documented properly." A review of Resident # 3's vital sign log revealed Employee # 1 documented Resident # 3's oxygen level was checked at 12/18/24 at 12:56 AM. (According to Employee # 1's statement this was when she noticed the bruises.) The reading was 94%. There was no notation it was taken again on Employee # 1's shift. Employee # 1 also documented Resident # 3's weight was 127 pounds at 6:38 AM on 12/18/24.	F 610	left arm without pain and there was swelling. The attending physician evaluated Resident #3 on 12/18/24 and the bruising was on the arms and chest wall which wrapped around some on the torso. Resident #3 had some left shoulder pain. Prior to 12/18/24, there was no history of the resident having a pacemaker. During investigation, Employee #1 was collecting Resident #3's routine oxygen saturation (94%) when noticed the resident had some bruising to the right shoulder and left side and the next shift also brought it to Employee #1s attention and reported it to the Unit Coordinator. There was no further notation by Employee #1 and did not clarify who had obtained a weight on the resident during the shift when the injuries were first identified to determine if something had happened while the resident was weighed (127 pounds documented as weighed). On 12/18/24, NA #6 passed Resident #1s breakfast tray on 12/18/24 and noted bruises on right shoulder and left upper quadrant. According to statement, NA #6 notified the 3rd shift nurse which was Employee #1. NA #6 saw Employee #1 go into Resident #3's room to look at the bruises. The facility did not clarify further with Employee #1 of discrepancies in the statements and who obtained Resident #3s weight. On 12/20/24, Unit Coordinator #1 noted Resident #3's bruising was spreading from bilateral shoulders down into the abdomen, left arm, and left side rib cage and Resident #3 was transferred to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 67 According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, "When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However I notice some bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I notice while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aid to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON." NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been "washed up" by the 2nd shift. He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was a golf ball sized bruise on his arm which appeared light reddish and turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise,	F 610	hospital for further evaluation. They thought something had happened to the pacemaker spontaneously, which had caused bleeding under the skin and had spread downwards. The facility did not identify and review closely the hospital CT results that revealed a large left subpectoral hematoma underlying the pacer control box measuring 9.5cm X 5.2cm and a superficial soft tissue contusion of the left flank and hip. The Emergency Department (ED) notes revealed Resident #3 had extensive chest and abdominal wall ecchymosis. The facility did not further investigate the contusion of the hip that was revealed on the CT scan. It was also not brought to the attending physicians attention that the CT in the ED showed a contusion to the left hip. The attending physician was unsure if the contusion to the left hip was related to the 12/18/24 incident or a separate event. The attending physician was not entirely sure but would think that something would have had to happen to cause a pacemaker to move if it had done so. On 4/10/25, an audit of current residents was completed by the Safety RN to ensure no other residents were identified with bruising, discomfort and swelling, and if so to ensure proper and timely notification and a thorough investigation was completed. Also, an audit of reportables involving injury of unknown sources was reviewed to ensure the investigation was thorough with identification, clarification as needed, and prevented or corrected the alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 68	F 610		

and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse. She thought Employee # 1 had been in Resident # 3's room before her (NA # 5) at some time during the night shift but she did not see Employee # 1 go into Resident # 3's room.

During a follow up interview with NA # 5 on 3/24/25 at 1:02 PM, NA # 5 reported she had not obtained Resident # 3's weight that had been documented on 12/18/24 at 6:38 AM.

Review of the facility's investigative file revealed a statement from NA # 6 which showed that Employee # 1 had claimed she knew nothing about the bruises when Nurse Aide # 6 approached her about the bruises at breakfast time on 12/18/24, although in Employee # 1's written statement she had written she was aware of them when she checked the resident's oxygen level during the night. NA # 6's statement read, "On 12/18/24 I came to work passing the trays (breakfast trays). I got [Resident # 3's] tray. As soon I drop it off, I saw him with no shirt on. I saw bruises on his right shoulder, left upper quadrant. As soon I saw the bruises I talked to 3rd shift nurse [Employee # 1]. I saw her go to [Resident # 3's] room and showed her the bruises. She told me that this first time seeing this, that they had no falls last night."

Employee # 1 was interviewed on 3/25/25 at 2:57 PM and reported she had been working as a nurse at the facility but had no license as a nurse and had not completed any formal health care program. Employee # 1 acknowledged she had

violation of abuse, neglect, or mistreatment.
Current and newly admitted residents with identified areas of bruising, discomfort and swelling will be reported immediately to administration for further investigation and the investigation will be thorough if they have unexplained areas.
Current facility staff were re-educated on reporting unexplained bruises, swelling and discomfort at the time it is noted because it could be a sign of abuse or neglect and require further investigation. The re-education was completed by the DON, SDC, and Administrator on 3/26/25.
Newly hired facility staff will receive this education during their job specific orientation by the Staff Development Coordinator (SDC).
The Administrator, DON and Administrative staff were re-educated by the Corporate Consultant on completing a thorough investigation such as for unexplained swelling, discomfort, and bruising when there had not been a reported incident or fall and the resident was not on an anticoagulant. The re-education also included to identify areas such as in hospital records that require further investigation, to investigate discrepancies further when noted in staff statements and/or residents medical records, and to further clarify and question staff when needed as the investigation reveals areas that are not completely explained, such as who and when the injuries were first identified in order to determine if something had happened during care. The re-education was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 69 falsely provided information to the facility and given them another individual's nursing license. Employee # 1 was interviewed regarding Resident #3's injury and reported she had called the DON at "12 something" when she did the oxygen level and saw bruising. Employee # 1 reported she did not know who obtained Resident # 3's weight which she had recorded. Interview with Unit Coodinator # 1 revealed she first became aware of the bruising on the morning of 12/18/24. She had been stopped in the hallway but did not recall who told her about it. She knew that Employee # 1 had been aware of the bruising and had said she had "just seen it." A review of nursing notes revealed the first entry documenting the resident's bruising was on 12/18/24 at 7:32 AM by Nurse # 1. The entry was entered into the record as a late entry on the date of 12/19/24 at 8:08 AM. The entry read, "Resident able to make needs writer made aware during report that resident had bruising to left side of chest, armpits, and arms. VS 128/77 (blood pressure), 97 % on RA (room air), 18 (respirations), 97.9 (temperature), 63 (pulse.) No s/s (signs and symptoms) of SOB (shortness of breath), wheezing or labored breathing . Facial grimacing noted when resident move his left arm. Resident refused to be repositioned ..." Nurse # 1 further noted Resident # 3 had an order for Tylenol 325 mg (milligrams) 2 tabs every 6 hours. Nurse # 1 also noted the physician was notified and orders were obtained for a stat x-ray on the chest, right arm and left arm. The DON, Unit Coordinator, and social worker were also notified. Review of nursing notes revealed on 12/20/24 at 2:21 PM the Unit Coordinator noted that Resident	F 610	completed on 4/14/25. Newly hired facility staff will receive this education during their job specific orientation by the Staff Development Coordinator (SDC). The Corporate Consultant will monitor 5 residents weekly for 12 weeks to ensure any identified unexplained bruises, discomfort and swelling is appropriately reported for further investigation. The monitoring will also include that a thorough investigation was completed, identified areas are further investigated and no details are missed, the investigation includes further investigation of any discrepancies with staff statements and/or residents medical records, and clarification and questioning of staff as needed for the investigation is completed. The results from the monitoring will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks. Identified issues or trends will be further discussed at the monthly Quality Assurance (QA) meeting with the team and recommendations made as indicated. The DON and Administrator are responsible for the ongoing compliance of F610. Compliance date is 4/25/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 70	F 610		

3's bruising was spreading from his bilateral shoulders down into his abdomen, left arm, and left side rib cage and he was being transferred to the hospital for further evaluation.

Review of 12/20/24 ED (Emergency Department) notes revealed the following information was documented. Resident # 3 had extensive chest and abdominal wall ecchymosis. A CT (computerized tomography) of the chest abdomen and pelvis with contrast was completed. The CT "impression" read, "1) large left subpectoral hematoma underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip 3) No other CT evidence of acute traumatic injury to the chest, abdomen, or pelvis. 4) emphysema, 5) coronary artery disease." Upon preparing for discharge, the ED physician did not note any further comments about the hip contusion. The ED physician did note "CT scan obtained demonstrating hematoma around his pacemaker site but otherwise superficial contusion." There was no notation regarding how the hematoma could have formed around the pacemaker site. The resident was noted to be stable for discharge from the ED with a final diagnosis of "chest wall hematoma, left" and "superficial bruising of back, left."

Resident # 3's physician was interviewed on 3/21/25 at 3:13 PM and reported the following information. When she evaluated Resident # 3 on 12/18/24 the bruising was all on his upper body which included areas on his arms and chest wall which wrapped around some on his torso. She did not recall any bruising extending to his hip when she examined him on 12/18/24. He was also having some left shoulder pain. Prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 71	F 610		

12/18/24 there had been no history the resident had a pacemaker. The resident was thin and on the date of 12/18/24 the pacemaker was noticeable and appeared to be turned more to a lateral position and more towards the antecubital area. The resident had poor safety awareness and was not able to explain how the bruising occurred when she talked to him. If he had told the staff he had fallen, she was not sure the staff could go totally by what the resident had said because of his confusion. He was sent to the ED to be reviewed also, but the ED physician did not make mention of problems with the pacemaker itself. The ED physician also had not put anything in his notes about the contusion to the left hip which had shown up on the CT scan. It had not been brought to her attention that the CT in the ED showed a contusion to the left hip. She was unsure if the contusion to the left hip was related to the 12/18/24 incident or a separate event. They had made a referral for a cardiologist, but the son had canceled the appointment. She (the physician) was not a cardiologist and was not aware of what type of stiches had been placed when the pacemaker had originally been placed. She would think that over time scar tissue would help hold the pacemaker in place. She could not say 100 % for sure, but would think that something would have had to happen to cause a pacemaker to move if it had done so. She did not know how far it could be moved. She would have to refer to a cardiologist's opinion.

Resident # 3 was interviewed on 3/20/25 at 2:45 PM and was unable to report how the injury had occurred.

Interview with the DON and Administrator on 3/21/25 at 5:30 PM revealed the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 72	F 610		

information. They had conducted their investigation following the identification of the bruising on 12/18/24. Employee # 1 had never called on her shift to report any injury. It was not reported until the dayshift on 12/18/24 and at that time they did an investigation and reported the incident to the state. None of the staff had reported they witnessed Resident # 3 to fall or have an accident for them to conclude a particular cause to the bruising. They thought something had happened to the pacemaker spontaneously, which had caused bleeding under the skin and had spread downwards. They had not been aware that the hospital CT showed there was a contusion of the hip also and had not included that in their investigation. The ED report had been sent to them and scanned into their computer without this being drawn to their attention.

During a follow up interview with the Administrator on 3/24/25 at 4:15 PM the Administrator reported they did not look into who actually did Resident # 3's weight on the shift on which he was identified to have the injury. The Administrator reported he assumed Employee # 1 did the weight since she noted it in the record.

Review of the facility's five-day report to the state agency revealed the DON submitted the report on 12/20/24 without any mention of the ED's findings that there had been a contusion to Resident # 3's left hip identified. Also, there was no mention in the five-day completed report that the facility had noted that by Employee # 1 writing that she had noted the bruises when she checked the resident's oxygen level, this would have indicated discrepancies in statements and the resident's record. According to Employee # 1's statement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 73 she knew about the bruises when she checked his oxygen level. According to NA # 6's statement, Employee # 1 denied she knew anything about the bruises when they were pointed out to her at breakfast time on 12/18/24. There was no indication Employee # 1 was further questioned in the five-day report and discrepancies accounted for.	F 610		
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, physician, and Nurse Practitioner, the facility failed to ensure Resident # 3 was initially assessed by a nurse after Nurse Aide # 5 identified the resident to have discomfort with positioning, swelling, and bruises on his arm and chest with no known cause and while the resident was not receiving an anticoagulant. When Resident # 3's was assessed the following shift by the physician multiple bruises were found on both arms and the resident's chest which was a broader area than had been reported by Nurse Aide # 5. The bruising was irregular in shape and included both red and purple bruising. The bruises continued to spread and two days following the initial identification of the bruises,	F 684	White Oak Manor Burlington strives to provide quality of care to the facility residents. The facility ensures that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. 1.Resident # 3 was noted with discomfort with positioning, swelling, and upper arm and chest bruising initially by the Nurse Aide # 5 (NA # 5) on 12/17/24. NA # 5 failed to notify a nurse and delayed assessment and treatment of Resident # 3 by the physician during the following	4/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 74 Resident # 3 was seen in the ED (Emergency Department) where a CT (Computed Tomography) of the chest abdomen and pelvis with contrast was completed. The CT "impression" read, "1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip." Additionally, the facility failed to ensure staff communicated amongst themselves effectively regarding Resident # 9's documented elevated finger stick blood sugar readings and also failed to ensure he was monitored for hyperglycemia in order that he receive treatment. On three consecutive days Resident # 9's documented finger stick blood sugar (FSBS) exceeded 400 or registered "high" on the glucometer after intermittent readings had already exceeded 400 during the month of January 2025. On the evening of 1/24/25 after Resident # 9's last documented finger stick blood sugar (FSBS) reading registered 524 the resident fell in the shower room after becoming dizzy. The resident was transferred to the hospital where he was diagnosed with a small subdural hematoma (type of bleeding near your brain that can happen after a head injury). The facility also failed to ensure Resident # 11 received an assessment by a nurse following falls while on an anticoagulant medication. This was for three of five sampled residents reviewed for professional standards of practice. Immediate Jeopardy began on 12/18/24 for Resident # 3 when Nurse Aide # 5 identified during her shift that Resident # 3 had unexplained bruises, swelling, and discomfort and there was no assessment by a nurse. Immediate Jeopardy	F 684	shift. When evaluated by the physician on 12/18/24, Resident # 3 had multiple bruises on both arms and a broader area on the chest than initially found. The area was irregular in shape with red and purple bruising. Resident # 3 was transferred to the Emergency Department on 12/20/24 for an evaluation and CT findings included a large left subpectoral hematoma underlying the pacer control box measuring 9.5cm X 5.2cm and a superficial soft tissue contusion of the left flank and hip. On 3/26/25, an audit of current residents was completed by the Unit Coordinators to ensure no other residents were identified with skin abnormalities such as bruising, discomfort and swelling, and were not communicated to the nurse or the provider to be assessed. No new skin abnormalities were identified. All identified abnormalities were previously communicated to the nurse for an initial assessment and reported to the provider with no delay in their assessment. Current and newly admitted residents with identified areas of bruising, discomfort and swelling will be reported to nurses to be initially assessed and will be reported to the provider for further assessment and no delay in care. On 3/26/25 to 3/27/25, the DON, Staff Development Coordinator (SDC) and the Administrator completed re-education with current staff in the process of notifying the nurse of any injuries or changes in the residents condition to ensure residents are initially assessed by a nurse. Newly hired staff will receive this education	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 75	F 684		

began for Resident # 9 on 1/8/25 when his FSBS registered 409 and the facility failed to effectively treat his dangerously high blood sugars. Immediate Jeopardy was removed on 3/28/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E to ensure education is completed and monitoring systems put in place are effective. Example # 3 was cited at a scope and severity level of "D."

The findings included:

1. Resident # 3 was admitted to the facility on 10/19/23. The resident's diagnoses in part included dementia, congestive heart failure, Parkinson's, atrial fibrillation, anxiety, and dysphagia.

Review of physician orders revealed Resident # 3 was not ordered to receive an anticoagulant.

Resident # 3's annual Minimum Data Set (MDS) assessment, dated 10/14/24, coded the resident as severely cognitively impaired and as needing total staff assistance for bathing, dressing, and hygiene needs. Resident # 3 was coded as needing partial to moderate assistance to roll from side to side in bed and as needing substantial to maximum assistance to transfer. The resident was coded as using a manual wheelchair to roll 50 feet after set-up assistance. The resident was not coded as having falls during the assessment period.

Review of Resident # 3's care plan revealed the following information. On 10/19/23 staff added the resident was at risk for falls. This remained part

during their job specific orientation by the SDC.
The DON and SDC also re-educated licensed nurses on the importance of assessing the residents immediately if an injury or change in condition is reported to them and to report to the provider to ensure there is no delay in their assessment and care for the residents. This re-education was also completed on 3/26/25 to 3/27/25. Newly hired licensed nurses will receive this education during their job specific orientation by the SDC.
The DON or designated management nurse will monitor 5 residents weekly for 12 weeks to ensure any significant change in condition such as identified bruises, discomfort and swelling is reported to nursing for initial assessment and reported to the provider to assess the residents and no delay in the residents care.
2.Resident # 9 is a diabetic and was noted with multiple occurrences (1/8/25 with a finger stick blood sugar (FSBS) of 409, 1/10/25 with a FSBSs of 433 and 423, 1/18/25 with a FSBS of 413, 1/22/25 with a FSBSs of 453 and 456, 1/23/25 with FSBSs of 419 and 403, 1/24/25 with FSBSs of high and 524) of seriously elevated blood sugars (greater than 400) and the provider was not notified to provide orders to address the elevated blood sugars. During this time period, Resident # 9 did not have orders for sliding scale insulin or parameters for notifying the physician of elevated blood sugars. On 1/24/25 after Resident # 9's last documented FSBS reading of 524,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 76	F 684		

of the resident's active care plan. On 10/27/23 staff added the resident picked at his skin causing skin tears and bruises at times. This remained as part of the resident's active care plan. On 2/10/24 staff added that Resident # 3 could be combative with care. This remained as part of the resident's active care plan.

Review of the facility's investigative file for reportable incidents of injuries for which there was no known cause revealed the following information. On 12/18/24 the facility submitted an initial report, which was completed by Unit Coordinator # 1, to the state agency noting that at 7:20 AM on 12/18/24 Resident # 3 had been identified with a baseball size bruise on the front right shoulder, large hematoma to his left side under arm, swelling and bruising on his left upper chest and below clavicle. The report also noted the resident was unable to lift his left arm without pain and there was swelling.

Review of staffing sheets revealed on the night shift which began at 11:00 PM on 12/17/24 and ended at 7:00 AM on 12/18/24, Employee # 1 was assigned to care for Resident # 3 as a nurse.

Review of Employee # 1's personnel file revealed Employee # 1 was hired as a nurse but was not licensed as a nurse and her application prior to hire indicated no nursing education.

During an interview with the DON (Director of Nursing) on 3/21/25 at 9:00 AM, the DON confirmed that Employee # 1 had submitted someone else's nursing license number upon hire in November 2024 and was terminated in February 2025 when this had been validated. At the time she had been caring for Resident # 3 on the resident fell after becoming dizzy. Resident # 9 was transferred to the hospital and diagnosed with a small subdural hematoma. In January, several nurses and nurses on subsequent shifts failed to notify the provider of the elevated blood sugars resulting in delayed assessments, treatments and monitoring. On 1/24/25, Resident # 9 readmitted with orders for sliding scale insulin and FSBS parameters of greater than 400 to contact the provider.

On 3/26/25, an audit was completed by the DON of current residents with FSBS readings was reviewed to ensure any noted elevated blood sugars (greater than 400) from 3/19/25 to 3/25/25 were communicated among the nursing staff and reported to the provider to obtain orders to address the elevated blood sugars and monitoring completed for hyperglycemia for proper treatment. Identified elevations without proper physician notifications were communicated by the DON to the provider on 3/25/25 and no further orders were given for the identified residents.

Current and newly admitted residents with FSBS readings will be communicated among nursing and the provider and monitored for hyperglycemia in order to receive proper treatment.

On 3/26/25, the Quality Information Manager (QIM) audited and entered the verbiage to each blood sugar on the Medication Administration Record (MAR) with the following, blood sugar greater than 400 call the provider for communication to the provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 77 the night shift of 12/17/24, the facility had not noted she was impersonating a nurse and was not licensed and trained to perform assessments and nursing duties. Review of Employee # 1's statement read, "I was collecting [Resident # 3's] routine 02 (oxygen) when I notice he had some bruising to his right shoulder as well as some to his left. No fall or bruising was reported from the previous shift to me in report, so my next thought was to bring it to our unit coordinators attn. that he had bruising on him. Before I could bring it to [Unit Coordinator's] attention it was brought to my attention once more by the next shift and when the unit coordinator got here, I immediately let her know my findings so it could be documented properly." Employee # 1 was interviewed on 3/25/25 at 2:57 PM and acknowledged she had given someone else's nursing license number who shared a similar name to the facility in order to work as a nurse. According to Employee # 1 she completed no type of Nurse Education or Nurse Aide training. She reported she had some medical assistant training from another state but had not completed that either. She was interviewed regarding Resident #3's bruises and reported she had called the DON at "12 something" when she saw them on the 11:00 PM to 7:00 AM shift which began on 12/17/24 when she did the oxygen level and saw the bruises. Employee # 1 reported she did not know who obtained Resident # 3's weight which she had recorded. Employee # 1 did not know how the bruises occurred and reported she would never do anything to hurt a resident. A review of Resident # 3's vital sign log revealed Employee # 1 documented Resident # 3's oxygen	F 684	The Licensed Nurses and Medication Aides were re-educated by the DON on communicating significantly elevated blood sugars to subsequent shifts for ongoing monitoring by the licensed nurse. The Licensed Nurses and Medication aides were educated on the elevated blood sugar readings will be recorded on the shift-to-shift report sheet to ensure that the elevations are communicated and addressed, and follow-up is completed. The re-education also included the communication to the provider when elevated FSBS readings that exceed 400 and the provider can provide orders to address the elevated blood sugars to prevent further issues such as dizziness or a fall. This re-education was completed on 3/26/25. Newly hired Licensed Nurses and Medication Aides will receive this education during their job specific orientation by the SDC. The DON or designated management nurse will monitor all recorded blood sugars from the previous day beginning on 3/27/25 to ensure all blood sugar elevations above 400 are addressed and reported to the provider 5 days a week for 4 weeks and then 3 days a week for 8 weeks. The DON or designated management nurse will monitor all shift-to shift reports to ensure that the elevated blood sugars are recorded on the report and communicated to the next shift. The monitoring will be completed 5 days a week for 4 weeks, and then 3 days a week for 8 weeks. 3.Resident # 11 experienced a fall on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 78 level was checked at 12/18/24 at 12:56 AM. The reading was 94%. There was no notation it was taken again on Employee # 1's shift. According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, "When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However, I noticed some bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I noticed while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aid to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON." NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been "washed up" by the 2nd shift (3:00 PM to 11:00 PM). He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was	F 684	1/9/25 and failed to ensure the resident received an assessment by a nurse following a fall while on an anticoagulant which increased their risk for bleeding. On 4/9/25, an audit of current residents with falls including residents on anticoagulant medications was reviewed to ensure they received an assessment by a licensed nurse following a fall. No other assessments by a licensed nurse were missing. This audit was completed by the DON and the Safety Licensed Nurse. Current and newly admitted residents will receive an assessment by a licensed nurse following any falls including residents on anticoagulant medication. The Licensed Nurses were re-educated by the DON, SDC, and management nurses on providing an assessment following falls including residents on anticoagulant medication which puts the residents at a greater risk of bleeding. This re-education was completed on 4/14/25. Newly hired Licensed Nurses will receive this education during their job specific orientation by the SDC. The DON or Safety Licensed Nurse will monitor all fall events beginning on 4/10/25 weekly for 4 weeks and then up to 5 falls a week for 8 weeks to ensure residents receive an assessment by a licensed nurse following falls including residents on anticoagulant medication. The results from the monitoring tools will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks. Identified issues or trends will be further discussed at the monthly Quality Assurance (QA) meeting with the team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 79 a golf ball sized bruise on his arm which appeared light reddish and turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise, and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift and therefore the nurses were already aware of it. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse. She thought Employee # 1 had been in Resident # 3's room before her (NA # 5) at some time during the night shift but she did not see Employee # 1 go into Resident # 3's room and did not know what all she had done for the resident that night. A review of nursing notes revealed the first entry documenting an assessment of Resident #3 was on 12/18/24 at 7:32 AM by Nurse # 1. The entry was entered into the record as a late entry on the date of 12/19/24 at 8:08 AM. The entry read, "Resident able to make needs writer made aware during report that resident had bruising to left side of chest, armpits, and arms. VS (vital signs) 128/77 (blood pressure), 97 % on RA (room air), 18 (respirations), 97.9 (temperature), 63 (pulse.) No s/s (signs and symptoms) of SOB (shortness of breath), wheezing or labored breathing. Facial grimacing noted when resident move his left arm. Resident refused to be repositioned ..." Nurse # 1 further noted Resident # 3 had an order for Tylenol 325 mg (milligrams) 2 tabs every 6 hours. Nurse # 1 also noted the physician was notified and orders were obtained for a stat x-ray on the chest, right arm and left arm. The DON, Unit Coordinator, and Social Worker were also notified.	F 684	and recommendations made as indicated. The DON is responsible for the ongoing compliance of F684. Compliance date is 4/25/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 80	F 684		

An attempt was made to interview Nurse # 1 on 3/21/25 at 12:01 PM and she could not be reached for an interview.

The next nursing entry was dated 12/18/24 at 7:36 PM by Nurse # 2 and read, "Was informed from previous shift nurse that resident had discoloration noted to chest area. Resident has discoloration noted to chest, sides of chest, armpits and arms. Measurements obtained and put in DON office Supervisor, MD (Medical Doctor), and DON aware."

Nurse # 2 was interviewed on 3/21/25 at 10:28 AM and reported the following information. On the date of 12/18/24 she had reported to work at 11:00 AM because Nurse # 1 had to leave early that day. She had been told about Resident # 3's bruises in report at 11:00 AM and went to assess him and found bruises on his arms and chest. When he talked, he mumbled but if she asked him yes and no questions he would answer simple questions. When asked if he had fallen, Resident # 3 had replied, "yes." When asked where he had fallen, Resident # 3 had pointed to the closet area of the room. The resident was not able to convey more about the incident.

Review of physician progress notes revealed the resident's physician, who served as the facility medical director, assessed Resident # 3 on 12/18/24. The physician noted, "He (Resident # 3) was noted this morning to have bruising on his upper body. Patient has cognitive impairment and is not able to tell us what happened. Last BIMS (brief interview for mental status) 2/15. He seems to only have pain when moving the left shoulder. No documented falls. He was given Tylenol for pain." The physician further documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 81	F 684		

measurements of the bruising as follows: "Note Bruises were irregular shaped and were measured at largest diameter. Right anterior chest upper near midline, about 5.5 X 3.5 cm (centimeters) reddish with some faint purplish area inferior to it. Right shoulder near AC joint (joint at the top of the shoulder) circular reddish abrasion. Right shoulder lateral clavicle about 7 x 6 cm irregular shaped reddish bruise with faint deeper purple underneath it extending further down about 5 X 8 cm at largest diameter. Right arm-3 circular bruises about 1 cm each-2 inner bicep mid to distal and 1 lateral inferior. Left chest wall- Pacemaker scar with 6 small irregular shaped purplish red bruises. Pacemaker appears more lateral and turned/sticking out. Left side -about 7 X 3 cm reddish bruise with faint edges in shoulder near clavicle. Large reddish purple about 10 X 4 cm inferior to tattoo on lateral upper arm. Left arm-irregular shaped bruise going down bicep with varying colors-reddish to darker purple inferior, 12 X 4 cm around to lateral aspect of arm. 8 X 3 cm circular bruise purplish inferior and medial to elbow. Large left chest wall bruise light purplish edges wraps around chest lateral to nipple, darker purple on posterior chest. No ecchymosis (discoloration of the skin, typically caused by bruising) neck, facial area, or body below waist." Within the progress note, the physician noted a chest x-ray and complete blood count would be obtained. The physician further noted that she was unsure when the pacemaker had been placed or last tested. She further noted the pacemaker appeared to be "turned/sticking out more."

On 12/18/24 at 7:38 PM Nurse # 2 noted Resident # 3's chest x-ray was normal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 82	F 684		

Review of the 12/18/24 Chest x-ray result showed that the pacemaker was present but did not note any abnormalities with the pacemaker or with the resident's heart or lungs. The radiologist noted the report was "negative."

A review of Resident # 3's 12/18/24 CBC result revealed the resident's platelet count was normal. (Low platelets can increase the chance of bleeding.)

On 12/19/24 Resident # 3 was seen by the NP (Nurse Practitioner) who noted the following information. Resident # 3's CBC (complete blood count) did not show thrombocytopenia (low platelets), and the chest x-ray had been normal. There had been a concern that the resident's pacemaker had been dislodged, and she had asked for a reread of the chest x-ray. Resident # 3 denied pain at the time.

Interview with Resident # 3's Nurse Practitioner on 3/24/25 at 5:15 PM revealed she was not aware of how the bruising had occurred. The NP reported she attempted to see if the radiologist, who performed the chest x-ray at the facility, could determine if something occurred to the resident's pacemaker, but they were not able to determine.

Review of nursing notes revealed on 12/20/24 at 2:21 PM Unit Coordinator #1 noted that Resident # 3's bruising was spreading from his bilateral shoulders down into his abdomen, left arm, and left side rib cage and he was being transferred to the hospital for further evaluation.

Interview with Unit Coordinator # 1 on 3/21/25 at 11:10 AM revealed she first became aware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 83	F 684		

bruising on the morning of 12/18/24. She had been stopped in the hallway but did not recall who told her about it. She initially recalled the bruising to be on the resident's shoulder and over time it spread downwards.

Review of 12/20/24 ED (Emergency Department) notes revealed the following information was documented. Resident # 3 had extensive chest and abdominal wall ecchymosis. A CT (Computed Tomography) of the chest abdomen and pelvis with contrast was completed. The CT "impression" read, "1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip 3) No other CT evidence of acute traumatic injury to the chest, abdomen, or pelvis. 4) emphysema, 5) coronary artery disease." Upon preparing for discharge, the ED physician did not note any further comments about the hip contusion. The ED physician did note "CT scan obtained demonstrating hematoma around his pacemaker site but otherwise superficial contusion." There was no notation regarding how the hematoma could have formed around the pacemaker site. The resident was noted to be stable for discharge from the ED with a final diagnosis of "chest wall hematoma, left" and "superficial bruising of back, left." There were no ED discharge orders.

On 12/20/24 at 10:55 PM Nurse # 1 documented Resident # 3 returned from the hospital in no distress, no pain, and no new orders.

Interview with the Director of Nursing at 5:30 PM on 3/21/25 revealed the facility had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 84	F 684		

recognized that Employee # 1 was not licensed and trained to do an assessment of Resident # 3 when she was caring for him during the time the injury was first observed on her shift.

2. Record review revealed Resident # 9 was admitted to the facility on 11/7/24 and had diagnoses which in part included diabetes, Alzheimer's dementia, atrial flutter, cardiomyopathy, and congestive heart failure.

Review of physician orders revealed Resident # 9 was ordered to receive Eliquis 5 mg (milligrams) every 12 hours for atrial flutter. This order began on 11/8/24. (Eliquis is an anticoagulant and increases the chances of bleeding).

Review of Resident # 9's admission Minimum Data Set assessment, dated 11/13/24, coded Resident #9 as severely cognitively impaired. The resident was also coded as needing partial to moderate assistance with his bathing needs, as ambulatory with supervision, and occasionally incontinent of urine.

Resident # 9's care plan included the information that Resident # 9 was a diabetic. This was added to the care plan on 11/8/24 and remained part of the Resident # 9's active care plan. Staff were directed on the care plan to monitor blood sugar levels as ordered and both observe and report any signs and symptoms of hyperglycemia or hypoglycemia.

Review of physician orders and Resident # 9's January 2025 MAR (medication administration record) revealed the following information.

Resident # 9 had an order for FSBS (fingerstick

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 85	F 684		

blood sugars) twice per day. This order originated on 11/8/24 and was in effect until discontinuation on 1/27/25.

According to the January 2025 MAR, the FSBS's were scheduled for 6:30 AM and 4:30 PM. There were no orders for parameters to call the provider regarding results and there was no order for sliding scale insulin coverage based on FSBS results.

Review of physician orders revealed between the dates of 1/1/25 and 1/24/25, the only type of insulin Resident # 3 was prescribed was a long-acting insulin given at night and there was one order change in Resident # 9's diabetic medication dosages. Specific medications and the dosage order change were as follows:

Jardiance 25 mg (milligram) tablet once per day. This order was in effect from 12/7/24 until its discontinuation on 1/27/25.

Metformin 500 mg tablet twice per day. This order was in effect from 12/13/24 until discontinuation on 1/27/25.

Ozempic pen injector; 0.5 mg; subcutaneous once per week on Monday. This order was in effect from 11/11/24 until discontinuation on 1/27/25.

Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); Administer 15 units subcutaneous at bedtime. This order was in effect from 12/31/2024 until the discontinuation on 01/06/2025. (Lantus is a long acting insulin which can last up to 24 hours but does not have a rapid onset of action).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 86	F 684		

Insulin glargine-yfgn insulin pen; 100 unit/mL (3 mL); Administer 15 units subcutaneous at bedtime. This order was in effect from 1/6/25 until discontinuation on 1/18/25. (Insulin glargine-yfgn is a biosimilar interchangeable insulin product to insulin glargine which the resident was already receiving. There were no dosage changes).

According to the record, the physician saw the resident on 1/18/25 and noted his hemoglobin HgbA1c (hemoglobin A1C) on 12/24/24 had been 9.2 and she would increase the resident's long-acting insulin from 15 to 18 units. (Hemoglobin A1c is a blood test that measures the average blood sugar result in the last two to three months. A result of 6.5% and above reflects diabetes.)

The date of 1/18/25 was the only date where an increase in insulin dosage order was noted in the chart from 1/1/25 to 1/24/25. The order was for insulin glargine-yfgn insulin pen; 100 unit/mL (3 mL); Administer 18 units subcutaneous at bedtime. This order was in effect until discontinuation on 1/27/25.

Review of Resident # 9's MAR revealed the following FSBS results documented.
On 1/8/25 at 6:30 AM Employee # 1 (an unlicensed employee) documented 409 on the MAR.
On 1/10/25 at 6:30 AM Nurse # 6 documented 433 on the MAR.
On 1/10/25 at 4:30 PM Nurse # 7 documented 423 on the MAR.
On 1/18/25 at 4:30 PM Nurse # 8 documented 413 on the MAR.
On 1/22/25 at 6:30 AM Medication Aide (MA) # 1 documented 453 on the MAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 87	F 684		

On 1/22/25 at 4:30 PM MA # 2 documented 456 on the MAR.
On 1/23/25 at 6:30 AM Nurse # 9 documented 419 on the MAR.
On 1/23/25 at 4:30 PM MA # 3 documented 403 on the MAR.
On 1/24/25 at 6:30 AM MA # 4 documented "high" on the MAR.
On 1/24/25 at 4:30 PM Nurse # 5 documented 524 on the MAR.

There was no documented nursing progress note with an assessment of Resident # 9 when the resident's blood sugar registered "high" on 1/24/25 at 6:30 AM. There were no orders entered into the record.

MA # 4 was interviewed on 3/25/25 at 10:28 PM and reported the following information. She recalled Resident #9's blood sugar registering "high" on the morning of 1/24/25. At the time she was to be reporting to Employee # 1, who she thought was a nurse at the time. She told Employee # 1 about the "high" blood sugar and Employee # 1 stated she would check the record for sliding scale orders and call the physician. She saw Employee # 1 make a phone call and talk to someone, but she did not know to whom she was talking to. Afterwards Employee # 1 asked to look in her (MA # 4's) medication cart, obtain an insulin pen, and go into Resident # 9's room. She did not know what insulin pen Employee # 1 had obtained or what she had done when she went into the room. When she had checked the FSBS, Resident # 9 had appeared okay.

Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 88	F 684		

had applied and been accepted to work at the facility as a nurse. She had provided a false license to the facility and had no nursing education nor a license to perform job duties of a nurse. She had taken care of diabetic family members and had some partial training as a medication assistant in another state. On the morning of 1/24/25 when Resident # 9's blood sugar registered "high" she had called the doctor and gotten an order for some insulin. She had given the insulin. When interviewed about the issue that Resident # 3 did not have any short acting insulin ordered and filled for her to access for him, Employee # 1 replied they kept some on the cart or in back up for times such as this.

An interview with Nurse # 9, who had worked on Resident #9's unit, revealed the facility did not keep back up insulin stored on medication carts for newly ordered insulin.

Interview with Resident # 9's NP (Nurse Practitioner) on 3/24/25 at 5:15 PM and with the Physician on 3/27/25 at 1:42 PM revealed they did not know who Employee # 1 had called on the morning of 1/24/25 because there was no history of calls to them or the on-call provider.

According to staffing sheets, Unit Coordinator #1 worked as a floor nurse on the day shift on 1/24/25 and cared for Resident # 9. Unit Coordinator # 1 was interviewed on 3/25/25 at 12:46 PM and reported the following information. She could not recall the details of 1/24/25. In general, if she had been informed in report that Resident # 9's blood sugar was high, then she would have asked what had been done about it and ensured that this was all documented. She would have rechecked it herself and monitored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 89	F 684		

the resident.

Review of the record revealed no nursing progress notes on dayshift showing the blood sugar was rechecked and the resident was monitored on the dayshift of 1/24/25.

According to the Medication Administration record, the next time the resident's blood sugar was checked again following the reading on 6:30 AM was on 1/24/25 at 4:30 PM by Nurse # 5. The result was 524. There was no assessment of the resident at that time or a documented follow-up reading.

Nurse # 5 was interviewed on 3/25/25 at 1:26 PM and reported the following information. She had never received information in report that Resident # 9's blood sugar had been too high to register on the glucometer earlier that morning. She had cared for him on the evening shift (3:00 P to 11:00 PM) on 1/24/25. She was new at the time on 1/24/25 when Resident # 9's FSBS registered 524. She was walking to the desk to call the physician when she saw MA # 1. She asked MA # 1 if Resident # 9's FSBS usually ran high, and MA # 1 told her that Resident # 9 would get sugary things on his hands and recommended to clean his finger better and recheck it. There was not much time between Nurse # 5 talking to MA # 1 before she then went back to recheck the FSBS. She then obtained a result in the 300s but did not recall what it was. Nurse #5 thought she had documented the repeat FSBS but had not done so. Nurse # 5 was interviewed regarding whether she had cleaned Resident # 9's finger well the first time and responded that she thought she had done so. Nurse #5 further stated during her shift Resident # 9 appeared to be okay.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 90	F 684		

Further review of nursing notes revealed the only nursing progress note on 1/24/25 was dated 1/24/25 at 7:16 PM and was written by Nurse # 10. Nurse # 10 documented at this time that Resident # 9 was in the shower with staff present. The resident became dizzy and fell. Resident # 9 sustained a laceration to his head with minimal bleeding. Nurse # 10 further documented that given the resident was on an anticoagulant, the resident was transferred by EMS (Emergency Medical Services) to the hospital.

Interview with Nurse # 10 on 3/25/25 at 10:44 AM revealed she had not been caring for Resident # 9 at the time he fell on 1/24/25 but was closest to the shower room when Resident #9 fell. He had a cut to his head, so he was not moved. A Nurse Aide held pressure to the cut to stop the bleeding and she called 911.

Interview with Nurse Aide # 7 on 1/25/25 at 1:40 PM revealed the following information. She had cared for Resident # 9 on the evening shift of 1/24/25. It seemed to her that Resident #9 did not feel well. He "barely ate" his evening meal. He was usually continent of urine and would go to the bathroom on his own. That evening he was soaked from urine. Therefore, she offered to take him to the shower room for a shower. When Resident # 9 initially stood up, he seemed dizzy and struggled to remain steady on his feet. She was able to walk him with a rolling walker to the shower. Once in the shower she let him sit to remove his top clothing. Then she helped him to stand, and as she was pulling down his pants he suddenly "went blank" and just fell over. She immediately called the nurse, and they called 911.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 91	F 684		

Review of EMS records revealed the EMS paramedics arrived at 7:23 PM on 1/24/25 and Resident # 9 was alert and did not complain of blurred vision or dizziness at the time of their arrival. The paramedics documented Resident # 9's blood pressure was 101/55, pulse 61, respirations, 20, and oxygen saturation 99%. The paramedics did not record a blood sugar check.

Review of the hospital records for the date of 1/24/25 to 1/30/25 revealed the following information. Resident # 9 was diagnosed with a small subdural hematoma. His blood sugar was 305 at 8:40 PM on 1/24/25 when drawn by the lab. The hospital physician noted Resident # 9's last HgbA1C was 10.2. The hospital physician noted the resident should receive both long acting and short acting insulin upon discharge back to the facility. Also, the hospital discharge summary included information that the resident had been hypotensive when he arrived to the hospital and his Toprol (used for heart failure) was held. Also, while hospitalized, neurosurgery was consulted and recommended holding the resident's anticoagulant medication. Prior to discharge, a repeat CT scan was performed to ensure the resident's subdural hematoma had not worsened. Discharge orders included that the resident should be placed on sliding scale insulin coverage and in addition to the prescribed sliding scale insulin, when the FSBS was greater than 400, the primary physician should be contacted.

On 1/30/25 Resident # 9 returned to the facility with the new insulin orders and designated parameters to call the physician.

On 3/25/25 at 8:55 PM the Administrator was informed of Immediate Jeopardy and provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 92	F 684		

the following Credible Allegation of Immediate Jeopardy Removal Plan.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Resident #3 was noted with significant chest and upper arm bruising on 12/18/24. NA #5 failed to notify any nurse of the bruising, discomfort with positioning, and swelling of the bruised area when she first saw the bruises. Her failure to report the bruising to the nurse delayed the assessment and treatment of Resident #3 by any nurse and the provider.

In the month of January 2025 Resident # 9 experienced multiple instances of seriously elevated blood sugars (greater than 400). During this time period resident # 9 did not have orders for sliding scale insulin or parameters for notifying physician of blood sugar elevations. During January several nurses, including employee #1 and nurse #5 failed to notify the provider or nurses on subsequent shifts of these seriously high blood sugars resulting in the delayed assessment, treatment, and monitoring. And, as a result of the failure resident # 9 experienced hyperglycemia.

On 1/24/25 at 6:30am a blood sugar check for resident # 9 was performed and the reading of "high" was recorded on the medication administration record. Per her statement at 6:30 a.m. MA # 5 witnessed unlicensed Employee # 1 go into the resident #9's room with an insulin pen although there were no orders for any insulin at that time and no record of the physician giving orders. On 1/24/25 the unit manager was working

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 93	F 684		

as the floor nurse for resident #9 during the day shift, and in her statement the unit manager could not recall the specifics of 1/24/25 but stated that if she had been told in report that the resident's blood sugar was "high" she would have made sure the resident was monitored and follow up done. The unit manager also indicated that if she had been aware of the seriously elevated blood sugar, she would have requested orders from the provider and entered a nursing progress note of her actions. No new orders or progress notes were entered for dayshift on 1/24/25.

A statement from the evening shift nurse for 1/24/25 indicated that it was never communicated to her that the resident's blood sugar was high at the 6:30 a.m. blood sugar check. When she performed the 4:30 p.m. blood sugar check the first time she received a reading of 524. A short time later the nurse re-checked the blood sugar again and received a reading in the 300s. Later in the evening shift on 1/24/25 resident #9 reported dizziness and did sustain a fall in the shower. The hyperglycemia experienced by Resident #9 shows that the Employee #1 failed to assess the resident, notify provider, and communicate the elevated blood sugar to the oncoming shift with this resulting in the resident experiencing a fall that evening.

On 3/26/25 body audits were completed by unit coordinators for all 3 units to identify any new skin abnormalities that were not communicated to the nurse or the provider. No new skin abnormalities were identified. All identified abnormalities were previously communicated to the provider and nurse.

On 3/26/25 the Director of Nursing (DON)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 94	F 684		

completed an audit from 3/19/2025-3/25/2025 of the Vital Signs (Blood Glucose Values) for elevated blood glucose levels over 400 for proper physician notification and communication of blood sugars greater than 400 to the nurse on subsequent shifts. Identified elevations without proper physician notification were communicated by the DON to the provider on 3/25/2025. No further orders were given by the provider for identified residents.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 3/26/25 and 3/27/25 the DON, SDC and Administrator completed education with all staff on the process of notifying the nurse of any injuries or changes in the resident's condition. The DON and SDC also educated nurses on the importance of assessing the resident immediately if an injury or change of condition is reported to them. The education was performed verbally by either face to face or via phone communication.

The facility does not currently have any agency contracts. Any new agency staff will receive education from the SDC on the process of notifying the nurse of any injuries or changes in the resident's condition.

On 3/26/25 the DON completed education with all nurses and Med Aides on communicating significantly elevated blood sugars to subsequent shifts for ongoing monitoring by the nurse. Elevated blood sugar readings will be recorded on the shift-to-shift report sheet to ensure that elevations are communicated and addressed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 95	F 684		

and follow-up is completed. The education was performed verbally by either face to face or via phone communication.

All newly hired nurses will receive education from the SDC on communicating significantly elevated blood sugars to subsequent shifts for ongoing monitoring by the nurse. The education will also include directions that all elevated blood sugar readings will be recorded on the shift-to-shift report sheet to ensure that elevations are communicated and addressed, and follow-up is completed. The SDC will ensure that education is completed as part of the facility orientation process.

All newly hired staff will receive education form the SDC on notifying the nurse of any injuries or changes in the resident's condition during facility orientation.

Date of Immediate Jeopardy removal will be 3/28/25.

On 3/31/25 the facility's Credible Allegation of Immediate Jeopardy Removal Plan was validated by the following actions:

The facility presented evidence of body audits per their action plan and progress note audits.

The facility presented evidence of blood sugar audits per their action plan.

The facility presented evidence of education per their action plan.

Interviews were done to validate training. Staff were able to verbalize training ponts. Although

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 96	F 684		

not all inclusive of what staff reported, some points staff emphasized they recalled from the training were to always report any problem a resident was having to other staff members and to "keep the information going" to other staff.

The facility's date of immediate jeopardy removal was validated to be 3/28/25.

3. Resident 11 was admitted to the facility on 12/10/24. Resident # 11's diagnoses in part included dementia and a history of pulmonary embolus.

Resident # 11's admission MDS (Minimum Data Set) assessment, dated 12/16/24 coded Resident # 11 as severely cognitively impaired. The resident was also coded as needing substantial to maximum assistance with his hygiene needs, requiring total staff assistance to turn in bed, not ambulatory during the assessment period, and as having no falls.

Review of orders revealed Resident # 11 was prescribed Eliquis 5 mg (milligrams) from 12/17/24 to 1/30/25. (Eliquis is an anticoagulant which places a resident at greater risk for bleeding).

On 12/28/24 12:30 AM Employee # 1 documented, "Resident slipped of the left side of the bed sitting on the floor, laid down on his left side, head propped up against the nightstand. No obvious injury or bruising. Head trauma protocol given and vitals record at the time of the fall. Temp-97.9, Pulse-71, Resp. 20 B/P (blood pressure) 115/64.

There was no documented assessment by a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 97	F 684		

licensed nurse when Resident # 11 fell on 12/28/25 at 12:30 AM.

Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She was not a licensed nurse and had never completed any formal training program in health care. She had taken care of bedridden family members, and she thought she knew what to do. Resident # 11 did not seem hurt to her on 12/28/24 and 1/9/25.

NA # 8 had cared for Resident # 11 on the night shift which had begun on 12/27/24 at 11:00 PM. NA # 8 was interviewed on 3/25/25 at 6:45 AM and reported she did not recall taking care of Resident # 11 that night and did not know how he had fallen.

Interview with the Director of Nursing on 3/21/25 at 9:00 AM revealed Employee # 1 had worked at the facility under false pretenses as a nurse from November 2024 until her termination in February 2025. She had not been a licensed nurse while caring for Resident # 11, but the facility had not been aware of that when Resident # 11 fell.

Review of nursing notes following 12/28/24 did not reveal any documented injury from the 12/28/24 fall.

On 1/9/25 at 7:27 AM Employee # 1 documented, "[Resident # 11] was laying on the floor in the room beside his bed and neuro assessment to make sure he did not sustain any blows to the head. T-94.6 P 64 R 20 B/P 126/83. He was alert and oriented." (A temperature reading of 94.6 would indicate a hypothermic reading which is a lower than normal body temperature).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 98 Review of the nursing notes revealed no assessment of Resident # 11 by a licensed nurse when Resident # 11 fell on 1/9/25.	F 684		
F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	F 726		4/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 99	F 726		

by:
Based on record review and staff and Physician interviews the facility failed to have a system in place to ensure staff who were hired as nurses were trained and competent to perform their job duties. Employee #1, who was not licensed as a nurse and had no documented nursing education, worked at the facility in the role of a licensed nurse from 11/5/24 until her termination on 2/6/25. Her job duties included, but were not limited to: insulin administration, blood sugar monitoring, medication administration, assessments of a resident who sustained falls while on an anticoagulant (blood thinner), and utilizing nursing judgement to make decisions. These job duties required knowledge and education to perform safely. There was no documented competency evaluation completed for Employee #1's job duties or nursing skills. On the nursing shift which began at 11:00 PM on 12/17/24 Employee #1 was assigned to Resident #3, who was not on an anticoagulant, when she identified bruising to the resident's shoulders with no known cause. Employee #1 was responsible for assessing the resident and utilizing nursing judgement for decisions on when to notify the physician. On 1/24/25 Employee #1 was informed by a Medication Aide (MA) that Resident #9's finger stick blood sugar (FSBS) registered outside of the meter's highest measurable range indicating a dangerously high blood sugar reading. Employee #1 was responsible for assessing the resident, providing insulin, and utilizing nursing judgement for decisions regarding when to notify the physician for blood sugar readings. On 12/8/24 and 1/9/25 Resident #11, who had severe cognitive impairment and was on an anticoagulant, experienced falls. Employee #1 was assigned to Resident #11 on

White Oak Manor Burlington will ensure quality nursing services by providing sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Employee #1 was hired as a nurse on 11/5/2024 without qualifications. A timecard report in the Paycom payroll system indicated that Employee #1 attended and completed 3 out of 4 days of scheduled orientation. The facility did not ensure that Employee #1 completed a formal nursing competency form to make sure the employee was competent to perform job duties and using nursing judgements to make decisions. During this time, unlicensed Employee #1 performed multiple job duties which required education and training to perform correctly to ensure residents are safe and not neglected. This included, but is not limited to, blood sugar checks, neurological checks following falls, insulin administration and other medication administration, and oxygen saturation level. Unlicensed Employee #1 through the actions of falsifying a nursing license had the high likelihood of failing to identify changes in resident conditions, and the high likelihood of providing inadequate care to any resident in the facility. Allowing Employee #1 to work in the capacity of a licensed nurse with no verification of their competencies placed all resident that Employee #1 was assigned to care for in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 100	F 726		

both dates and was responsible for assessing the resident and utilizing nursing judgement for decisions regarding when to call the physician. Allowing Employee #1 to work in the capacity of a licensed nurse with no verification of her competencies affected Resident #3, Resident #9, and Resident #11 in addition to placing all residents Employee #1 was assigned to care for in the capacity of licensed nurse at a high likelihood of a serious adverse outcome or harm. Additionally, the facility failed to verify the competencies of Nurse #13 and Nurse #14. This was for three of three staff (Employee #1, Nurse #13, and Nurse #14) whose personnel files were reviewed for competency.

Immediate jeopardy began on 11/5/24 when the facility allowed Employee #1, who fraudulently presented herself to the facility as a licensed nurse, to work in the capacity of a licensed nurse without verifying she was trained and competent to perform licensed nurse skills and duties. Immediate Jeopardy was removed on 3/28/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity E to ensure education is completed and monitoring systems put in place are effective. Example 1b. and 1c. were cited at a scope and severity of E.

The findings included:

1a. Review of Employee # 1's personnel file records provided to the state surveyor revealed the following information. Employee # 1's application for employment was signed as submitted on 10/21/24 for a position as a licensed practical nurse/registered nurse on third shift from

the capacity of licensed nurse had a high likelihood of a serious adverse outcome or harm to the residents. Employee #1 was terminated on 2/6/25 when discovered the employee falsified as a licensed nurse. Employee #1 was responsible as a nurse for Resident #3 on the night shift when Nursing Assistant # 5 (NA #5) noted Resident #3 to have bruises, swelling and discomfort with positioning. There was no documentation of an assessment by Employee #1 and there was no documentation that Employee #1 had been evaluated to be competent in assessment skills in the personnel file. Resident #9 did experience an untreated elevated blood sugar of 409 on 1/8/25 at 6:30 AM and a high blood sugar on 1/24/25 at 6:30 A.M. The unlicensed Employee #1 failed to notify the provider of the hyperglycemic event and Resident #9 was not treated for hyperglycemia. Resident #11 had severe cognitive impairment and was on an anticoagulant with recurrent falls. Employee #1 was assigned to Resident #11 on 12/8/24 and 1/9/25 and was responsible for assessing the resident and utilizing nursing judgement for decisions regarding when to call the physician without the nursing skills to do so.
Current and newly admitted residents will be provided with verified, qualified and competent licensed nurses to ensure the residents are safe and cared for appropriately in order to maintain the highest practicable physical, mental, and psychological well-being of each resident. The facility also did not verify the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 101 11:00 PM to 7:00 AM. The only employment history included on the application noted Employee # 1 had attended an out-of-state high school. No further education experience was listed. Under the question, "Please indicate education or skills training which you believe qualifies you for the position you are applying," Employee # 1's typed response was, "CNA (certified Nurse Aide and 5 years of home health." The Administrator and DON (Director of Nursing) were interviewed together on 3/21/25 at 9:00 AM and a follow up interview was conducted with the DON again on 3/21/25 at 9:45 AM revealing the following information. Employee # 1 presented herself falsely as a licensed nurse when she applied for employment and provided the facility with another individual's nursing license. The name on the nursing license, which was provided to the facility, was similar to Employee # 1's name. She was hired on 11/5/24 and continued to work until her termination on 2/6/25. The records of three residents, who were cared for by Employee # 1 while she worked as a Nurse, were reviewed. Although not all inclusive of all the nursing task performed and judgements made by Employee # 1 while employed at the facility, these three records revealed some of the following examples of nursing duties performed or required of Employee # 1 to be done safely. Employee # 1 had been the responsible assigned Nurse for Resident # 3 on the night shift which began on 12/17/24 at 11:00 PM. Review of a facility investigative report revealed during this shift, revealed Resident # 3 was identified by Resident # 3's Nurse Aide to have unexplained bruises to his chest and arm which were	F 726	competencies of Licensed Nurse #13 and Licensed Nurse #14. An audit was conducted on 3/26/25 by the Staff Development Coordinator (SDC) to identify all newly hired nurses since 2/6/2025 to ensure that all components of the current nurse orientation process were completed. No discrepancies were identified. On 3/27/25, the Director of Nursing (DON) and SDC were educated by the Assistant Regional Nurse Consultant on a newly implemented nursing competency form. The education also included a system in place to ensure staff who were hired as nurses were trained and competent to perform their nursing job duties and competencies are verified in the nurses personnel file (education, license and employment history). The newly hired nurses will have 4 days of nursing skills orientation and then will be partnered with a seasoned licensed nurse prior to performing nursing job duties independently. This will be verified on the competency form. On 3/27/25, the Assistant Regional Nurse Consultant educated the DON and SDC of the following process: The SDC will initiate the nursing competency form in orientation for all newly hired nurses. The newly hired nurse will be partnered with an experienced nurse and the experienced nurse will observe the newly hired nurse complete the tasks on the competency form. Any unsatisfactory demonstrations will be communicated to the SDC for further training with the newly hired nurse. The newly hired nurse will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 102 accompanied by swelling and discomfort with positioning during this shift. Employee # 1 would have been responsible for the assessment and notification of the physician during the night shift, and per her statement in the investigative file she was aware of the bruises during the night shift. She noted in her statement she had seen bruises on his shoulders. The interview with the physician on 3/21/25 at 3:13 PM revealed she or another provider had not been notified by Employee # 1, and this should have been done. During the interview with the physician, the physician reported the bruising was all on the resident's upper body which included areas on his arms and chest wall which wrapped around some on his torso. He was also having some left shoulder pain. The physician further reported that Resident # 3 was a cognitively impaired resident and could not report what had happened. Further review of Resident # 3's nursing notes and 12/20/24 and hospital ED (Emergency Department) records revealed Resident # 3's bruising continued to spread, and a CT (computerized tomography) scan performed on 12/20/24 at the hospital showed the resident had a large left subpectoral hematoma underlying his pacer control box measuring 9.5 X 5.2 cm. (centimeters) and superficial soft tissue contusion (bruising) of the left flank and hip. Per record review Employee # 1 was responsible for performing FSBS (Finger Stick Blood Sugar Checks) for Resident # 9 and making judgements about when to call the physician for blood sugar readings. There was documentation in Resident # 9's record that Employee # 1 administered Insulin to Resident # 9 according to Resident # 9's MAR (Medication Administrator Record). On 1/8/25 when Employee # 1 documented on the MAR	F 726	have 90 days to complete the nursing competency form. The SDC will review the newly hired nursing competency form after 90 days and any areas the newly hired nurse could not complete on the competency (i.e. nasogastric tubes, tracheostomies) will be performed on the nursing training mannequin for competency. On 3/27/25 the DON and SDC was educated by the Assistant Regional Nurse Consultant that licensed nurses who are partnered with the newly hired nurses will be educated on the competency form by the SDC prior to being scheduled with the newly hired nurse and their responsibility to check the newly hired nurse off on the competency form when they are scheduled to work with the newly hired nurse. On 3/27/25 the Assistant Regional Nurse Consultant educated the Nurse Staffing Coordinator on the responsibility for notifying the SDC which nurses the newly hired nurse will be working with. Newly hired nursing administration will receive this education during their job specific nursing orientation by the Assistant Regional Nurse Consultant. The DON will monitor by reviewing the weekly log of newly hired nurses that were validated with education, license and employment history in nurse skills provided by the SDC to record and ensure that the new nurse is paired and works with an experienced nurse for the first four shifts after facility orientation. The monitoring will be completed weekly for 12 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 103 Resident # 9's FSBS was 409, there was no documentation the physician was notified and orders received although the resident had no sliding scale insulin coverage ordered at the time. Furthermore, per a 3/25/25 interview at 10:28 AM with Medication Aide (MA) #4, MA # 4 reported the following information. She (MA # 4) had taken Resident # 9's FSBS on 1/24/25 when it was due to be checked at 6:30 AM. The result was "high" and did not register on the glucometer. She reported the result to Employee # 1, who at the time MA # 4 believed to be a nurse. She (MA # 4) observed Employee # 1 call someone. She did not know who Employee # 1 called and did not know what she said to them. Later Employee # 1 received a notice that someone was on the phone line for her. She (MA # 4) again saw Employee # 1 talk to someone but did not hear the conversation. After the conversation, Employee # 1 went through the insulin pens on the medication cart, removed one, and walked into Resident #9's room. MA # 4 did not know what type of insulin pen was removed or to whom it belonged. A review of the chart revealed no documentation or orders for any insulin administration to address Resident # 9's 1/24/25 6:30 AM FSBS reading of "high." Resident # 9's next blood sugar check was performed next when it was scheduled to be completed at 4:30 PM, and the result was documented as 524. During an interview with Resident # 9's NP (Nurse Practitioner) on 3/25/25 at 9:00 AM, the NP validated she had not been called on the morning of 1/24/25. The NP further reported she had checked the on-call log for that date, and there was no record of a call being placed to the on-call provider on the morning of 1/24/25 regarding Resident # 9. The NP did not know to whom Employee # 1 had spoken before Employee # 1	F 726	The DON will also monitor by reviewing weekly of newly hired nurses maintained by the SDC to record when the new nurses competency form is completed and returned to the SDC (must be by the 90th day). The SDC will then follow-up on any areas the newly hired nurse may need additional training on. The monitoring will be completed weekly for 12 weeks. The results from the monitoring tools will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks. Identified issues or trends will be further discussed at the monthly Quality Assurance (QA) meeting with the team and recommendations made as indicated. The DON is responsible for the ongoing compliance of F726. Compliance date is 4/25/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 104	F 726		

went into Resident # 9's room with an insulin pen. The interview with Resident # 9's physician revealed she only had given her personal number to the Unit Managers and therefore she did not know how the employee could have reached her. She did not usually answer her phone before 7:00 AM when she was not on call for the medical practice, and she did not know to whom Employee # 1 had spoken.

According to Resident # 11's record, the resident's 12/16/24 Minimum Data Set assessment coded the resident as severely cognitively impaired, and a review of physician orders revealed he received an anticoagulant. According to nursing notes, Employee # 1 documented Resident # 1 was on the floor on the dates of 12/28/24 and 1/9/25. Within her nursing note of 1/9/25, Employee # 1 documented she did a neurological assessment to make sure the resident did not sustain any "blows" to the head. Employee # 1 was responsible for making a nursing judgment regarding whether to call the physician that night and there was no documentation she did so although a review of Resident # 11's orders revealed he was receiving Eliquis (an anticoagulant) when the falls were sustained.

Review of Employee # 1's personnel file and training records revealed there was a "Nursing Assistant-Skills Checklist" in the file. The checklist had multiple job duties typically assigned to Nurse Aides and areas where the form was to be dated and signed showing satisfactory return demonstration. According to the form, Employee # 1 had this form completed in her file with the notation that the SDC (Staff Development Coordinator) had observed return

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 105	F 726		

demonstration on the Nurse Aide skills listed. There was no similar skills checklist to demonstrate Nurse competency for tasks and skills Employee # 1 was responsible for while working as a nurse. The file also contained: directions on how to perform the Heimlich Maneuver; an "ADL Coding Quiz;" a "check-off sheet" for use of a mechanical lift and safe handling of residents; the facility's electronic medical system "Nurse Aide Checklist;" a "checklist orientation of nursing assistants" (which included resident rights and abuse and neglect); "handwashing" checklist; a "hand hygiene quiz;" "competency on PPE (personal protective equipment;" "a nursing home infection prevention test;" a general orientation checklist; education regarding the role of a licensed nurse as it relates to what a medication aide and Nurse Aide II can do; a checklist for the facility's electronic medical record system; a copy of instructions on how to perform a FSBS; an unsigned job description for a "NC licensed Practical Nurse/Charge Nurse;" and a multiple choice test entitled, "Nurse Orientation Program Evaluation Questions," which included some medication questions. The last page of the evaluation form was the only page that indicated the evaluation was completed by Employee # 1 by requiring a signature and date. Employee # 1's signature with the date of 11/8/24 was on this last page. The last two medication questions were marked through and not answered. There were a total of 40 questions on the evaluation form. One example on the evaluation form was the question, "Before preparing a resident's medication, the nurse should A) take a deep breath or B) check to be sure the resident is in his/her room." Employee # 1 had circled both A and B. Another question read, "Correct medication administration time for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 106	F 726		

a scheduled dose is A) plus or minus 1 hour of the scheduled dose B) plus or minus 30 minutes of the scheduled dose C) plus or minus 2 hours of the scheduled dose or D) all but "A." Employee # 1 had answered, "D" indicating she incorrectly thought that she could administer scheduled medications plus or minus 2 hours.

The SDC was interviewed on 3/21/25 at 9:20 AM and on 3/21/25 at 4:00 PM and reported the following information. When nurses were hired, they went through a four-day classroom orientation. The first two days were general education with all new employees. The third and fourth day included Nurse Aides, Medication Aides, and Nurses together. She checked the nurses off on Nurse Aide duties which nurses would be overseeing. She then included the Nurse Aide checklist in the Nurse's personnel file. The nurses were also required to watch instructional videos and complete the evaluation form with questions. There were four tasks she observed nurses to perform during the four-day orientation. They were: a glucometer check, putting on and taking off of PPE (personal protective equipment), use of mechanical lifts, and handwashing. Nurses were also required to show they could use an insulin pen but there was no sign off on that during orientation. According to the SDC she had done these tasks with Employee # 1. Following their four-day orientation, then the nurse was partnered with another experienced nurse for at least three days. The Scheduler would know with whom Employee # 1 was partnered after Employee # 1 completed the four-day orientation. The SDC was interviewed regarding competencies and training on other nursing tasks which there was no indication of evaluation and validation in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 107	F 726		

Employee # 1's file. The SDC reported nurses were also required to watch a library of further videos on their own and take quizzes. The SDC indicated the last two questions on Employee # 1's form, which were blank, had not been required of the group when the test was taken.

The Nurse Staffing Coordinator was interviewed on 3/21/25 at 3:05 PM and reported the following information. Employee # 1 had been partnered with Nurse # 11, Nurse # 12, and Nurse # 7 following her classroom orientation. She typically partnered a new nurse with an experienced nurse for a week and the new nurse could let her know if they needed more time with an experienced nurse. Employee # 1 did not request any further time. The interview further revealed the facility used to have a competency form used to check and validate a new nurse's skills, but that was not done for Employee #1 and was not being utilized anymore for newly hired nurses. The Nursing Staffing Coordinator provided no reason a competency form was not being used.

Nurse # 7, who was one of the nurses partnered with Employee # 1, was interviewed on 3/24/25 at 6:50 AM and reported the following information. She had only been partnered with Employee # 1 for orientation purposes one night. Employee # 1 had "acted disinterested" and followed her (Nurse #7) around as she cared for residents. Employee # 1 watched Nurse # 7 do tasks and duties, but she (Nurse #7) did not observe Employee # 1 perform tasks and duties. It was more of showing Employee # 1 routines. Following that night, she (Nurse # 7) did not work directly with Employee # 1 but she (Nurse # 7) was aware that Nurse # 9 would receive a nursing report from Employee # 1 in the morning at times and Nurse # 9 had some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 108	F 726		

concerns.

Nurse # 9, who would at times receive report from Employee # 1, was interviewed on 3/24/25 at 7:18 AM and reported the following information. She thought Employee # 1 was "dumb" and just had not received a good education. An example was regarding checking oxygen saturation levels. Employee # 1 reported in shift change report a particular resident's oxygen level had been around 86% or 87% and Employee # 1 was not able to say in report what was done about it. She (Nurse # 7) went to that resident's room and checked it herself and the oxygen level was okay when she checked it. She took Employee # 1 to this resident's room and showed her what to do, while thinking that she just had not been educated well about checking oxygen saturation levels and measures to take if it was low. Nurse # 7 reported she was not aware of this resident, who utilized oxygen, ever being harmed or experiencing difficulty due to Employee # 1 taking care of him.

Nurse # 11, who was one of the nurses partnered with Employee # 1, was interviewed on 3/24/25 at 9:23 AM and reported the following information. Employee # 1 "struck her as a new nurse." She (Nurse # 11) had mainly helped Employee # 1 with paperwork. The first few nights Employee # 1 followed her (Nurse # 11) and she showed Employee # 1 routines. Then she told Employee # 1 she would be there for back up and Employee #1 had her own assignment. Nurse # 11 was interviewed regarding what tasks and duties she observed Employee # 1 to perform. She reported that tube feedings "were difficult" for Employee #1. Employee # 1 didn't seem to know how to get started, and she (Nurse # 11) thought it was just

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 109	F 726		

because Employee # 1 was a new graduate. She (Nurse # 11) had therefore showed Employee # 1 how to administer a tube feeding and afterwards watched her do it. After she showed Employee # 1 what to do, she did it correctly. She (Nurse # 11) watched her administer some medications but never watched Employee # 1 do a complete medication pass. She did not recall ever watching her administer insulin to anyone. She never observed Employee # 1 performing dressing changes or a physical assessment of a resident which would entail listening to their heart and lungs or a neurological assessment. She (Nurse # 11) only worked at the facility as needed and had only worked with Employee # 1 for a few nights. She (Nurse # 11) thought it might have been six or seven times she had worked with her. She was not aware of any cases where a resident was hurt while under Employee # 1's care. She (Nurse #11) never signed off on anything she had observed Employee # 1 to do. There had been no competency checklist to complete for Employee # 1.

Nurse # 12, who according to the Nurse Staffing Coordinator had worked as one of the three partnering nurses with Employee # 1, was interviewed on 3/25/25 at 9:37 AM and reported the following information. She did not recall how many days she had worked with Employee # 1. When she worked with Employee # 1, she let Employee # 1 first watch her and follow along. Employee # 1 asked questions which seemed appropriate to Nurse # 12, and it did not stand out that Employee # 1's abilities should be questioned. There were not a lot of night shift (11:00 PM to 7:00 AM) medications to be given and night shift was when she worked with Employee # 1. She also watched Employee # 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 110	F 726		

perform some tasks but there was no competency check off list that was completed showing all the tasks that she had observed Employee # 1 to perform. She had watched Employee #1 check a blood sugar and give insulin. She had never watched her do a neurological assessment of a resident. She had instructed Employee # 1 that a neurological assessment would need to be done after a resident fell but never watched her do one and did not check to make sure she knew how to do one. She did not recall how many days she had worked with Employee # 1 before Employee # 1 started working independently. The only thing that stood out as problematic was that one time it was brought to Nurse # 12's attention that Employee # 1 was not documenting in a professional manner by using medical terms.

The Wound Care Nurse was interviewed on 3/21/25 at 9:55 AM and reported the following information. She had noticed that Employee # 1's documentation did not appear professional. Examples she had noted were as follows: Employee # 1 documented that she had mixed some cream and applied the cream to a resident's "lady parts." The Wound Nurse did not recall which resident this was. Also, Employee # 1 would refer to checking a resident for "blows to the head." She had called it to the attention of the Director of Nursing and the DON immediately looked into this.

NA # 4 was interviewed on 3/24/25 at 3:21 PM and reported the following information. She had worked with Employee # 1. There was nothing that seemed to stand out that Employee # 1 did not know what she was doing except for a couple times when a Medication Aide mentioned that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 111	F 726		

Employee # 1 did not know how to catheterize a resident to get a urine specimen. NA # 4 did not recall the specific resident. She reported she was not aware of anything bad that happened to the resident that needed a urine specimen, and she did not know how the specimen was finally obtained.

NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following. There was a resident who had a catheter, but his brief would become wet during the night. He would ask her (NA # 5) to have the nurse check it. She would report it to Employee # 1 and even after she reported it, the resident's brief was still wet as if nothing had been done. She did not recall specific dates this had occurred.

Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She knew it was a "shot in the dark" when she applied for a nurse job at the facility. She never thought that the facility would reach out to her after she submitted the application, but they did. Although she had never finished any type of formal health care training, she had gone to medical assistant school in another state, and she did know about health care to some degree. She also had taken care of family members who were "bedridden" or diabetics and reported herself to be a fast learner. She told the facility during the interview she had health care experience. They never asked her for a license. She was surprised when the facility did call her and offer her a job. They called and texted her to come to training and the training had already started. There was supposed to be four days of orientation, and she started on the last two days of the scheduled orientation. Then they put her with a nurse on night shift for about two or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 112	F 726		

three days and she went to work. She had been working for about two weeks before they even asked her about a license. She looked up her name on a website and found someone with a similar name to her that had a nursing license, and she decided to give that to the facility. She did not think the facility would accept it and she was "baffled myself" when they did, but they never questioned it and let her come back to work. Her intent was never to hurt anyone, and it was her perception that she did just as well as the other nurses who had a license. She was trying to go back to school to actually get a license while she was working at the facility.

The Administrator was notified on 3/25/25 at 8:55 PM of Immediate Jeopardy.

The Administrator presented the following Credible Allegation of Immediate Jeopardy Removal Plan.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

Employee #1 was hired as a nurse on 11/5/2024 without qualifications. A timecard report in the Paycom payroll system indicated that employee #1 attended and completed 3 out of 4 days of her scheduled orientation. The center failed to ensure that employee #1 completed a formal nursing competency form to ensure she was competent to perform job duties. During this time, unlicensed Employee # 1 performed multiple job duties which require education and training to perform correctly to ensure residents are safe and not neglected. This includes but is not limited to blood sugar checks, neurological checks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 113	F 726		

following falls, insulin administration and other medication administration, and oxygen saturation level. Unlicensed employee #1 through her actions of falsifying her nursing license had the high likelihood of failing to identify changes in resident conditions, and the high likelihood of providing inadequate care to any resident in the facility.

Resident #9 did experience an untreated elevated blood sugar of 409 on 1/8/25 at 6:30 AM and a "high" blood sugar on 1/24/25 at 6:30 A.M. The unlicensed employee #1 failed to notify the provider of the hyperglycemic event and Resident #9 was not treated for hyperglycemia.

Employee #1 was responsible as a nurse for Resident #3 on the night shift when NA #5 noted Resident #3 to have bruises, swelling and discomfort with positioning. There was no documentation of an assessment by employee #1 and there was no documentation that employee #1 had been evaluated to be competent in assessment skills in the personnel file.

An audit was conducted on 3/26/25 by the Staff Development Coordinator (SDC) to identify all newly hired nurses since 2/6/2025 to ensure that all components of the current nurse orientation process were completed. No discrepancies were identified.

Specify the action the entity will take to alter the process or system failure to prevent a serous adverse outcome form occurring or recurring, and when the action will be complete.

Employee #1 was terminated on 2/6/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 114	F 726		

On 3/27/25 the Director of Nursing (DON) and SDC were educated by the Assistant Regional nurse consultant on a nursing competency form.

On 3/27/25 the Assistant Regional nurse consultant notified the Staff Development Coordinator (SDC) of the following process: The SDC will initiate the nursing competency form in orientation for all newly hired nurses. The newly hired nurse will be partnered with an experienced nurse and the experienced nurse will observe the newly hired nurse complete the tasks on the competency form. Any unsatisfactory demonstrations will be communicated to the Staff Development nurse for further training with the newly hired nurse. The newly hired nurse will have 90 days to complete the nursing competency form. The SDC will review the newly hired nursing competency form after 90 days and any areas the newly hired nurse could not complete on the competency (i.e. nasogastric tubes, tracheostomies) will be performed on the nursing training mannequin for competency.

On 3/27/25 the SDC was educated by the Assistant Regional nurse that nurses who are partnered with the newly hired nurse will be educated on the competency form by the Staff Development coordinator prior to being scheduled with the newly hired nurse and their responsibility to check the newly hired nurse off on the competency when they are scheduled to work with the newly hired nurse.

On 3/27/25 the Assistant Regional Nurse educated the Staffing coordinator that she will be responsible for notifying the SDC which nurses the newly hired nurse will be working with.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 115	F 726		

Immediate jeopardy removal will be 3/28/2025

On 3/31/25 the facility's Credible Allegation of Immediate Jeopardy Removal Plan was validated by the following actions:

The facility presented a nursing competency form which they had devised to utilize for newly hired nursing staff. The multipage competency form covered multiple tasks that nurses were required to demonstrate as evidence of competency.

The facility presented evidence the Staff Development Nurse had been educated about competency evaluations for nurses.

A nurse, who had recently been hired within the past few weeks, was interviewed and reported the facility began using the new competency form with her and she had started having her skills checked off on 3/28/25 as being observed by another nurse.

The facility's date of immediate jeopardy removal was validated to be 3/28/25.

1b. Review of Nurse # 14's personnel records and training records provided to the state surveyor revealed Nurse # 14 was hired on 2/25/25.

Nurse # 14 was interviewed on 3/24/25 at 3:27 PM and reported she had already been an employee at an earlier time period and was familiar with the facility policies and procedures. Upon her rehire she watched videos and took test. She was then partnered with another nurse on the floor who did skills with her and showed her how to use the facility's electronic medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 116	F 726		

record system.

A review of training records did not reveal a competency validation form for all the nursing skills for which Nurse # 14 would be responsible.

The Nurse Staffing Coordinator was interviewed on 3/21/25 at 3:05 PM and reported the following information. She typically partnered a new nurse with an experienced nurse for a week and the new nurse could let her know if they needed more time with an experienced nurse. They used to have a competency form used to check and validate a new nurse's skills, but that was not being utilized anymore. The Nursing Staffing Coordinator did not provide a reason why the competency form was not being used anymore.

1c. Review of Nurse # 13's personnel records and training records provided to the state surveyor revealed Nurse # 13 was hired on 2/25/25.

An attempt was made to interview Nurse # 13 on 3/24/25 at 1:33 PM and she could not be reached.

A review of training records did not reveal a competency validation form for all the nursing skills for which Nurse # 14 would be responsible.

The Nurse Staffing Coordinator was interviewed on 3/21/25 at 3:05 PM and reported the following information. She typically partnered a new nurse with an experienced nurse for a week and the new nurse could let her know if they needed more time with an experienced nurse. They used to have a competency form used to check and validate a new nurse's skills, but that was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 03/31/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 117 being utilized anymore. The Nursing Staffing Coordinator did not provide a reason why the competency form was not being	F 726		