PRINTED: 04/30/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345301	B. WING				34/2025
NAME OF P	ROVIDER OR SUPPLIER	0-0001	1		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	31/2025
I WAWL OF TH	TOVIDER OR OUT FIELD				323 BALDWIN ROAD		
WHITE OA	AK MANOR - BURLINGTO	ON			BURLINGTON, NC 27217		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
					1		
F 000	INITIAL COMMENTS		F	000	0		
	The surveyor was on	site at the facility to conduct					
	-	tion survey from 3/20/25					
		ditional information was					
		3/24/25 through 3/27/25.					
		d to the facility on 3/31/25 to					
		mation, validate the credible ate jeopardy removal, and					
	, 0	rence. Therefore the exit					
		3/31/25. Event ID# XL4L11.					
	The following intakes	were investigated:					
	_	24672, NC00224716,					
	NC00225347, NC002 NC00228117, and NC	226841, NC00227524, C00228729.					
	Intakes NC00228117	, NC00227524,					
	NC00225347, and NO immediate jeopardy.	C00228729 resulted in					
	ininiculate jeopardy.						
	Immediate Jeopardy	was identified at:					
	CFR 483.10 at tag F5	580 at a scope and severity					
		600 at a scope and severity J					
		607 at a scope and severity					
	CFR 483.25 at tag F6	684 at a scope and severity					
	K CFR 483.35 at tag F7	726 at a scope and severity					
	К						
	Substandard Quality	of Care was identified at:					
		600 at a scope and severity J					
	_	607 at a scope and severity					
	K   CED 483 25 at tag E6	S94 at a scope and accepts					
	CFR 483.25 at tag Fb   K	684 at a scope and severity					
						ĺ	
I A B O D A T O D V	DIDECTOR'S OR DROVIDEDIS	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

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

04/14/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345301	B. WING		C 03/31/2025	
	ROVIDER OR SUPPLIER	ON	STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 000	removed on 3/28/25  A partial extended so	began on 11/5/24 and was	F 00	00		
F 580 SS=K	CFR(s): 483.10(g)(1 §483.10(g)(14) Notif (i) A facility must immoderate consult with the residual consistent with his of representative(s) who is a consistent in the consults in injury and physician intervention (B) A significant charmental, or psychosodeterioration in health status in either life-the clinical complications (C) A need to alter the commence of the commence of the commence of the commence of the consultation of the consulta	ication of Changes. nediately inform the resident; dent's physician; and notify, r her authority, the resident en there is- lving the resident which has the potential for requiring in; nge in the resident's physical, cial status (that is, a th, mental, or psychosocial meatening conditions or s); eeatment significantly (that is, e an existing form of verse consequences, or to rm of treatment); or nsfer or discharge the	F 58	80	4/25/25	
	§483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent informat is available and prouphysician. (iii) The facility must	tification under paragraph (g) , the facility must ensure that ion specified in §483.15(c)(2) rided upon request to the also promptly notify the ident representative, if any,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345301	B. WING _			C 03/31/2025	
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		1 00/01/2020	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	as specified in §483. (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a competitate is a composite of §483.5) must discloss its physical configural locations that compripart, and must speciment and must speciment for the section of t	n or roommate assignment 10(e)(6); or lent rights under Federal or ons as specified in paragraph in.  record and periodically mailing and email) and resident  losite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct for the policies that apply to be its different locations  If is not met as evidenced in either the physician was notified in the physician was notified in the physician was not wing shift. When Resident # tified and a complete ducted, multiple bruises arms and the resident's chest	F 5	White Oak Manor Burlington that all residents that experier accident resulting in an injury, significant change in condition change in orders or treatment treatment plan, or are being tr discharged from the facility witimely notification to the reside representative, and the provid 1.Resident # 3 was noted with with positioning, swelling, and and chest bruising initially by Aide # 5 (NA # 5) on 12/17/24 failed to notify a nurse and de assessment and treatment of 3 by the physician during the shift. When evaluated by the physician during the shift. When evaluated by the physician the shift when evaluated by the physician the shift when evaluated by the physician during the shift.	have an have a h		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(×	(3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
		С	
<b>345301</b> B. WING		03/31/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, O	CITY, STATE, ZIP CODE	00/01/2020	
323 BALDWIN ROA	D		
WHITE OAK MANOR - BURLINGTON BURLINGTON, NO			
		2/2	
(X.1) is	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
	EFERENCED TO THE APPROPRIATE	DATE	
	DEFICIENCY)		
F 580   Continued From page 3   F 580			
	oth arms and a broader area	1	
	than initially found. The area	a	
	in shape with red and purple		
· · · · · · · · · · · · · · · · · · ·	sident # 3 was transferred to		
	cy Department on 12/20/24		
, , , , , , , , , , , , , , , , , , , ,	tion and CT findings include	ed	
	ubpectoral hematoma		
	e pacer control box		
	5cm X 5.2cm and a		
	oft tissue contusion of the left	l	
investigation. According to an interview with Resident # 3's physician, the provider should On 3/26/25, a	an audit of current residents		
	ed by the Unit Coordinators		
	other residents were		
	n bruising, discomfort and		
	if so to ensure proper		
, , , , , , , , , , , , , , , , , , , ,	nd/or investigation was		
occurrences when Resident # 9's documented completed.	3		
	newly admitted residents wit	th	
exceeded 400 and both the Nurse Practitioner identified are	as of bruising, discomfort		
and Physician reported they should have been and swelling	will be reported for further		
notified so that orders could be given. (Normal investigation	if they have unexplained		
	tification to the provider will		
, , , , , , , , , , , , , , , , , , , ,	d when noted.		
	d Nurses, Medication Aides,		
	stants, Activities Department		
	es Department, and Therap	У	
	educated on reporting		
	bruises at the time it is noted	<b>a</b>	
, , , , , , , , , , , , , , , , , , , ,	ould be a sign of abuse or		
	require further investigation.  ation also included the		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ation also included the the provider as soon as an		
	d/or unexplained bruising,		
	discomfort is identified. Staf	ff	
	and report significant	"	
	ondition and proper chain of	:	
	on to the provider for		

Immediate Jeopardy began on 12/18/24 for

reporting bruising or other changes in

Facility ID: 953553

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345301	B. WING		C 03/31/2025	
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
				323 BALDWIN ROAD		
WHITE OA	AK MANOR - BURLINGTO	ON		BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 580	during her shift that R bruises, swelling, and no physician notification physician notification began for Resident # registered 409 and the notification. Immedia on 3/28/25 when the acceptable credible a jeopardy removal. The compliance at a lowe E to ensure education monitoring systems phexample # 3 was cited level of "D."  The findings included 1. Resident # 3 was a 10/19/23. The resider included dementia, con Parkinson's, atrial fibridysphagia.  Resident # 3's annual assessment, dated 10 as severely cognitived total staff assistance hygiene needs. Resident meeding partial to monfrom side to side in be substantial to maximus.	urse Aide # 5 identified desident # 3 had unexplained discomfort and there was ion. Immediate Jeopardy 9 on 1/8/25 when his FSBS ere was no physician te Jeopardy was removed facility implemented an llegation of immediate e facility will remain out of r scope and severity level of n is completed and ut in place are effective. d at a scope and severity  : admitted to the facility on nt's diagnoses in part ongestive heart failure, rillation, anxiety, and  I Minimum Data Set (MDS) 0/14/24, coded the resident by impaired and as needing for bathing, dressing, and dent # 3 was coded as derate assistance to roll	F 58	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 will receive this education during their specific orientation by the SDC. The DON or designated management nurse will monitor 5 residents weekly f 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 nowith multiple occurrences (1/8/25 with finger stick blood sugar (FSBS) of 409 1/10/25 with a FSBS of 413, 1/22/25 with FSBSs of 419 and 403, 1/24/25 with FSBSs of high and 524) of seriously elevated blood sugars (greater than 40 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 last documented FSBS reading of 524 the resident fell after becoming dizzy. Resident # 9 was transferred to the hospital and diagnosed with a small	staff job  or  ne  oted a , with  oo)	
		eets revealed on the night 11:00 PM on 12/17/24 and		subdural hematoma. In January, seven nurses and nurses on subsequent shift		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			D WING				С
		345301	B. WING _			03	/31/2025
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
WHITE O	AK MANOR - BURLIN	CTON		323	B BALDWIN ROAD		
WHILE OF	AR WANCE - BURLIN	GION		BU	IRLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From p	age 5	F 5	580			
	ended at 7:00 AM	on 12/18/24, Employee # 1			failed to notify the provider of the eleva	ated	
		are for Resident # 3 as a nurse.			blood sugars resulting in delayed		
					assessments, treatments and monitori	ng.	
	Review of Employ	ee # 1's statement revealed it			On 1/24/25, Resident # 9 readmitted w	•	
		9/24 and read, "I was collecting			orders for sliding scale insulin and FSE		
		utine 02 when I notice he had			parameters of greater than 400 to cont		
	some bruising to h	is right shoulder as well as			the provider.		
	some to his left. N	o fall or bruising was reported			On 3/25/25, an audit was completed by	y	
	from the previous	shift to me in report so my next			the DON of current residents with FSB	S	
	thought was to bri	ng it to our unit coordinators			readings was reviewed to ensure any		
		ruising on him. Before I could			noted elevated blood sugars (greater t	han	
		ordinator's] attention it was			400) from 3/19/25 to 3/25/25 were		
		ntion once more by the next			reported to the provider and obtained		
		unit coordinator got here I			orders to address the elevated blood		
		r know my findings so it could			sugars. Identified elevations without		
	be documented pr	operly."			proper physician notifications were		
					communicated by the DON to the prov		
		interviewed on 3/25/25 at 2:57			on 3/25/25 and no further orders were		
		revealed Employee # 1 was			given for the identified residents.	***	
		id not know how the bruises			Current and newly admitted residents	with	
	i i	she had not notified the			FSBS readings will be monitored and		
	priysician about K	esident # 3's bruises.			notifications will be made to the provide when blood sugars are significantly	ei ei	
	According to staffi	ng sheets, NA#5 was			elevated.		
		or Resident # 3 on the night			On 3/26/25, the Quality Information		
		at 11:00 PM on 12/17/24. NA #			Manager (QIM) audited and entered th	10	
	_	ent within the facility's			verbiage to each blood sugar on the	C	
		ead, "When I was doing my 3:00			Medication Administration Record (MA	R)	
		entering [Resident # 3's] room I			with the following, blood sugar greater	,	
		noved his gown and blanket			than 400 call the provider.		
		loes. However I notice some			The Licensed Nurses and Medication		
		n and chest along with some			Aides were re-educated by the DON or	n	<b> </b>
		waking him up he seemed			notifying the provider when elevated		
		n usual) but he eventually			FSBS readings that exceed 400 and th	ıе	<b> </b>
	,	· I talked with him. I notice while			provider can provide orders to address		
		eft he jerked himself back and			the elevated blood sugars to prevent		
		table so I turned him back on			further issues such as dizziness or a fa	all.	
		he had not soiled himself, I			The re-education also included that		
	put the gown and	blanket back over him. When I			normal blood sugar values for nondiab	etic	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345301	B. WING		0.	C 3/31/2025	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0/3 1/2025	
	10 7.15 2.11 0.11 00.11 2.12.11			323 BALDWIN ROAD			
WHITE OA	K MANOR - BURLINGTO	ON					
				BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	Continued From page	÷ 6	F 5	80			
	came back around 5	AM I did change him but		individuals typically do not ex	xceed 125.		
		him on his left arm since		This re-education was comp			
		se that I noticed was located.		3/26/25. Newly hired License			
	Moving forward I will	make sure to have another		Medication Aides will receive			
	aid to do a walk throu	gh with me and/or assist		education during their job sp	ecific		
	with changes. No mat	tter how minor or major it be		orientation by the SDC.			
	if I notice ANYTHING	it will be reported to the		On 3/25/25, the DON educat	ted the		
	NURSE and I will leave	ve written reports to the		Licensed Nurses to add bloc	od sugar		
	DON."			greater than 400 call the pro	vider to newly		
				admitted residents or new or	ders for		
		ed on 3/21/25 at 11:25 AM		current residents with FSBS			
		wing information about her		proper notification to the pro			
		pegan at 11:00 PM. When		hired Licensed Nurses will re			
		he got report and had been		education during their job sp	ecific		
		had been "washed up" by		orientation.			
	the 2nd shift. He was			The QIM will monitor by revie			
	-	:00 AM and she did not		blood sugar orders entered i			
	disturb him. Around 3			residents electronic medical	` ,		
		sing. There was a golf ball		to ensure that the verbiage b			
		m which appeared light		greater than 400 call the pro			
	his chest which was la	urple. There was bruising on arger than what was on his		monitoring will be completed week for 4 weeks and then v			
		tially covered the bruise,		weeks.			
	· · · · · · · · · · · · · · · · · · ·	ne gown down to look at the		The DON or designated mar	-		
	-	She assumed the bruising		nurse will monitor all recorde			
		during another shift and		sugars from the previous day			
		are it was there. Nothing		on 3/26/25 to ensure all bloo	•		
	had happened on her			elevations above 400 are ad			
		ne thought was a nurse.		reported to the provider 5 da 4 weeks and then 3 days a v	-		
		otes revealed the first entry		weeks.			
	_	dent's bruising and that the		3.Resident # 11 experienced			
		d was on 12/18/24 at 7:32		1/9/25 and nursing failed to			
		e entry was entered into the		physician was notified follow			
	•	on the date of 12/19/24 at		while the resident was received	•		
		ead, "Resident able to make		anticoagulant medication wh	iich increased		
		vare during report that		their risk for bleeding.	at regidents		
		to left side of chest, armpits, (blood pressure), 97 % on		On 4/9/25, an audit of currer with falls including residents			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		Ι,	C
		345301	B. WING				31/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	31/2023
					23 BALDWIN ROAD		
WHITE OA	AK MANOR - BURLING	ΓΟN			SURLINGTON, NC 27217		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 580	Continued From pag	ne 7	F!	580			
	RA (room air), 18 (re				anticoagulant medications was reviewe	.d	
		ulse.) No s/s (signs and			to ensure the provider and resident	٦ ا	
	,	shortness of breath),			representatives were notified. No failur	e of	
		breathing. Facial grimacing			notification was noted in the audit. This		
	_	move his left arm. Resident			audit was completed by the DON and t		
	refused to be reposi	tioned" Nurse # 1 further			Safety Licensed Nurse.		
	noted Resident # 3 I	nad an order for Tylenol 325			Current and newly admitted residents t	hat	
	mg (milligrams) 2 tal	bs every 6 hours. Nurse # 1			experience a fall including residents on		
		cian was notified and orders			anticoagulant medications, will have th		
		stat x-ray on the chest, right			occurrence reported to their provider for	r	
		e Director of Nursing (DON),			evaluation, treatment and monitoring.		
		d Social Worker were also			The Licensed Nurses were re-educated		
	notified.				by the DON, SDC, and nursing supervi		
	Poviow of physician	progress notes revealed the			on notifying the provider following a fall including residents receiving anticoagu		
		who served as the facility			medication which places them at a great		
		sessed Resident # 3 on			risk of bleeding. This re-education was		
		cian noted, "He (Resident #			completed on 4/14/25. Newly hired		
		orning to have bruising on his			Licensed Nurses will receive this		
		has cognitive impairment and			education during their job specific		
		what happened. Last BIMS			orientation by the SDC.		
		iental status) 2/15. He seems			The DON or Safety Licensed Nurse wil	ı	
		nen moving the left shoulder.			monitor all fall events beginning on		
		s. He was given Tylenol for			4/10/25 weekly for 4 weeks and then u	p to	
		further documented			5 falls a week for 8 weeks to ensure the	e	
	measurements of the	e bruising as follows: "Note			provider is notified following a fall.		
	Bruises were irregul	ar shaped and were			The results from the monitoring tools w		
		diameter. Right anterior			be discussed during the morning Quali		
		dline, about 5.5 X 3.5 cm			Improvement (QI) meetings, weekly for		
	` ′	h with some faint purplish			weeks. Identified issues or trends will b		
		ght shoulder near AC joint			further discussed at the monthly Qualit	•	
		sion. Right shoulder lateral			Assurance (QA) meeting with the team		
		cm irregular shaped reddish			and recommendations made as indicat		
		per purple underneath it wn about 5 X 8 cm at largest			The DON is responsible for the ongoing compliance of F580.	j j	
	_	-3 circular bruises about 1 cm			Compliance of F560.  Compliance date is 4/25/25.		
	_	nid to distal and 1 lateral			Compliance date is 4/20/20.		
		all- Pacemaker scar with 6					
		ed purplish red bruises.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			C <b>3/31/2025</b>
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD 323 BALDWIN ROAD BURLINGTON, NC 27217		33/3 1/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 580	reddish bruise with faclavicle. Large reddisinferior to tattoo on la arm-irregular shaped with varying colors-reinferior, 12 X 4 cm ar arm. 8 X 3 cm circula medial to elbow. Large purplish edges wraps nipple, darker purple ecchymosis (discolor caused by bruising) rebelow waist." Within the physician noted a checount would be obtain noted that she was unhad been placed or latter pacemaker appear out more."  Resident # 3's Physic facility's medical directly a facility's medical directly a facility's medical directly a facility and information. When she had been called dured bruising was found dibruising was found dibruising. She learned arrived at the facility of 12/18/24.  2. Record review reveadmitted to the facility and armived are the facility of 12/18/24.	eft side -about 7 X 3 cm aint edges in shoulder near th purple about 10 X 4 cm ateral upper arm. Left bruise going down bicep addish to darker purple ound to lateral aspect of ar bruise purplish inferior and ge left chest wall bruise light around chest lateral to on posterior chest. No ation of the skin, typically neck, facial area, or body the progress note, the est x-ray and complete blood ned. The physician further insure when the pacemaker ast tested. She further noted ared to be "turned/sticking" being any on his arms and chest wall and some on his trunk. Sician the provider should ling the night when the ue to the extent of the laft of the bruising when she during the dayshift of ealed Resident # 9 was	F 5	80		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED		
		345301	B. WING		03/31/202	25
	ROVIDER OR SUPPLIER  AK MANOR - BURLING	TON		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217	1 33/3/12323	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	(5) LETION ATE
F 580	Continued From pa	9	F 58	80		
	Data Set assessme Resident #9 as seve as receiving Insulin. Review of physiciar was ordered to rece every 12 hours for a on 11/8/24. (Eliquis	n orders revealed Resident # 9 sive Eliquis 5 mg (milligrams) atrial flutter. This order began is an anticoagulant and				
	that Resident # 9 was to the care plan on the resident's active on the care plan to	plan included the information as a diabetic. This was added 11/8/24 and remained part of a care plan. Staff were directed monitor blood sugar levels as oserve and report any signs				
	January 2025 MAR	n orders and Resident # 9's (medication administration e following information.				
	blood sugars) twice originated on 11/8/2 discontinuation on 1 physician orders reg	n order for FSBS (fingerstick per day. This order had 24 and was in effect until 1/27/25. There were no garding what parameters the e notified when the FSBSs				
	were scheduled for were no orders for p regarding results ar	nuary 2025 MAR, the FSBS 6:30 AM and 4:30 PM. There parameters to call the provider and there was no order for coverage based on FSBS				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345301	B. WING			C <b>03/31/2025</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI 323 BALDWIN ROAD BURLINGTON, NC 27217	E, ZIP CODE	03/31/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	(X5) COMPLETION DATE
F 580	results.  Review of physician of dates of 1/1/25 and 1/25 and 1/26 and 1/27 and 1/27/25.  Ozempic pen injector; once per week on Mo effect from 11/11/24 and 1/27/25.  Lantus Solostar U-10 insulin pen; 100 unit/r units subcutaneous and effect from 12/31/2020 on 01/06/2025. (Lantum which can last up to 2 rapid onset of action).  Insulin glargine-yfgn in mL); Administer 15 un bedtime. This order we discontinuation on 1/1 is a biosimilar interchainsulin glargine which	orders revealed between the 1/24/25, the only type of 1/24/25, the only type of 1/24 prescribed was a long 1/24 and there was one 1/25 diabetic specific medications and 1/25 negative as follows:  1/2/25 diabetic sigram tablet once per day.  1/2/25 diet twice per day. This order 1/2/24 until discontinuation  1/2/25 diet twice per day. This order 1/2/24 until discontinuation  1/2/26 negative from 1/2/24 until discontinuation  1/2/27 diabetic from 1/2/24 until discontinuation  1/2/25 diet twice per day. This order 1/2/25 until discontinuation  1/2/26 negative from 1/2/24 until discontinuation on  1/2/27 until discontinuation on	F	580		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345301	B. WING		C 03/31/2025
	ROVIDER OR SUPPLIER	1	3	STREET ADDRESS, CITY, STATE, ZIP CODE 23 BALDWIN ROAD BURLINGTON, NC 27217	03/31/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 580	increase in insulin do chart from 1/1/25 to insulin glargine-yfgm mL); Administer 18 ubedtime. This order of discontinuation on 1/1 According to the recoprogress note on 1/1 hemoglobin HgbA1c and she would increasinsulin from 15 to 18 blood test that measuresult in the last two 6.5% and above reflectimes Resident # 9's 1/1/25 to 1/24/25 with physician was notified are as follows  On 1/8/25 at 6:30 AM 409 on the MAR. On 1/10/25 at 4:30 Physician was notified are as follows  On 1/10/25 at 4:30 Physician was notified are as follows  On 1/10/25 at 4:30 Physician was notified are as follows  On 1/10/25 at 4:30 Physician was notified are as follows  On 1/10/25 at 4:30 Physician was notified are as follows  On 1/10/25 at 4:30 Physician was notified at 30 Physician wa	was the only date where an esage order was noted in the 1/24/25. The order was for insulin pen; 100 unit/mL (3 nits subcutaneous at was in effect until 27/25.  ord, the physician entered a 8/25 and noted his on 12/24/24 had been 9.2 ase the resident's long-acting units. (Hemoglobin A1c is a ures the average blood sugar to three months. A result of ects diabetes.)  # 9's MAR revealed multiple FSBS exceeded 400 from nout any documentation the d in the record. Specifics  # Employee # 1 documented  M Nurse # 6 documented  M Nurse # 7 documented  M Nurse # 8 documented	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			C 3/31/2025	
NAME OF PROVIDER OR SUPPLIER  WHITE OAK MANOR - BURLINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		00/01/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	on the MAR. On 1/24/25 at 4:30 P. 524 on the MAR.  Nurse # 6 was intervi and reported she did of 1/10/25 but she wo	M MA # 4 documented "high"  M Nurse # 5 documented  ewed on 3/25/25 at 1:45 PM  not recall details of the date ould normally call the a note she had done so for	F 5	80			
	and reported she was blood sugars over 40 the blood sugars wer  An attempt was made 3/25/25 at 1:21 PM a reached by phone.  MA # 1 was interview and reported she woo	ewed on 3/26/25 at 9:48 AM sn't aware she was to call for 0 but would have done so if at over 500.  The to talk to Nurse # 8 on and the nurse could not be seed on 3/25/25 at 6:30 AM all have reported to a nurse but did not recall who the					
	nurse was. MA # 1 re and that Resident # 9 items brought in by the MA # 2 was interview and reported she could of 1/22/25 but she was an elevated blood sugan hour and put it on Nurse # 9 was interviph and reported she shift on 1/23/25 at 6:3 FSBS of 419 and did were signed off on the	ported she always did so, would often eat sugary					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	COMPLETED	
		345301	B. WING		C	
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		03/31/2025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 580	3/25/25 at 11:29 AM reached.  MA # 4 was intervie and reported the fol recalled Resident # "high" on the morning was to be reporting thought was a nurse Employee # 1 about Employee # 1 state for sliding scale ord She saw Employee talk to someone, bushe was talking to asked to look in her	de to interview MA # 3 on If and she could not be  wed on 3/25/25 at 10:28 PM llowing information. She 9's blood sugar registering ng of 1/24/25. At the time she to Employee # 1, who she e at the time. She told t the "high" blood sugar and d she would check the record ers and call the physician. # 1 make a phone call and it she did not know to whom Afterwards Employee # 1 (MA # 4's) medication cart,	F 58			
	room. She did not ke Employee # 1 had of when she went into checked the FSBS, okay.  Employee # 1 was in PM and reported the had applied and be facility as a nurse. Solicense to the facility education nor a lice nurse. She had take members and had somedication assistant morning of 1/24/25 sugar registered "hi and gotten an order	n, and go into Resident # 9's now what insulin pen obtained or what she had done the room. When she had Resident # 9 had appeared  Interviewed on 3/25/25 at 3:30 the following information. She ten accepted to work at the She had provided a false by and had no nursing the care of diabetic family the come partial training as a that in another state. On the when Resident # 9's blood gh" she had called the doctor for some insulin. She had then interviewed about the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SU COMPLE	
		345301	B. WING _			C <b>03/3</b> 1	1/2025
	ROVIDER OR SUPPLIER	ON	STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217			·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 580	acting insulin ordered for him, Employee # the cart or in back up Nurse # 5 was interviand reported the follonew at the time on 1/FSBS registered 524 desk when she saw I Resident # 9's FSBS told her that Residen on his hands and recifinger better and recifinger better and recifinger between Nurse she then went back to then obtained a result recall what it was. She documented the FSB Nurse # 5 was interviand cleaned Resident time and responded to done so. She had no physician following e further stated during appeared to be okay.  Interview with Unit Contact of the communication book.	is 9 did not have any short d and filled for her to access 1 replied they kept some on a for times such as this.  Itewed on 3/25/25 at 1:26 PM owing information. She was 24/25 when Resident # 9's and She was walking to the MA # 1. She asked MA # 1 if a usually ran high, and MA # 1 if a usually ran high, and MA # 1 at # 9 would get sugary things sommended to clean his sheck it. There was not much # 5 talking to MA # 1 before to recheck the FSBS. She at in the 300s but did not the thought she had as but had not done so. Itewed regarding whether she at # 9's finger well the first that she thought she had at communicated with the ither FSBS check. Nurse #5 ther shift Resident # 9  Doordinator # 1 on 3/25/25 at the facility kept a that the provider could	F	580	ICIENCY)		
	had looked through the book and found no refor the provider between 1/24/25 about Resident sugar readings.	arrived at the facility. She he physician communication ecord of communication left een the dates of 1/1/25 to ent # 9's elevated blood sing notes revealed the only dated 1/24/25 at 7:16 PM					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345301	B. WING				31/ <b>2025</b>
	ROVIDER OR SUPPLIER	ON		3	STREET ADDRESS, CITY, STATE, ZIP CODE  23 BALDWIN ROAD  BURLINGTON, NC 27217		0172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	documented at this ti the shower with staff and fell. Resident # 9 head with minimal ble documented that give anticoagulant the res EMS services to the Interview with Nurse revealed she had not 9 at the time of the fa shower room when th Review of EMS recor the EMS paramedics 1/24/25 and Residen blurred vision or dizz arrival.  Review of the hospita 1/24/25 to 1/30/25 re information. Resident small subdural hema 305 at 8:40 PM on 1/ lab. The hospital phy last HgbA1C was 10. noted the resident sh and short acting insu the facility. Also, the included information hypotensive when he his Toprol (used for h while hospitalized, no and recommended he anticoagulant medica repeat CT scan was resident's subdural h	urse # 10. Nurse # 10 me that Resident # 9 was in present and became dizzy sustained a laceration to his eeding. Nurse # 10 further en the resident was on an ident was transferred by hospital.  # 10 on 3/25/25 at 10:44 AM been caring for Resident # ill, but was closet to the ne resident fell.  # 3 dated 1/24/25 revealed arrived at 7:23 PM on t # 9 did not complain of iness at the time of their  # 10 was diagnosed with a toma. His blood sugar was 24/25 when drawn by the sician noted Resident # 9's 2. The hospital physician ould receive both long acting thin upon discharge summary that the resident had been earrived to the hospital and eart failure) was held. Also, eurosurgery was consulted	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		ATE SURVEY DMPLETED
		345301	B. WING _			C 03/31/2025
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 580	scale insulin, when the 400, the primary physical of the 1/30/25 Resident with the new insuling parameters to call the 1/30/25 at 11:21 AM information. She was week. She also took not been notified of the 1/30/25 then she would have During the night if the registered over 400, on-call provider. She provider log and four that came into the or dates of 1/1/25 and 9's blood sugars being with the provider sugars being the provider of the 1/30/25 and 1/30/25 and 1/30/25 blood sugars being the provider of the 1/30/25 and 1/30/25 blood sugars being the 1/30/25 and 1/30/2	sliding scale insulin ition to the prescribed sliding the FSBS was greater than sician should be contacted.  # 9 returned to the facility porders and designated to physician.	F 5	· · · · · · · · · · · · · · · · · · ·		
	Resident # 9's long-asubstitution and was covering one form of had not been due to sugar readings.  The facility's Medical Resident # 9's physical 3/21/25 at 3:13 PM as PM. The physician reinformation. The staff about blood sugars wunless there are spe	acting insulin was a probably due to insurance insulin. The order change notification of elevated blood  Director, who also was cian, was interviewed on and again on 3/27/25 at 1:42				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED	
		345301	B. WING _			C 03/31/2025	
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP COI 323 BALDWIN ROAD BURLINGTON, NC 27217	DE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	had been notified of 400 then she would address it. She did no before 7:00 AM unler not know to whom E 1/24/25. The Physicia about whether residucould affect a FSBS sounded strange that finger that such a lar would occur as reposomething was wrong The Physician report the 300s that also not the 300s that also not the 300s that also not the Administrator proceedible Allegation of Removal Plan.  Identify those recipies are likely to suffer, a a result of the noncongesident #3 was not upper arm bruising in Assistant (CNA) on to notify any nurse or report the bruising to assessment and treat provider.  In the month of Janual experienced multiple elevated blood sugar this time period resident.	eir individual history. If she a blood sugar greater than have given an order to ot typically answer her phone ss she was on call and did mployee # 1 had talked to on an was further interviewed are on an individual's finger result and reported that it to by just cleaning someone's ge difference in a result red by Nurse # 5 unless growth the glucometer itself. Its ded even if the FSBS was in beded to be addressed.  PM the Administrator was a Jeopardy.  The Administrator was a Jeopardy.  The Administrator was a growth and interviewed with significant Chest and intially by a Certified Nursing 12/18/2024. The CNA failed if the bruising. Her failure to	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		345301	B. WING			C 03/31/2025
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217	<b> </b>	00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	January several nurs and nurse #5 failed to nurses on subseque high blood sugars reassessment, treatmeresult of the failure rehyperglycemia.  On 3/26/25 The DOM nursing progress not ensure that the province sidents with a sign. The audit revealed the condition that were reprovider.  A complete audit from Vital Signs (Blood Gillood glucose levels physician notification on 3/25/2025. Identify physician notification DON to the provider orders were given by residents.  Specify the action the process or system fails.	agar elevations. During ses including employee #1 or notify the provider or not shifts of these seriously sulting in the delayed ent, and monitoring. And as a esident # 9 experienced  N conducted an audit of all less from 3/19/25-3/25/25 to der had been notified of any ifficant change in condition. The notice communicated to the lucose Values) for elevated over 400 with proper a was completed by the DON fied elevations without proper a were communicated by the on 3/25/2025. No further of the provider for identified entity will take to alter the ulture to prevent a serious	F 5			
	when the action will On 3/26/25 The Dire conducted education Medication Aides on and the necessity of reading above 400.	m occurring or recurring, and be complete.  ctor of Nursing (DON)  with all licensed nurses and blood glucose parameters notifying the provider of any All nurses and Medication d either face to face or via				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		COMPLETED
		345301	B. WING			C 03/31/2025
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217	03/31/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	phone communication provided to prevent at to notify providers are hyperglycemia in factors. On 3/27/25 the Staff was educated by the nurses, medication a receive this training. Development Coord. On 3/26/2025 the Qu (QIM) audited and elblood sugar order or greater than 400 call provider" to finger stick blood sugnotification to the provider sugar greater than 4 added by the nurse stick blood sugar order revisugar greater than 4 added by the nurse stick blood sugar order. On 3/26 & 3/27/2025 Development Coord education with all nutenrichment), social strecognition and reportant provider for reporting and proper chain of provider for reporting	on on 3/26/25. Education was any further failures of nurses and to prevent uncontrolled cility residents.  Development Coordinator DoN that all Newly hired aides and agency nurses will in orientation by the Staff inator.  Luality information manager intered the verbiage to each in the MAR: "blood sugar I provider".  Lotor of nursing educated do "blood sugar greater than newly admitted resident with gar orders for proper povider.  Let was educated by the Director of in the current QIM ew process to ensure "blood on call provider" has been to those residents with finger ders for proper notification to	F 5	80		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345301	B. WING _		_		31/ <b>2025</b>
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STA 323 BALDWIN ROAD BURLINGTON, NC 2721		, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	The SDC will also edic CNAs, Activities (Life and social services streporting of significant of communication to the bruising or other reside part of the facility ories. Date of Immediate Je 3/28/25.  On 3/31/25 the facility Immediate Jeopardy by the following action. The facility presented records in which the I reviewed progress not changes in condition, were printed by the Dwritten notations regardance on any progres resident was experient condition.  The facility presented checks to ensure the informed of elevated. Review of a random or revealed the informat resident's record that contacted for blood such that the such as the such	cucate all newly hired nurses, enrichment) staff, therapy staff on the recognition and it changes, and proper chain the provider for reporting dent changes in condition as entation process.  The provider for reporting dent changes in condition as entation process.  The provider for reporting dent changes in condition as entation process.  The provider for reporting dent changes in condition as entation process.  The provider for reporting dent changes in condition as entation process.  The provider for reporting dent change in cities and vill be dentation of the process and vill be dentated and the physician was as note which indicated and the physician was being dentated and the physician was being dentation and the physician was being dentation and the provider for the provid	F	580			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			C 03/31/2025	
	ROVIDER OR SUPPLIER	ON	STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217			1 00/01/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		
F 580	outlined in their remote The facility's date of was validated to be 3 3. Resident # 11 was 12/10/24. Resident # included dementia at embolus.  Resident # 11's adm Set) assessment, da # 11 as severely cog resident was also comaximum assistance requiring total staff a ambulatory during th having no falls.  Review of orders rev prescribed Eliquis 5 12/17/24 to 1/30/25. which places a residule bleeding).  On 12/28/24 12:30 Adocumented, "Residute bed sitting on the side, head propped uobvious injury or bruigiven and vitals reco	d evidence of education as oval plan.  immediate jeopardy removal 8/28/25.  admitted to the facility on a fact and a history of pulmonary  ission MDS (Minimum Data atted 12/16/24 coded Resident initively impaired. The ded as needing substantial to a with his hygiene needs, assistance to turn in bed, not be assessment period, and as ealed Resident # 11 was a mg (milligrams) from (Eliquis is an anticoagulant ent at greater risk for	F	580			
	PM and reported the was not a licensed n	terviewed on 3/25/25 at 3:30 following information. She urse and had never al training program in health					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345301	B. WING		C 02/24/2025	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		03/31/2025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 580	members, and she Resident # 11 did n 12/28/24 and 1/9/25 physician.  There was no recorregarding the reside Eliquis.  Review of nursing r not reveal any docu 12/28/24 fall.  NA # 8 had cared for shift which had beg NA # 8 was intervier and reported she did Resident # 11 that is had fallen.  Interview with the Dat 9:00 AM revealed the facility from Nov termination in February pretenses as a nurse licensed nurse while On 1/9/25 at 7:27 A "[Resident # 11] war room beside his beginned in the sure he did in head. T-94.6 P 64 F and oriented." (A te would indicate a hy lower than normal begins to the sure with the nursi Review of the nursi	thought she knew what to do. ot seem hurt to her on and she had not called the difference of and she had not called the ent's fall he sustained while on the following 12/28/24 did at the ent's fall he sustained while on the following 12/28/24 did at the ent's fall he sustained while on the following 12/28/24 did at the ent's fall he sustained while on 12/27/24 at 11:00 PM. wed on 3/25/25 at 6:45 AM do not recall taking care of hight and did not know how he director of Nursing on 3/21/25 did Employee # 1 had worked at the entire following for Resident # 11.  If the following 12/28/24 did at the following following following for following f	F 580			

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG	(X	(3) DATE SURVEY COMPLETED
		345301	B. WING _			C <b>03/31/2025</b>
	ROVIDER OR SUPPLIER	אכ	•	STREET ADDRESS, CITY, STATE, ZIP CO 323 BALDWIN ROAD BURLINGTON, NC 27217	DE '	00/0 H2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From page		F 5	580		
F 600 SS=J	3/21/25 at 3:13 PM rebe contacted when a resident, who was on known if the resident	Eliquis, falls and it is not hit their head. In those ould be sent out to the d. Neglect	F 6	600		4/25/25
	§483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	m Abuse, Neglect, and right to be free from abuse, stion of resident property, efined in this subpart. This sited to freedom from involuntary seclusion and ical restraint not required to				
	physical abuse, corporinvoluntary seclusion. This REQUIREMENT by: Based on observation interview with resider. Nurse Practitioner the Resident #3's right to unknown source; and 3, who was a cognitive identified to have signand chest which wrap 12/18/24. The bruises	e verbal, mental, sexual, or oral punishment, or		White Oak Manor Burlingto to protect the residents and to be free from abuse, neglect, and injury of unknown source While under the care of Emp (non-licensed employee), Rewas found to have an injury source on 12/17/24, but did provider, resident representa Administration. On 12/18/24	their right to exploitation, e. bloyee # 1 esident # 3 of unknown not notify ative or	

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				CIVID IVC	<u>7. 0930-039 i</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345301	B. WING _			03/	31/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE O	W MANOR BURLINGT	ON		32	23 BALDWIN ROAD		
WHILE OF	AK MANOR - BURLINGT	ON		В	URLINGTON, NC 27217		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 24	F	300			
	initially found. Staff re				the Unit Coordinator noted the bruising	to	
		it which had caused the			Resident # 3s chest and arm area.	10	
	-	could not provide detailed			Resident # 3 was noted with a signification	int	
		w the bruises occurred, and			bruising to chest and arms that were		
		sing without a known cause			reddish with a faint deeper purple, loca	ted	
		of neglect or abuse. Also,			over the right clavicle extending to the		
	Resident # 3 was und	<del>-</del>			upper chest over the pacemaker site.	he	
	non-licensed employe	ee (Employee # 1), who was			bruising was noted to be an irregular		
		under the false pretense			shape measuring 7cm X 6cm. The Uni	t	
	she was a nurse whe	n the bruises were found.			Coordinator then reported the bruising		
	The bruises continue	d to spread and on 12/20/24			the Director of Nursing (DON). The DC	N	
	Resident # 3 was eva	aluated at the local hospital			then instructed the Unit Coordinator to		
	ED (Emergency Depa	artment) where it was noted			complete and send the initial report to	the	
	Resident # 3 had exte	ensive chest and abdominal			State for an injury of unknown source.		
	wall ecchymosis (disc	coloration of the skin,			Resident # 3 was observed having		
	typically caused by b	ruising). A CT (computerized			swelling and discomfort with positioning		
	tomography) of the cl	hest abdomen and pelvis			when the bruising was initially noted by	1	
	with contrast was cor	•			Nurse Assistant # 5 (NA # 5). No		
		) large left subpectoral			documented incident was noted relating	g to	
		on of blood, usually clotted,			the bruises and Resident # 3 was not		
		ssel) underlying pacer			cognitively able to explain how the brui	ses	
	control box measurin	- '			occurred. NA # 5 failed to notify any		
		e contusion of the left flank			licensed nurses of the significant bruisi	-	
		or one (Resident # 3) of three			swelling and discomfort. This failure of		
	residents reviewed for	· · · · · · · · · · · · · · · · · · ·			notification resulted in a delay in notifyi	•	
	injuries of unknown o	rigiri.			the provider, assessment, treatment ar monitoring of Resident # 3s bruising,	iu	
	Immodiato iconardy k	pegan on 12/18/24 when				tho	
	, , ,	fied during her shift that			swelling and discomfort. On/12/20/25, bruises continued to spread and the	u IC	
		explained bruises, swelling,			resident was transferred to the		
	and discomfort. Imm				Emergency Department and diagnosed	4	
	removed on 3/28/25				with extensive chest and abdominal wa		
		eptable credible allegation of			ecchymosis, a large left subpectoral	•••	
		emoval. The facility will			hematoma underlying the pacemaker		
		ance at a lower scope and			measuring 9.5 X 5.2 cm, and a superfic	cial	
	severity level of D to				soft tissue contusion of the left flank ar		
		oring systems put in place			hip.		
	are effective.				The DON began the investigation into		
					Resident # 3s injury of unknown source	€.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	
		345301	B. WING _			03/	31/2025
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		•••		32	23 BALDWIN ROAD		
WHILE OF	K MANOR - BURLINGT	ON		В	SURLINGTON, NC 27217		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 25	F	300			
	The findings included				The investigation revealed the resident		
	The infange melace	•			had no documented injury that have		
	Resident # 3 was ad	mitted to the facility on			contributed to the bruising and unable t	o	
		nt's diagnoses in part			substantiate abuse. The probable caus		
		ongestive heart failure,			for the bruises could possibly be		
	Parkinson's, atrial fib	-			contributed to dislodgement of		
	dysphagia.	•			pacemaker. Resident # 3s body audits	;	
					reveal no further areas with no swelling		
	Resident # 3's annua	l Minimum Data Set (MDS)			and discomfort.		
	assessment, dated 1	0/14/24, coded the resident			On 2/6/25 and 2/7/25, the Unit 300		
		ly impaired and as needing			Licensed Nurse and Wound Care Nurs	e	
		for bathing, dressing, and			conducted body audits on current		
		dent # 3 was coded as			residents to ensure no other residents		
		derate assistance to roll			were identified with bruising, discomfor		
	from side to side in b	<u> </u>			and swelling, and if so to ensure prope	r	
		um assistance to transfer.			notification and/or investigation was		
		ded as using a manual			completed. No further signs or symptor		
		feet after set-up assistance.			of injuries or new skin abnormalities we	ere	
		coded as having falls during			noted.		
	the assessment period	od.			Current and newly admitted residents v	vitn	
	Daview of Decident 4	4 Ola sana mlam maya alad tha			identified areas of bruising, discomfort		
		\$ 3's care plan revealed the			and swelling will be reported to	ı.	
		On 10/19/23 staff added the or falls. This remained part			Administration for further investigation in they have unexplained areas.	II	
		re care plan. On 10/27/23			On 2/6/25 to 2/7/25, an audit of all		
	staff added the reside				resident hospital transfers and recorder	۱ ا	
		nd bruises at times. This also			incidents/events (events include reporte		
		he resident's active care			falls, skin tears and infections) to ensur		
	•	f added that Resident # 3			the completeness of the documentation		
	•	vith care. This remained as			proper notification of the resident	''	
	part of the resident's				representative and provider, and follow	-up	
		•			interventions were implemented. The	'	
	Review of November	2024 nursing notes			audit included the timeframes/shifts		
		3 sustained one fall which			Employee # 1 worked from 11/5/24 to		
	was on the date of 1	1/2/24 at 6:15 PM. According			2/6/25 and was conducted by the Nurse	e	
		sident # 3 had attempted to			Consultant to identify any care concern		
	_	from the chair to the bed			The review of hospital transfers and		
	_	sist him. His upper body had			reported falls, skin tears or infections d	id	
		nd then his body had slid to			not reveal any obvious care concerns.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
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		345301	B. WING _			03	3/31/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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WHITE OF	AK MANOR - BURLING	SION		В	BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From po	ogo 26	F.	200			
F 000	Continued From pa	-	F 6	600		_	
		g to the nursing note at 6:15			On 3/26/25 and 3/27/25, the DON, SD	С	
		resident's range of motion			and the Administrator completed		
	was at his baseline	e. A later nursing note on			re-education with current staff on the		
	11/2/24 at 9:57 PM	noted the resident had some			Abuse/Neglect Protocol including		
	discoloration but no	o swelling to his left knee, and			protecting the residents right to be free	<del>)</del>	
	orders were given	for an x-ray. Review of x-ray			from injury of unknown source, and		
		11/3/24 revealed Resident # 3			reporting protocols for suspicion of abo	use	
	had sustained no f	ractures from the 11/2/24 fall.			or neglect. The re-education also inclu	ded	
					recognizing and reporting injuries or		
	Review of Residen	t # 3's medical record revealed			changes in residents condition, and th	е	
	no falls in Decemb	er 2024 were documented.			chain of reporting. Significant bruising		
					without a known source indicates a		
	Review of Residen	t # 3's medication regimen for			suspicion of abuse or neglect and sho	uld	
		vealed Resident # 3 was not			be reported to Administration as soon		
	on an anticoagular	ıt.			is noted for further investigation and to		
					report to the State Agency. Newly hire		
	Review of nursing	progress notes revealed no			staff will receive this education during		
	_	f 12/17/24, which was the date			job specific orientation by the SDC.		
		3's injury being identified.			The DON or designated management		
	p 10 . 100.00.11.	o c,ayg .a.cca.			nurse will monitor all nursing progress		
	Review of staffing	sheets revealed NA (Nurse			notes weekly for 4 weeks, then 5 prog		
		d for Resident # 3 on the			notes weekly for 8 weeks to ensure ar		
	· '	7:00 AM to 3:00 PM) prior to			indication of an injury of unknown soul	-	
	,	identified on 12/18/24. A			has been reported to Administration fo		
		y NA # 1 read, "I [Nurse Aide #			further investigation and to report to the		
		3] from 7 AM 3 PM. No			State Agency.	Ü	
		at the time me and coworker			The DON or designated management		
		use [mechanical] lift to get			nurse will monitor 5 completed skin		
		17/2024 and resident was			assessment sheets 3 days a week for	1	
	•	12/17/2024 and resident was 12/17/2024 around 11 AM."			weeks then 5 completed skin assessm		
	diessed by file off	12/11/2024 aloulu 11 Aw.			sheets weekly for 8 weeks to ensure the		
	NA#1 was intensis	ewed on 3/21/25 at 12:25 PM			is no evidence of unreported injury of	ICIC	
		ollowing information. She			unknown source.		
	•	•			I .	vill	
		Resident # 3. On 12/17/24			The results from the monitoring tools w		
		problems with his care or			be discussed during the morning Qual		
		had been no bruising on his			Improvement (QI) meetings, weekly fo		
	l -	ther staff member used a lift to			weeks. Identified issues or trends will		
		nt, and he was still up when			further discussed at the monthly Quali	•	
	she left at the end	ot ner shift.			Assurance (QA) meeting with the tean	1	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			1	31/ <b>2025</b>	
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00.	<u>•</u>	
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F 600	Review of the investig statement by NA # 2 assisted NA # 1 on 12 transfer to the chair a incident or bruising of Review of the facility? Nurse # 1 had been a # 3 on 12/17/24 during evening shift (3:00 PN statement within the fread, "On 12/17/24 I AM to 3:00 PM) and 2 PM) as [Resident # 3 any bruising or swelling last seen [Resident # 9:25 PM with no shirt meds. No bruising or An attempt was made 3/21/25 at 12:01 PM areached for an intervious Review of staffing she cared for Resident # 3 shift. A review of the inthe surveyor did not in # 3.	gative file revealed a noting that she (NA # 2) had 2/17/24 with Resident # 3's nd there had been no in the resident.  Is investigative file revealed assigned to care for Resident g both the day shift and the M to 11:00 PM). Nurse # 1's facility's investigative file [Nurse # 1] worked 1st (7:00 2nd shift (3:00 PM to 11:00 's] nurse. I did not observe ing on resident body. No one or bruising. I [Nurse # 1] 3] approximately around on while giving him his night swelling noted."	F 6	a T re		ed.	DATE	
	not fallen and there h had no bruises. She ( Resident # 3 back in with the help of NA #	ad been no incidents. He						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345301	B. WING _			C <b>03/31/2025</b>
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP COD 323 BALDWIN ROAD BURLINGTON, NC 27217	I	03/3 1/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 600	checked on him ever been fine. She had si the facility's investigal had happened to it.  NA # 4 was interview and corroborated NA reported she did assi Resident # 3 on the element of the facility's reported Resident and she had not obserview of the facility's reportable incidents of was no known cause information. On 12/18 initial report, which we Coordinator # 1, to the 7:20 AM on 12/18/24 identified with a base right shoulder, large lunder arm, swelling a chest and below clave the resident was una pain and there was signed at 7:00 AM on was assigned to care.  Review of Employee Employee # 1 was hi	y two hours and he had ubmitted a statement during tion and did not know what ed on 3/24/25 at 3:21 PM # 3's statement. NA # 4 st NA # 3 with transferring evening shift of 12/17/24. NA t # 3 was okay at the time, erved any injuries.  Is investigative file for of injuries for which there revealed the following 8/24 the facility submitted an as completed by Unit e state agency noting that at Resident # 3 had been ball size bruise on the front nematoma to his left side and bruising on his left upper icle. The report also noted ble to lift his left arm without welling.  Beets revealed on the night 11:00 PM on 12/17/24 and 12/18/24, Employee # 1 for Resident # 3 as a nurse.  # 1's personnel file revealed red as a nurse but was not	F6	600		
	hire indicated no nurs  During an interview w  Nursing) on 3/21/25 a	vith the DON (Director of				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345301	B. WING		C 03/31/2025
	ROVIDER OR SUPPLIER	ON	3:	TREET ADDRESS, CITY, STATE, ZIP CODE 23 BALDWIN ROAD SURLINGTON, NC 27217	1 00/0 1/2020
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F 600	November 2024 and 2025 when this had she had been caring shift of 12/17/24, the was impersonating at A review of Resident Employee # 1 documented was checked a (According to Employee was checked a (According to Employee # 1's standard was a feet on Employee collecting [Resident when I notice he had shoulder as well as standard was reported me in report, so my four unit coordinators bruising on him. Before Coordinator's attention once more the unit coordinator of know my findings so properly."  According to staffing assigned to care for shift which began at 5's written statement investigative file read AM rounds, upon en noticed he had removed.	sing license upon hire in was terminated in February been validated. At the time for Resident # 3 on the night a facility had not noted she a nurse and was not licensed.  It # 3's vital sign log revealed mented Resident # 3's oxygen to 12/18/24 at 12:56 AM.  It yee # 1's statement this was be bruises.) The reading was notation it was taken again hift. Employee # 1 also in the # 3's weight was 127 on 12/18/24.  It # 1's statement read, "I was # 3's routine 02 (oxygen) if some bruising to his right some to his left. No fall or of from the previous shift to mext thought was to bring it to a attn. (attention) that he had one I could bring it to [Unit ion it was brought to my by the next shift and when got here, I immediately let her it could be documented  I sheets, NA # 5 was Resident # 3 on the night 11:00 PM on 12/17/24. NA #	F 600		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	' '	ATE SURVEY DMPLETED
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F 600	swelling. Upon me w startled (more than u calmed down after I t	nd chest along with some aking him up he seemed sual) but he eventually alked with him. I notice while	F 6	500		
	became uncomfortable his back and since he put the gown and bla came back around 5 made sure not to roll	he jerked himself back and ble so I turned him back on he had not soiled himself, I nket back over him. When I AM I did change him but him on his left arm since se that I noticed was located.				
	Moving forward I will aide to do a walk thro with changes. No ma if I notice ANYTHING	make sure to have another bugh with me and/or assist ter how minor or major it be it will be reported to the ve written reports to the				
	and reported the folion 12/17/24 shift which is she arrived at work, so told that Resident # 3 the 2nd shift. He was rounds and again at disturb him. Around 3 Resident # 3 had brusized bruise on his air reddish and was turn bruising on his chest was on his arm, but it bruise, and she did in look at the extent of the bruising had hap shift and therefore the of it. Nothing had hap had the shift and therefore the shift and therefore the of it.	ed on 3/21/25 at 11:25 AM owing information about her began at 11:00 PM. When she got report and had been had been "washed up" by asleep in bed on first 1:00 AM and she did not 3:00 AM she noticed ising. There was a golf ball m which appeared light ing purple. There was which was larger than what his gown partially covered the ot pull the gown down to he bruising. She assumed bened earlier during another e nurses were already aware opened on her shift. She did , who she thought was a				
	nurse. She thought I	Employee # 1 had been in before her (NA # 5) at some				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	OATE SURVEY COMPLETED
		345301	B. WING			C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		03/31/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 600	Employee # 1 go in  During a follow up i 3/24/25 at 1:02 PM obtained Resident # documented on 12/  Review of the facilit statement from NA discrepancies in wh in her statement. As statement she had checked Resident # been recorded in R Employee # 1 at 12 statement read, "Or passing the trays (b # 3's] tray. As soon shirt on. I saw bruis upper quadrant. As talked to 3rd shift (1 [Employee # 1]. I sa room and showed h that this first time so falls last night."  Employee # 1 was PM and acknowled else's nursing certif	at shift but she did not see to Resident # 3's room.  Interview with NA # 5 on Interview with NA # 6 on Interview with NA # 5 on Interview with NA # 6 on Interview with NA # 5 on Interview with NA	F 60			
	nurse. According to no type of Nursing I training. She report assistant training for completed that either regarding Resident had called the DON	facility in order to work as a Employee # 1 she completed Education or Nurse Aide ed she had some medical om another state but had not er. She was interviewed #3's bruises and reported she lat "12 something" when she :00 PM to 7:00 AM shift which				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY LETED
		345301	B. WING _				31/2025
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP C 323 BALDWIN ROAD BURLINGTON, NC 27217	ODE	, 33.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 600	and saw the bruises. did not know who obt which she had record know how the bruises would never do anyth. A review of nursing n documenting the resi 12/18/24 at 7:32 AM entered into the record 12/19/24 at 8:08 A able to make needs wreport that resident hochest, armpits, and a pressure), 97 % on R (respirations), 97.9 (trustian), wheezing or grimacing noted whee Resident refused to be further noted Resident Tylenol 325 mg (millig Nurse # 1 also noted and orders were obtained and orders were obtained and condition.  An attempt was made 3/21/25 at 12:01 PM reached for an intervious shift nursing entry 7:36 PM by Nurse # 2 from previous shift nursing entry of the previous s	Employee # 1 reported she ained Resident # 3's weight led. Employee # 1 did not so occurred and reported she aing to hurt a resident.  Otes revealed the first entry dent's bruising was on by Nurse # 1. The entry was rd as a late entry on the date M. The entry read, "Resident writer made aware during and bruising to left side of rms. VS 128/77 (blood tA (room air), 18 temperature), 63 (pulse.) No oms) of SOB (shortness of labored breathing. Facial on resident move his left arm. The physician was notified ined for a stat x-ray on the left arm. The DON, Unit sial Worker were also to interview Nurse # 1 on and she could not be ew.  Ty was dated 12/18/24 at 2 and read, "Was informed	F	600			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	, ,	DATE SURVEY COMPLETED
		345301	B. WING			C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		03/31/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	Review of Nurse # 2 was located in the f Came into my shift [Nurse # 1] about [F Went to go see [Re to chest, arms, arm [Resident # 3] what asked [Resident # 3] what asked [Resident # 3 other night. I asked pointed to the close did anyone hurt him obtained measurem them in DON office  Nurse # 2 was inter AM and reported th date of 12/18/24 sh 11:00 AM because that day. She had be bruises in report at him and found bruis When he talked, he him yes and no que simple questions. We sident # 3 had rewhere he had faller the closet area of the able to convey more	upervisor, MD, and DON  2's written statement which acility's investigative file read," and was made aware by Resident # 3] having bruising. sident # 3] and noted bruising pits, sides of chest. I asked happened he just mumbled. I B] did he fall. He said yes the where did he fall. He then it area. I asked [Resident # 3] in and he stated no. I then nents of bruising and placed in the properties of the work at the properties of the work at the properties of the work at the properties on his arms and chest. I will be asked in the had fallen, when asked if he had fa	F 60			
	3/24/25 at 10:56 AN information. She ha 12/18/24 after the battention. Resident what happened. Sh	Vorker was interviewed on A and reported the following d interviewed Resident # 3 on ruises were brought to her # 3 was not able to convey e also interviewed Resident # dent # 12), who also had				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345301	B. WING			C
NAME OF PR	ROVIDER OR SUPPLIER	343301		STREET ADDRESS, CITY, STATE, ZIP COD		3/31/2025
				323 BALDWIN ROAD		
WHITE OA	K MANOR - BURLINGT	ON		BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	Continued From pag- cognitive impairment	e 34 . Resident # 12 had reported	F 60	00		
	during the night and roommate. Resident # 3 had fallen. He wa	nachine into their room it was not used for his # 12 did not report Resident as not able to say what the is pushed into the room.				
	Resident # 3's physic facility medical direct on 12/18/24 and in a	progress notes revealed cian, who served as the or, assessed Resident # 3 ddition to documenting the				
	"abrasion" to his skin (Resident # 3) was n	nted the resident had an  . The physician noted, "He oted this morning to have body. Patient has cognitive				
	happened. Last BIMS status) 2/15. He seer moving the left shoul	6 (brief interview for mental ms to only have pain when der. No documented falls.				
	further documented r bruising as follows: "	I for pain." The physician measurements of the Note Bruises were irregular easured at largest diameter.				
	Right anterior chest of X 3.5 cm (centimeter purplish area inferior	upper near midline, about 5.5 s) reddish with some faint to it. Right shoulder near AC				
	blade) circular reddis	r bone meets the shoulder h abrasion. Right shoulder 7 x 6 cm irregular shaped aint deeper purple				
	cm at largest diamete bruises about 1 cm e	ing further down about 5 X 8 er. Right arm-3 circular ach-2 inner bicep mid to ferior. Left chest wall-				
	Pacemaker scar with purplish red bruises. lateral and turned/stid 3 cm reddish bruise was a scalar part of the scalar part of t	6 small irregular shaped Pacemaker appears more cking out. Left side about 7 X with faint edges in shoulder reddish purple about 10 X 4				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345301	B. WING		C 03/31/2025		
	ROVIDER OR SUPPLIER	1	3	STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217	1 33/01/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 600	arm-irregular shaped with varying colors-rinferior, 12 X 4 cm a arm. 8 X 3 cm circular medial to elbow. Lar purplish edges wrap nipple, darker purple ecchymosis (discolocaused by bruising) below waist." Within physician noted a ch count would be obtained that she was unad been placed or lithe pacemaker appeared to the pacemaker appeared to the pacemaker wais any abnormalities wiresident's heart or luthe report was "negative any abnormalities wiresident's heart or luthe report was "negative any abnormalities wiresident's heart or luthe report was "negative any abnormalities wiresident's heart or luthe report was "negative and the resident (Low platelets can in bleeding.)  On 12/19/24 Resider (Nurse Practitioner) information. Resider thrombocytopenia (lox-ray had been norm concern that the resident that the resid	on lateral upper arm. Left d bruise going down bicep eddish to darker purple round to lateral aspect of ar bruise purplish inferior and ge left chest wall bruise light is around chest lateral to e on posterior chest. No ration of the skin, typically neck, facial area, or body the progress note, the lest x-ray and complete blood ined. The physician further unsure when the pacemaker ast tested. She further noted eared to be "turned/sticking"  PM Nurse # 2 noted x-ray was normal.  (24 Chest x-ray result showed was present but did not note ith the pacemaker or with the ngs. The radiologist noted	F 600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345301	B. WING			C 03/31/2025		
	ROVIDER OR SUPPLIER	DN		3	TREET ADDRESS, CITY, STATE, ZIP CODE  23 BALDWIN ROAD  BURLINGTON, NC 27217	1 03/	31/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Review of nursing no 2:21 PM Unit Coordin # 3's bruising was spishoulders down into I left side rib cage and the hospital for further Review of 12/20/24 Enotes revealed the form documented. Resider and abdominal wall end (computerized tomograbdomen and pelvis of The CT "impression" subpectoral hematom usually clotted, outside underlying pacer concern. 2) Superficial sofflank and hip 3) No of traumatic injury to the 4) emphysema, 5) compreparing for dischargente any further commontusion. The ED physobal demonstration pacemaker site but of contusion." There was the hematoma could pacemaker site. The stable for discharge fidiagnosis of "chest we "superficial bruising of ED discharge orders."	tes revealed on 12/20/24 at lator # 1 noted that Resident reading from his bilateral his abdomen, left arm, and he was being transferred to revaluation.  ED (Emergency Department) Illowing information was had extensive chest cochymosis. A CT raphy) of the chest with contrast was completed. read, "1) large left had (a collection of blood, the of a blood vessel) trol box measuring 9.5 X 5.2 at tissue contusion of the left ther CT evidence of acute exchest, abdomen, or pelvis. Ironary artery disease." Upon the ED physician did not ments about the hip hysician did note "CT scaning hematoma around his therwise superficial is no notation regarding how have formed around the resident was noted to be from the ED with a final all hematoma, left" and if back, left." There were no	F	600				
		1 documented Resident # 3 spital in no distress, no pain,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345301	D. WING_		_	03/	31/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WHITE OA	AK MANOR - BURLINGTO	ON		323 BALDWIN ROAD			
2 0,	ar any aron Donzarron			BURLINGTON, NC 2721	17		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 37	F	500			
	on 3/24/25 at 5:15 PM aware of how the bru reported she attempted who performed the checould determine if sour resident's pacemaker determine. It had not attention that the hose contusion on the resident # 3's physica 3/21/25 at 3:13 PM attention. When she 12/18/24 the bruising which included areas which wrapped around did not recall any bruit when she examined had a pacemaker. The the date of 12/18/24 the had be had a pacemaker. The the date of 12/18/24 the noticeable and appearance and was not able to examine the staff he had faller could go totally by who because of his confust to be reviewed also, the make mention of protitiself. The ED physici in her notes about the which had shown up	pital's CT showed a dent's hip.  ian was interviewed on nd reported the following e evaluated Resident # 3 on was all on his upper body on his arms and chest wall id some on his torso. She ising extending to his hip nim on 12/18/24. He was shoulder pain. Prior to een no history the resident e resident was thin and on					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345301	B. WING		C 03/31/2025		
	ROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE  23 BALDWIN ROAD  BURLINGTON, NC 27217	1 03/31/2023		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 600	to the 12/18/24 inci- had made a referra had canceled the a was further intervier pacemaker could h- resident's injuries. To following informatio a cardiologist and w stitches had been p had originally been over time scar tissue pacemaker in place sure but would thind had to happen to ca had done so. She co	sion to the left hip was related dent or a separate event. They I for a cardiologist, but the son popointment. The physician wed regarding whether the ave moved causing the The physician reported the n. She (the physician) was not was not aware of what type of placed when the pacemaker placed. She would think that e would help hold the see that something would have ause a pacemaker to move if it lid not know how far it could all have to refer to a	F 600				
	on 3/21/25 at 2:55 la cardiology appoin 12/18/24 incident b appointment. Due to sources, he was to provider. They had arranged for the apand it was rescheduled Resident # 3 was in PM. During the interand his words could the interview, Residently. He will be to propel the words to be several times he will the wall or objects at	acility appointment scheduler PM revealed Resident # 3 had atment scheduled after the but the son canceled the to the resident's payment be seen at a particular talked to the son and pointment to be rescheduled builed for 4/7/25.  Atterviewed on 3/20/25 at 2:45 rview Resident # 3 mumbled do not be understood. Following lent # 3 was observed to roll from and into the hallway was not observed to use his sheelchair, only his arms. build run his wheelchair into as he propelled himself and wheelchair himself to continue					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		IPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED		
		345301	B. WING _			C 03/31/2025		
	ROVIDER OR SUPPLIER	ON	'	STREET ADDRESS, CITY, STATE, ZIP COD 323 BALDWIN ROAD BURLINGTON, NC 27217	E			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 600	interviewed on 3/20// Resident # 12's reco Interview for Mental MDS assessment wa cognitive impairment had never witnessed roommate. Resident March during the inte had two falls he had (Resident # 12) about another one prior to the hallway near the happened in the roor resident off the floor reported at times Re moving his wheelcha  Interview with Unit C 11:10 AM revealed is bruising on the morn been stopped in the told her about it. She been aware of the bi "just seen it." When is made aware on the in notified the DON, an needed to complete unknown origin to the  During an interview of Nurse # 3, who over facility, Nurse # 3 rep	mate (Resident # 12) was 25 at 3:00 PM. A review of rd revealed his BIMS (Brief Status) score on a 2/18/25 as a "6," indicating severe to Resident # 12 reported he I anyone mistreat him or his # 12, who was aware it was erview, stated Resident # 3 recalled. One seemed to him ut a month ago and then that. One had happened in doorway and the other had m. The staff had helped the both times. Resident # 12 sident # 3 had problems air in the room.  Soordinator # 1 on 3/21/25 at the first became aware of the ing of 12/18/24. She had hallway but did not recall who we knew that Employee # 1 had ruising and had said she had she (Unit Manager # 1) was morning of 12/18/24, she did the DON informed her they a reportable injury of	F	500				
		nt # 3's roommate (Resident and was not a reliable source						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345301	B. WING		C 03/34/3035		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217	03/31/2025		
(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 CORRECTIC  (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION		
F 600	Continued From page	ge 40	F 60	00			
	interview, Nurse # 3 11/2/24 fall was the record that the residence resided at the facilit. Interview with the D 3/21/25 at 5:30 PM information. They have stigation following bruising on 12/18/24 called on her shift to reported until the datime they did an invincident to the state reported they witness have an accident for particular cause of the something had hap spontaneously, which	ON and Administrator on revealed the following ad conducted their ing the identification of the 4. Employee # 1 had never or report any injury. It was not ayshift on 12/18/24 and at that estigation and reported the . None of the staff had issed Resident # 3 to fall or in them to conclude a the bruising. They thought opened to the pacemaker in the conduction of the staff had caused bleeding under					
	to the DON, she had other individuals. The hospital CT shows the hip also and had investigation. The Exthem and scanned in being drawn to their A "Device Nurse" at Resident # 3 had be interviewed on 3/24 the following inform nurse" for 30 years pacemaker to spont pacemakers are sufficiently the sp	the cardiology clinic, where een historically seen, was /25 at 11:55 AM and reported ation. She had been a "device and had never known a taneously move. The tured in place and then scar and them to hold them in place.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			C 03/31/2025	
	ROVIDER OR SUPPLIER	GTON		STREET ADDRESS, CITY, STATE, ZIP CO 323 BALDWIN ROAD BURLINGTON, NC 27217	•	01011/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE	
F 600	had a pacemaker defibrillator.  The hospital ED (ephysician, who evalue 12/20/24, was intered AM. Prior to the inbeen sent a mession which the surveyor whether a pacema During the interviet the following informat pacemaker moves a pacemaker a pacemaker of the pacemaker could be also did not the pacemaker could be als	emergency department) aluated Resident # 3 on rviewed on 3/31/25 at 10:11 terview the ED physician had age that one of the questions r would like to discuss was aker could spontaneously move. w, the ED physician reported mation. She had never heard of ing. After receiving the n, she had reviewed studies and found one case in which an ingrate causing some external tient's left side. This had been a she did not recall anything being ent # 3's pacemaker when she 24. A chest CT would have with any lead or displacement. hink a problem with a ead to a hip contusion as well. opinion that Resident # 3's consistent with some sort of ecurred to him.  5 PM the Administrator was ate Jeopardy. The mitted the following Credible ediate Jeopardy Removal Plan. Dients who have suffered, or a serious adverse outcome as	F	600			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345301	B. WING		03/31/2025
	ROVIDER OR SUPPLIER	DN		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217	1 00/01/2020
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 600	have an injury of unk was noted with signiff and arms. The bruised deeper purple, locate extending to the upper site. The bruising was shape measuring 7cr In addition to the bruishift NA (NA #5) wrot facility's investigative resident had swelling uncomfortable with protify any nurse of the resident's discomfort. The sident's discomfort. The unit coordinator of the DON. The DON to coordinator to complete the DON. The investigation into Resorigin. The investigation into Resorigin. The investigation of the bruit wound care nurse cooresidents who received on unit 300. No signs	esident # 3 was found to nown origin. Resident #3 icant bruising to his chest is were reddish with faint dover the right clavicle or chest over the pacemaker is noted to be an irregular in x 6cm in the largest area. Sing to the chest, a night in her statement in the file that she saw that the and appeared ositioning. NA #5 failed to be significant bruising and the This failure of notification assessment and treatment ising and discomfort by the mand the unit coordinator noted in the instructed the bruising to the instructed the unit of the earth and Human in the DON began the sident #3's injury of unknown or revealed that the resident by that would have	F 60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
	345301	B. WING _			C <b>03/31/2025</b>		
NAME OF PROVIDER OR SUPPLIE WHITE OAK MANOR - BURLI			STREET ADDRESS, CITY, STATE, ZIP CO 323 BALDWIN ROAD BURLINGTON, NC 27217	)DE	00.0 1.12020		
PREFIX (EACH DEFI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
transfers and recinclude reported to ensure comple proper notification and provider, an implemented. Autimeframes/shifts 11/5/24 to 2/6/25 consultant to ide review of hospita skin tears, or information obvious care consultant to ide review of hospita skin tears, or information obvious care consultant to ide review of hospita skin tears, or information obvious care consultant to ide review of hospita skin tears, or information obvious care consultant to ide review of hospita skin tears, or information obvious care consultant to information obvious care consultant and staff on recognizing. All staff on recognizing protoconneglect. The eduvia phone. We constaff. Any hired a recognizing and resident condition reporting, abuse reporting protoconneglect.  The SDC was not regional on 3/26 receive education.	or a review of all resident hospital corded incidents/events (events falls, skin tears, and infections) eteness of the documentation, on of the resident representative d follow-up interventions were udit included the semployee #1 worked from was conducted by the nurse entify any care concerns. The all transfers and reported falls, ections did not reveal any	F6					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345301	B. WING	B. WING		C 03/31/2025		
	ROVIDER OR SUPPLIER			32	TREET ADDRESS, CITY, STATE, ZIP CODE 23 BALDWIN ROAD 3 BURLINGTON, NC 27217	1 03/	31/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 600	neglect recognition, a suspicion of abuse or orientation process.  Date of Immediate Jet 3/28/25.  On 3/31/25 the facility Immediate Jeopardy by the following action Different staff members and undergone training plan. Staff members at that were covered in reported no instances instances of injuries of they were aware.  The facility presented records as outlined in The facility's date of it was validated to be 3 Develop/Implement A CFR(s): 483.12(b)(1): §483.12(b) The facility implement written policy \$483.12(b)(1) Prohibit neglect, and exploitat misappropriation of records.	n, education on abuse or and reporting protocols for an elect during the facility reparty removal will be greatly removal will be greatly removal Plan was validated ans:  Pers from different rerviewed and validated they are per the facility's action were able to verbalize points the training. Staff members as of abuse, neglect or of unknown cause of which all documentation of in-service at their plan.  In the plan removal (28/25).  Abuse/Neglect Policies (5)(ii)(iii)  The provent abuse, and procedures that:  It and prevent abuse, and resident property,  Shippolicies and procedures		600			4/25/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER:  A. BUILDII		IPLE CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED	
		345301	B. WING			03/31/2025	
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP ( 323 BALDWIN ROAD BURLINGTON, NC 27217	•	0172020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 607	Continued From pag	e 45	F 6	607			
	§483.12(b)(3) Include paragraph §483.95,	e training as required at					
	§483.12(b)(4) Establ QAPI program requir	ish coordination with the ed under §483.75.					
	facilities in accordance Act. The policies and	e reporting of crimes -funded long-term care ce with section 1150B of the d procedures must include 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.						
	retaliation, as defined (2) of the Act.	ohibiting and preventing d at section 1150B(d)(1) and Γ is not met as evidenced					
	facility failed to imple employees who work licensed nurse by no Employee #1's crede licensed nurse and a licensed nurse duties documented education Employee #1 provide information for an incompaniem a name that was sim worked at the facility nurse from 11/5/24 u 2/6/25. During this tir resident assignments nurse responsibilities	iew and staff interviews, the ment their abuse policy for ted in the capacity of a screening and verifying entials prior to hiring her as a sullowing her to perform for which she had no on or nursing license. The facility nurse license stividual she found online with filar to her own and she in the role of a licensed in the remination on the frame, Employee #1 had a and performed licensed that she was not qualified to that started on 11:00 PM on		White Oak Manor Burling developed and implement policies and procedures the prevent abuse, neglect and residents, and misappropring resident property, including verifying credentials and resident property, including verifying credentials and resident property.  1. The facility failed to implemabuse and neglect policy to conduct reference checks, evaluate Employee #1 when November 2024. As a result was hired as a licensed not being licensed as a nurprovided care to multiple reference employment at the face	ed written nat prohibit and d exploitation of iation of g screening and eporting injuries  ement their to screen, , and thoroughly en hired in fult, Employee # nurse, despite furse and esidents during		

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				OIVID INC	<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345301	B. WING _				31/2025
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	
				32	23 BALDWIN ROAD		
WHITE OA	AK MANOR - BURLINGT	ON			URLINGTON, NC 27217		
()(1) ID	QUIMMADV QT	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(VE)
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					DEFICIENCY)		
F 607	Continued From page	e 46	F 6	07			
		<sup>‡</sup> 1 was assigned to Resident			from 11/5/24 until her termination on		
		an anticoagulant (blood			2/6/25.		
	,	entified bruising to the			During this time period, unlicensed		
		with no known cause.			Employee #1 performed multiple job		
		sponsible for assessing the			duties which required education and		
	, ,	the physician of significant			training to perform correctly to ensure t		
		changes. Employee #1 did not notify the physician and there was no evidence of an			residents were safe and not neglected.		
					This includes, but not limited to, blood		
		entions implemented for			sugar checks, neurological checks		
		was assessed the following  . The bruises continued to			following falls and implementing interventions, insulin administration,		
		/24 Resident #3 was seen in			physical assessments, and notification	to	
	the Emergency Depa			provider of significant change in	10		
		hy (CT) scan revealed a			conditions for residents.		
	large (9.5 centimeters	- , ,			On 2/6/25, the current Human Resource	es	
		under the chest muscles)			Manager (HRM) conducted a complete		
		on of blood, usually clotted,			audit of all nursing licenses and nursing		
	,	ssel) and a superficial soft			assistant certifications to ensure no	•	
		ising) of the left flank and			discrepancies in name spelling or state	of	
	hip. On 1/24/25 Med	~·			residence. There were no discrepancie		
	reported to Employee	e #1, who she believed to be			except for Employee #1 in regard to the	•	
	a nurse, that Resider	nt #9's finger stick blood			spelling of Employee #1s name on her		
	sugar (FSBS) registe	red outside of the meter's			identification (ID) and the name on the		
	highest measurable r				presented Georgia LPN (Licensed		
		od sugar reading (normal			Practical Nurse) license. It was also no		
		e between 70 and 100).			that Employee #1 had a Burlington, No	rth	
	There was no eviden				Carolina address on her ID and was		
	1 -	ent to address the high blood			practicing with a Georgia LPN license.		
		ohysician was not notified.			Employee #1 was questioned by the H		
	On 12/8/24 and 1/9/2	· ·			and the Director of Nursing (DON) rela		
	_	t #11, who had severe			to the discrepancies and was immediat		
	cognitive impairment				removed from resident care duties and terminated on 2/6/25.	ſ	
		role of a licensed nurse d falls. The assigned nurse				ſ	
		completing a comprehensive			On 2/6/25, the DON submitted a complaint to the North Carolina Borad	of	
					Nursing (NCBON) related to unlicensed		
		ssessment and utilizing nursing judgment egarding whether to call the physician. Employee			Employee #1 and the suspicion that sh		
	#1 was not qualified t				had falsified her credentials as a LPN.	-	
		ssment of Resident #11 nor			On 3/18/25, the NCBON contacted the	ſ	
			1	- 1	,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BU			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345301	B. WING			03/31/2025	
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WHITE OAK MANOR - BURLINGTON				В	BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 607	Continued From page	÷ 47	F	607			
	was she qualified to use make decisions. Add did not implement the reporting injuries of use identified that Resides positioning, swelling, chest with no known of practices affected Resident #11 in addit Employee #1 was assequently of licensed nof a serious adverse occurred for 1 of 3 en records were reviewer #1) and 1 of 3 nurses	itionally, Nurse Aide (NA) #5 abuse policy related to nknown source when she nt #3 had discomfort with and bruises on his arm and cause. These deficient sident #3, Resident #9, and ion to placing all residents signed to care for in the nurse for the high likelihood butcome or harm. This nployes whose personnel d for credentials (Employee aides reviewed for reporting source or allegation of			DON to inform them that they had completed their investigation and unlicensed Employee #1 had falsified t LPN credentials. The NCBON advised DON to contact law enforcement. On 3/18/25, the DON contacted the Burlington Police Department and filed report with the findings from the facility internal investigation and the NCBONs investigation.  Since 2/6/25, the HRM has continued the evaluate licenses and certifications for 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 there are the transported to the NCBON.	the a 's o any re with	
	facility failed to screet Employee #1, who frato the facility as a lice her and allowing her to duties. Immediate Jed 3/28/25 when the faci acceptable credible a jeopardy removal. The compliance at a lower E to ensure education monitoring systems p Example 2 is being cilevel severity of "E."  The findings included Review of the facility's Elder Abuse," which we the surveyor as the facility and the surveyor as the	llegation of immediate e facility will remain out of r scope and severity level of n is completed and ut in place are effective. ted at a scope and severity  : s "Plan for the Prevention of was undated and provided to acility's current policy,			checks. This is to prevent any unlicens 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 proces 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 negle policies for employees who work as licensed nurses or nursing assistants be screening and verifying their credential prior to being hired and allowing them to perform licensed nurse duties and nurse assistant duties with the proper educat and credentials. Licensed nurse educat will be confirmed prior to hire. Newly hired Human Resources Managers will	ect by s to sing ion tion	
		icility's current policy, information. "A thorough			receive this education during their job		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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WHILE OF	AK MANOR - BURLINGTO	JN .		E	BURLINGTON, NC 27217		
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F 607	Continued From page	÷ 48	F	607			
	efforts to prevent neg	ening" would be conducted in ligence or abuse. This yment interview, reference e verification.			specific orientation by the Corporate HRM. On 3/27/25, the decision was made by the Corporate HRM to review and revision the current hiring policy for the facility that facility the facility the facility the facility the facility the facility the facility that facility the facility the facility that f	se	
	the following informat application for employ	ne state surveyor revealed ion. Employee # 1's			state the HRM will obtain 2 professional references prior to employment. The HRM will monitor weekly for 12 weeks of newly hired licensed nurses a nursing assistants credentials by	al	
	11:00 PM to 7:00 AM history included on th	ered nurse on third shift from  The only employment e application noted ended an out-of-state high			indicating that it has been checked for validation and for discrepancies to ens that they are in good standing.  The HRM will also monitor weekly for		
	listed. There was one history listed. This wa	ucation experience was e record of employment as from the dates of 2/1/2016			weeks by providing copies of 2 professional reference checks for newl hired employees to Administration.	у	
	"USA." Employee # 1 as her job duty for this	employer located in the I listed "chat support agent" s employer. There was one erence whose relationship to			The facility failed to implement their abuse and neglect policy including injured of unknown source protocol when Nurse Aide #5 (NA #5) failed to report	-	
	Employee # 1 was no This individual, who w	oted to be her "employer." was listed as Employee # 1's noted to share the same last			unexplained injuries (bruises) found or Resident #3 during night shift of 12/17/ to the charge licensed nurse on the sh	/24	
	# 2" on the application submitted, "I do not h	1. Under "Reference Entry n form, Employee # 1 had ave a # 2 Reference Entry."			On 2/20/25, the DON identified during investigation of Resident #3s injury of unknown source that NA #5 had noted		
	skills training which ye the position you are a	Please indicate education or ou believe qualifies you for applying," Employee # 1's "CNA (Certified Nurse Aide)			bruising, swelling and discomfort, but failed to report it to any licensed nurse The DON then implemented education with all licensed nurses and nursing		
	and 5 years of home application there were	health." At the bottom of the e some scribbled notes care currently dementia 2			assistants on Unit 300 about reporting bruising or injuries of unknown source. This education was completed on 2/27		
	yrs-Nurse for 4 ½ year There was no docume the notes on the appli documentation in the	ars 3rd shifts M-F FT." entation of who had made			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, discomform	se	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION  IG	(X:	(X3) DATE SURVEY COMPLETED	
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				323 BALDWIN ROAD			
WHITE OA	K MANOR - BURLINGTO	ON		BURLINGTON, NC 27217			
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F 607	Continued From page	<del>2</del> 49	F 6	07			
	there was no resume			and swelling, and if so to en- notification and/or investigat			
	Also located in the pe	ersonnel file, there was an		completed. No further signs	or symptoms		
		record for Employee # 1		of injuries or new skin abnor			
	which did not note for	which employment position		noted.			
	she was being hired.	It did note the hours would		Current and newly admitted	residents with	n	
	be from 11 PM to 7:00	0 AM as a full-time		identified areas of bruising, o	discomfort		
	employee. It was sign	ned by a corporate Human		and swelling will be reported			
	Resources Consultan	t on the date of 11/5/24.		Administration for further investigation they have unexplained areas	•		
	There was no evidence	ce of nursing license		reported as injury of unknow	n source as		
	verification prior to 11	/5/24 in the personnel		indicated in the abuse and n	eglect policy.		
	records provided to the	ne surveyor.		On 3/26/25 and 3/27/25, the			
				and the Administrator compl			
	-	file were different records		re-education with current sta			
		Development Coordinator		abuse and neglect policy reg			
		yee # 1 on dates which		immediately reporting any in			
		11/8/24 indicating she had		unknown source to the DON			
	reported to work for tr	raining on those days.		Administrator. The re-educa recognizing and reporting in			
		cation in Employee # 1's		unknown source or changes			
	personnel file was a c			condition, and the chain of re			
		DON (Director of Nursing).		Significant bruising without a			
		19/24, only contained a		source indicates a suspicion			
		nfirm License Verification		neglect and should be repor			
	Report" from "QNursy	/s." ("QNursys" is an online		Administration as soon as it			
	national nurse licensu	· · · · · · · · · · · · · · · · · · ·		further investigation and to r	-		
		e within the email noted that icense was licensed in the		State Agency. Newly hired s			
				receive this education during			
		rgia with a multistate license		specific orientation by the St Development Coordinator (S			
		Within the personnel file byee # 1's social security		Corporate Consultant.	5DC) 01		
	card and driver's licer	-		The DON or designated mar	nadement		
		11/19/24 email varied from		nurse will monitor all nursing			
	_	ee # 1's copies of her social		notes weekly for 4 weeks an			
		driver's license. They		progress notes a week for 8			
	_	ways. The first name of		ensure there is no indication		of	
		extra "a" letter in it than the		unknown source that has no		•	
		sing license. The middle		reported to Administration.	. = = - :		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		E SURVEY IPLETED
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F 607	Continued From page	e 50	F 60	07		
F 607	name was totally diffesame. According to Elicense, she was born nursing license issue license provided in the indicated that Employ nine years old when some the indicated that Employ nine years old when some interviewed toge and a follow up interviewed toge and a follow up interviewed by Human Resources Mould have been responded the following interviewes. Employee 11/5/24. The DON dicting interview or what was recalled that it was calling tha	erent. The last name was the Employee # 1's driver's in 1996. The original date was 4/5/2006 on the e email to the DON, which yee # 1 would have been	F 60	The DON or designated maninurse will also monitor 5 com assessment sheets 3 days a weeks then 5 completed skin sheets weekly for 8 weeks to is no evidence of unreported unknown source.  The results from the monitoring be discussed during the morn Improvement (QI) meetings, weeks. Identified issues or transcription of the further discussed at the month Assurance (QA) meeting with and recommendations made. The DON and Administrator as responsible for the ongoing complete for the ongoing complete for the ongoing complete for the date is 4/25/25.	pleted skin week for 4 assessment ensure there injury of  ng tools will ning Quality weekly for 12 ends will be thly Quality a the team as indicated. are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP		
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	ROVIDER OR SUPPLIER AK MANOR - BURLINGT	ON		3	TREET ADDRESS, CITY, STATE, ZIP CODE  23 BALDWIN ROAD  BURLINGTON, NC 27217			
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F 607	nurse on third shift upoint prior to 2/6/25 in DON's attention that documentation skills. Therefore, she looke and started to questin DON) pulled Employ herself. At that time in Georgia as a single is DON) noted during the license issue date work meant that Employee years old when licen noted Employee # 1' slightly and that the insame. Employee # 1' slightly and that the insame. Employee # 1' terminated. When comminate to the DOS State Board of Nursing's in unable to verify any if the total the which they did.  A review of a police in Administrator called them of Employee # The responding officing report that there was documentation proving facility and the case review and possible fraud.	rough 2/6/25 as a licensed ntil her termination. At some thad been brought to the Employee # 1's were not professional. It at Employee # 1's notes on things. On 2/6/25 she (the ree # 1's license again the license came up in state again and she (the reat check that the nursing as in 2006, which would have the # 1 would have been nine sed. She (the DON) then is first name varied very middle name was not the was confronted by her and confronted, Employee # 1 have a nursing license and DN, which she never did. The ing was contacted on 2/6/25 in d with them. After the State investigation, they were also nursing license for Employee facility to call the police	F	607				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 323 BALDWIN ROAD BURLINGTON, NC 27217	DE	03/31/2025
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F 607	employment at the fa October 2024. She h Employee # 1 being	e 52 acility in the middle of ad nothing to do with hired and knew nothing	F€	607		
	interviewed on 3/24/2 the following informal Employment notificat to help get Employee and her start date wa was assisting the face facility was without a HRM # 1 had already paperwork before lead have been HRM #1's to have checked to s nursing license. This whoever did her intel personally met Employee helping in November when there was no h he had noted that Emprovided a nursing lic licensure for Georgia single state licensure that Employee # 1 w floor until they could did not know what ha nursing license she h not on file in the pers surveyor. According which the Corporate Consultant reference the surveyor, Employ 11/14/24 through 11/ Employee # 1 sent a 11/19/24 and he also	aving on 10/25/24. It would sor the DON's responsibility ee if Employee # 1 had a task would have fallen to rview. He had never oyee # 1. When he was 2024, during the interim uman resources manager, inployee # 1 had initially beense that said single state only. When he noted the end only. When he noted the verify her nursing license. He had happened to this initial had submitted and why it was sonnel record given to the to human resource records, Human Resources and during the interview with the wee # 1 did not work from 18/24 because of this.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 607	nursing license, h suspicious. He no really the person so thought was that if the nursing license multi state, then so nursing license. To Consultant was in education and nursing license. It was to initially apply the their organization their corporate symight not be compathen provide some gaps.	s Consultant) looked up her e did not note anything ever suspected that she was not she was presenting to be. His f she had the capability to get e changed from single state to he must be the person on the he corporate Human Resource terviewed regarding the lack of rsing experience on Employee # d reported the following s not uncommon for employees rough a third-party website to and then the application fed into stem. At times the application plete, but the applicant would be sort of resume to fill in the	F	607			
	knew it was a "she for a nurse job at homeless, living in support. She never reach out to her a application, but th interview. She did of HR# 1. She wa and someone else Although she had formal health care medical assistant she did know abo She also had take were "bedridden" herself to be a fast during the interview.	ot in the dark" when she applied the facility. She had been in a car, and had a child to be thought that the facility would fter she submitted the ey did. She went to an not know anybody by the name is interviewed by a male person e, who was not the DON.  never finished any type of e training, she attended a school in another state, and but health care to some degree. In care of family members who or diabetics and reported it learner. She told the facility we she had health care never asked her for a license.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ON	STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217				
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F 607	and offered her a job to come to training working at the facility. HRM # 1 the system on 10/25/at the facility can proemployment through	hen the facility called her . They called and texted her hich had already started. to be four days of training, e last two days only. Then arse on night shift for about d she went to work. She had but two weeks before they at a nursing license. She on a website and found ar name to hers that had a she decided to give that to not think the facility would d she was "baffled myself" ey never questioned it and work. Her intent was never t was her perception that she her nurses who had a nursing ing to go back to school to g license while she was  ministrator on 3/21/25 at RM # 1 had been responsible f 1 and no longer worked at had been terminated out of 24. Applicants for positions vide an application for a third-party system on the Employee # 1's application	F 60	77			
	everything HRM # 1 # 1 but did know she documents" through Administrator stated license should have	had done in hiring Employee had sent some "on boarding					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		03/31/2023
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F 607	The records of three for by Employee # 1 Nurse, were reviewed of all the nursing tas made by Employee # impersonating a licethe facility, these through the following example performed or required done safely.  Employee # 1 had be Nurse for Resident # began on 12/17/24 a facility investigative is shift, Resident # 3 w 3's Nurse Aide to had chest and arm which swelling and discome Employee # 1 would the assessment and during the night shift facility's investigative bruises during the night shoulders on 3/21/25 at 3:13 P provider had not bee and this should have interview with the phreported the bruising upper body which inchest wall which wratorso. He was also he pain. The physician if # 3 was a cognitively not report what had Resident # 3's nursir	residents, who were cared while she worked as a d. Although not all inclusive k performed and judgements # 1 while she was used nurse and employed at the records revealed some of the est of nursing duties do f Employee # 1 to be the responsible assigned as 3 on the night shift which the theorem 11:00 PM. Review of a report revealed during this as identified by Resident # we unexplained bruises to his were accompanied by	F 6	07		

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED	
	345301	B. WING		C 03/31/2025	
ROVIDER OR SUPPLIER	TON	STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217			
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
revealed Resident # spread, and a CT (of scan performed on showed the residen hematoma underlyin measuring 9.5 X 5.2 superficial soft tissue left flank and hip.  Per record review Efor performing FSBS Checks) for Residen about when to call to readings. There was 9's record that Emp to Resident # 9 acco (Medication Administ when Employee # 1 Resident # 9's FSBS documentation the porders received alth sliding scale insulin Furthermore, per a with Medication Aid the following inform taken Resident # 9's was due to be check was "high" and did in She reported the re the time MA # 4 bel # 4) observed Empl did not know who E not know what she se # 1 received a notic phone line for her. Se Employee # 1 talk to	de 3's bruising continued to computerized tomography) 12/20/24 at the hospital thad a large left subpectoral and his pacer control box 2 cm. (centimeters) and the contusion (bruising) of the contusi	F 60	7		
	Continued From parevealed Resident # spread, and a CT (of scan performed on showed the resident hematoma underlying measuring 9.5 X 5.2 superficial soft tissureft flank and hip.  Per record review E for performing FSBS Checks) for Resident about when to call the readings. There was 9's record that Empto Resident # 9 accomposed for the flowing information the porders received althe sliding scale insuling Furthermore, per a with Medication Aid the following information the following information the following information the porders received althe sliding scale insuling Furthermore, per a with Medication Aid the following information the following information. The following information th	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 56 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	ROVIDER OR SUPPLIER  AK MANOR - BURLINGTON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 56 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 called and did not know what she said to them. Later Employee # 1 talk to someone but did not hear the conversation. After the conversation, Employee # 1 talk to someone but did not hear the conversation. After the conversation, Employee # 1 went through the insulin pens on	ROVIDER OR SUPPLIER  AK MANOR - BURLINGTON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REQUIATION YOU SEED (EACH DEFICIENCY MUST BE PRECEDED BY PULL REQUIATION OF DEFICIENCY)  Continued From page 56  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 kmAR (Medication Administrator Record). On 1/8/25 when Employee # 1 administered Insulin to Resident # 9's FSBS was 409, there was no documentation the physician was notified and orders received although the resident had no silding 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 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 called and did not know what she said to them. Later Employee # 1 talk to someone but did not hear the conversation. After the conversation. Employee # 1 talk to someone but did not hear the conversation. Employee # 1 twent through the insulin pens on	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345301	B. WING		C 03/31/2025		
	NAME OF PROVIDER OR SUPPLIER  WHITE OAK MANOR - BURLINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETION		
F 607	what type of insuling it belonged. A review documentation or or administration to add 6:30 AM FSBS readd next blood sugar chair was scheduled to and the result was dinterview with Resid Practitioner) on 3/25 validated she had not of 1/24/25. The NP 1 checked the on-call was no record of a coprovider on the morn Resident #9. The NI Employee # 1 had swent into Resident # The interview with Revealed she only had to the Unit Managers know how the employee # 1 had signing into Resident pen.  According to Resident resident's 12/16/24 I	oom. MA # 4 did not know pen was removed or to whom w of the chart revealed no ders for any insulin dress Resident # 9's 1/24/25 ing of "high." Resident # 4's eck was next performed when be completed at 4:30 PM, focumented as 524. During an ent # 9's NP (Nurse 6/25 at 9:00 AM, the NP of been called on the morning further reported she had log for that date, and there call being placed to the on-call hing of 1/24/25 regarding P did not know to whom poken before Employee # 1 ft 9's room with an insulin pen. Lesident # 9's physician and given her personal number and given her personal number and therefore she did not how to whom poken on 1/24/25 before # 9's room with an insulin	F 607	· · · · · · · · · · · · · · · · · · ·			
	pen.  According to Reside resident's 12/16/24 I assessment coded t cognitively impaired orders revealed he r According to nursing documented Reside	ent # 11's record, the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			C 03/31/2025
	ROVIDER OR SUPPLIER	DN		STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217		0000112020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	resident did not sustate Employee # 1 was re nursing judgment reg physician that night a documentation she did Resident # 11's order Eliquis (an anticoagus sustained.  On 3/24/25 at 8:55 Protified of Immediate following Credible Allo Jeopardy Removal Protified of Immediate following Credible Allo Jeopardy Removal Protified of Immediate following Credible Allo Jeopardy Removal Protified for incomplete the number of the	sment to make sure the in any "blows" to the head. sponsible for making a arding whether to call the nd there was no id so although a review of its revealed he was receiving lant) when the falls were.  M the Administrator was Jeopardy and provided the legation of Immediate lan and the was adverse outcome as impliance.  Inplement their abuse and len, conduct reference lay evaluate Employee # 1 in November 2024. As a least a nurse, insed as a nurse, insed as a nurse and liple residents during her to the facility which lasted November 2024 until her 25.  It is duties which require go to perform correctly to safe and not neglected. This litted to blood sugar checks, ollowing falls, insulin	F 6	07		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345301	B. WING			C	
	ROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP COD 323 BALDWIN ROAD BURLINGTON, NC 27217	JE	03/31/2025	
(X4) ID PREFIX TAG			ID PREFI: TAG	PROVIDER'S PLAN OF CC  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 607	abuse/neglect/ and in when Nursing aide # unexplained injuries-Resident #3 during ni 12/18/25 7am to the of the conducted a complete and CNA certification in name spelling or si were no discrepancies. Specify the action the process or system fai adverse outcome from when the action will be the conducted a slight discrepe Employee #1's name and the name on the license. It was also not Burlington North Carowas practicing with a #1 was questioned by DON related to the discrepe aid when the discrepe the conduction in the license. It was also not but the conduction in the license in the license was practicing with a #1 was questioned by DON related to the discrepe in the license in the licens	lity failed to implement their sjury of unknown origin policy 5 failed to report bruises she found on 19ht shift of 12/17/25 11pm to charge nurse on the shift.  In Resource (HR) manager e audit of all nursing licenses is to ensure no discrepancies atte of residence. There is noted in the audit.  In e entity will take to alter the flure to prevent a serious in occurring or recurring, and the complete.  In Resources (HR) manager adit of nursing licenses and lancy in the spelling of on her identification (ID) presented Georgia LPN of the total control	F	607			
	complaint to the Nort (NCBON) related to u the suspicion that she credentials as an LPN	٧.					
	On 3/18/25 the NCB0	ON contacted the Director of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217	1 00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 607	Continued From pag	ge 60	F 60	07	
	Nursing and informe completed their inverse employee #1 had fa and advised the DO On 3/18/25 The DO NC Police and filed the facility internal in investigation.  Since 2/6/25 the HR evaluate licenses ar potential nurse or Clensure there are no spelling of names or manager also ensur seeking employmen good standing with the HR manager also Nurse Aide Registry seeking employmen active certification a	et d her that they had estigation and unlicensed laified her LPN credentials N to contact law enforcement.  N contacted the Burlington a report with the findings from exestigation and the NCBON  A manager has continued to ad certifications for any NA seeking employment to discrepancies with the extate of residence. The HR est hat any potential nurse thas a valid license and is in the Board of Nursing (BON). So checks the North Carolina for any potential CNA to ensure that they have an and are in good standing. This censed or uncertified staff	FOI		
	and written re-educa all of the above-mer Corporate Human R newly hired HR man education from the Manager as part of the Corporate HR Manacurrent hiring policy the HR Manager will references prior to each of the All Manager will references prior to each of the All Manager will references prior to each of the All Manager will references prior to each of the All Manager will references prior to each of the All Manager will references prior to each of the All Manager will references prior to each of the All Manager will reference the All Manager will refe	manager received verbal ation on the hiring policy and ationed steps from the desources Manager. Any magers will receive this Corporate Human Resources their orientation process.  Sion was made by the ager to review and revise the for this center to state that I obtain two professional employment. The HR may be a sure that all employees			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTI	RUCTION	(X3) DATE COMP	SURVEY LETED
		345301	B. WING				31/ <b>2025</b>
	ROVIDER OR SUPPLIER	DN		323 BALD	DDRESS, CITY, STATE, ZIP CODE DWIN ROAD GTON, NC 27217	1 00/	01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	On 2/20/25 the DON of Resident #3's injur #5 had noted bruising failed to report it to an implemented education unit 300 about repunknown origin. The and was completed on 3/26/25 through 3 Administrator completon immediately report origin to the DON or a presented face to fact are no Agency nurses hired agency staff will orientation by the State to immediately report to the DON or administrator by the State of Immediate Jegopardy by the following action.  The facility presented verification audits per The facility presented their plan of action to screened to prevent as	identified in her investigation by of unknown origin that NA gand discomfort but had any nurse. The DON then on with all nurses and CNAs orting bruising or injuries of education was face to face in 2/27/25.  Identified in her investigation by of unknown was face to face in 2/27/25.  Identified education was face to face in 2/27/25.  Identified education with all staff ting any injury of unknown was entified educated during in the educated in the educated during in the educated in the educated with all staff ting any injury of unknown origin in the educated during in the educated in the e	F	507			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		OATE SURVEY OMPLETED
		345301	B. WING _			C 03/31/2025
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217	•	03/31/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From pag	e 62	F 6	507		
	staff had been traine and injuries of unkno	ducted and validated that d regarding abuse, neglect, wn origin and were aware ly report instances when				
	The facility's date of was validated to be 3	immediate jeopardy removal 8/28/25.				
	of Elder Abuse," which to the surveyor as the included information	ity's "Plan for the Prevention ch was undated and provided e facility's current policy, that it was the responsibility nptly report any instances of origin.				
	reportable incidents was no known cause information. On 12/1 initial report, which w Coordinator # 1, to the 7:20 AM on 12/18/24 identified with a base right shoulder, large under arm, swelling a chest and below clay	's investigative file for of injuries for which there is revealed the following 8/24 the facility submitted an eas completed by Unit in e state agency noting that at Resident # 3 had been shall size bruise on the front hematoma to his left side and bruising on his left upper ricle. The report also noted ble to lift his left arm without welling.				
	shift which began at 5's written statement investigative file read AM rounds, upon en noticed he had remo	Resident # 3 on the night 11:00 PM on 12/17/24. NA #				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	, ,	ATE SURVEY DMPLETED
		345301	B. WING _			C 03/31/2025
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217	<u>'</u>	00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	Continued From pag	e 63 and chest along with some	F 6	07		
	startled (more than use calmed down after I turning him to his left became uncomfortal his back and since hout the gown and blacame back around 5 made sure not to roll that is where his brue Moving forward I will aid to do a walk throwith changes. No maif I notice ANYTHING NURSE and I will lead DON."	raking him up he seemed usual) but he eventually talked with him. I notice while the jerked himself back and ble so I turned him back on the had not soiled himself, I wanket back over him. When I am I did change him but him on his left arm since that I noticed was located. The make sure to have another ugh with me and/or assist after how minor or major it be and we written reports to the				
	and reported the follo 12/17/24 shift which she arrived at work, told that Resident # 3 the 2nd shift. He was rounds and again at disturb him. Around Resident # 3 had bruise on his arm whand turning purple. To chest which was large but his gown partially did not pull the gown the bruising. She asshappened earlier durwere already aware report it. Nothing had did not tell Employee nurse. She did not in	wed on 3/21/25 at 11:25 AM owing information about her began at 11:00 PM. When she got report and had been 3 had been "washed up" by a sasleep in bed on first 1:00 AM and she did not 3:00 AM she noticed uising. There was a golf sized uich appeared light reddish there was bruising on his ger than what was on his arm, or covered the bruise, and she a down to look at the extent of sumed the bruising had ring another shift and staff and therefore she did not d happened on her shift. She at 1, who she thought was a mediately report the bruises at 1 further reported that				

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345301	B. WING		C 03/31/2025
	ROVIDER OR SUPPLIER	ON	STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		1 33/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION
F 607	Continued From pag	e 64 ded, she later received a	F 60	7	
F 610	phone call from the I DON (Director of Nui was supposed to rep the nurse on duty an Investigate/Prevent/0	Director of Nursing and the rsing) informed her that she ort bruises immediately to d not to wait to report.  Correct Alleged Violation	F 61	0	4/25/25
SS=D		-(4) se to allegations of abuse, or mistreatment, the facility			
	§483.12(c)(2) Have e violations are thorou	evidence that all alleged ghly investigated.			
		nt further potential abuse, or mistreatment while the ogress.			
	designated represen accordance with Stat Survey Agency, withi incident, and if the al appropriate correctiv This REQUIREMENT by:	administrator or his or her tative and to other officials in the law, including to the State in 5 working days of the leged violation is verified e action must be taken.			
	interview and Physic to complete a thorou unexplained swelling Resident # 3 experie been no reported acc not on an anticoagula completed investigat failed to identify a ho	riew, resident interview, staff ian Interview the facility failed gh investigation related to , discomfort, and bruising nced although there had cident and the resident was ant. Review of the facility's ion revealed the facility 1) spital CT (computerized I the resident's bruising		White Oak Manor Burlington will ento identify, investigate, clarify, preverous correct alleged violation of abuse, not or mistreatment.  The facility failed to complete a thore investigation related to Resident #3s unexplained swelling, discomfort, and bruising, and had no reported incide the resident was not on an anticoaguresulting in an injury of unknown sour	nt and eglect,  bugh id nt and ulant,

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(3	X3) DATE SURVEY COMPLETED
		345301	B. WING _			C <b>03/31/2025</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	03/31/2023
				323 BALDWIN ROAD		
WHITE OA	K MANOR - BURLINGT	ON		BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 610	Continued From page	e 65	F 6	10		
F 610	extended to his hip a identified in their inversity investigate discrepant noted by reviewing E with other employees resident's record and and clarify who had or resident during the strict identified in order had happened while. The findings included Resident # 3 was addred 10/19/23. The resident included dementia, or Parkinsons, atrial fibric dysphagia.  Resident # 3's annual assessment, dated 1 as severely cognitive total staff assistance hygiene needs. Resident was converted to maximum the resident was converted to the substantial to maximum the resident was not the assessment period Review of Resident # no falls in December 1.	rea which they had not estigation 2) failed to cies further which were imployee # 1's statements is statements and the an	F 6	Further the investigation of facility failed to identify a land (computerized tomograph the resident's bruising ext area; failed to investigate which were noted in staff the resident's medical rect to further clarify and questobtained a weight on Resthe shift when the injuries identified in order to deter something had happened resident was weighed. Resident # 3 was noted with positioning, swelling, and chest bruising initially Aide # 5 (NA # 5) on 12/1 report the areas to nursing administration. Employee contacted a unit coordinate administration on 3rd shift injury. It was not reported on 12/18/24 and at that tir investigation and reported the State. There was no received the state and was not able to explain bruising occurred. On 12/18/25 submitted an initial report Coordinator #1 to the State that at 7:20 AM on 12/18/25 had been identified with a bruise on the front right she in the state of the foot of the state of	nospital CT y) that showed ended to the hi discrepancies statements and ord; and failed tion who had ident #3 during were first mine if while the with discomfort and upper arm by the Nurse 7/24, and did n g or #1 never for or it to report any until the daysh me they did an if the incident to eport that an incident that jury. Resident is an incident that jury. Resident is and confusio in how the 18/24, the facili by Unit the Agency notir 24 Resident #3 baseball size noulder, large	ip id
		f 3's medication regimen for aled Resident # 3 was not		hematoma to his left side swelling and bruising on h chest and below clavicle. noted the resident was un	is left upper The report also	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDII	_		، ا	C
		345301	B. WING _				31/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	31/2023
					23 BALDWIN ROAD		
WHITE OA	K MANOR - BURLINGTO	ON			URLINGTON, NC 27217		
	OLIMAN DV OT	ATEMENT OF REFIGIENCIES		_	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	e 66	F	310			
	Review of the facility's	s investigative file for			left arm without pain and there was		
	reportable incidents of	of injuries for which there			swelling. The attending physician		
	was no known cause	revealed the following			evaluated Resident #3 on 12/18/24 and	t	
		3/24 the facility submitted an			the bruising was on the arms and ches		
	initial report, which wa				wall which wrapped around some on th		
		e state agency noting that at			torso. Resident #3 had some left shoul	der	
		Resident # 3 had been			pain. Prior to 12/18/24, there was no		
		ball size bruise on the front			history of the resident having a		
		nematoma to his left side			pacemaker.		
	_	nd bruising on his left upper icle. The report also noted			During investigation, Employee #1 was collecting Resident #3's routine oxyger		
		ole to lift his left arm without			saturation (94%) when noticed the	•	
	pain and there was sv				resident had some bruising to the right		
	pain and thoro was o	weiling.			shoulder and left side and the next shif		
	Review of Employee	# 1's statement, which was			also brought it to Employee #1s attenti		
		s investigative file read, "I			and reported it to the Unit Coordinator.		
	was collecting [Resid				There was no further notation by		
	(oxygen) when I notic	e he had some bruising to			Employee #1 and did not clarify who ha	ad	
	_	well as some to his left. No			obtained a weight on the resident durin	g	
	_	ported from the previous			the shift when the injuries were first		
		o my next thought was to			identified to determine if something had		
	_	ordinators attn. (attention)			happened while the resident was weigh		
		on him. Before I could bring it			(127 pounds documented as weighed)		
	_	attention it was brought to			On 12/18/24, NA #6 passed Resident # breakfast tray on 12/18/24 and noted	FIS	
	l	ore by the next shift and ator got here I immediately			bruises on right shoulder and left upper	-	
	let her know my findir	•			quadrant. According to statement, NA		
	documented properly	•			notified the 3rd shift nurse which was	70	
	accamented property	•			Employee #1. NA #6 saw Employee #1	go	
	A review of Resident	# 3's vital sign log revealed			into Resident #3's room to look at the	5	
		ented Resident # 3's oxygen			bruises. The facility did not clarify furth	er	
		12/18/24 at 12:56 AM.			with Employee #1 of discrepancies in t		
	,	ee # 1's statement this was			statements and who obtained Residen	t	
		bruises.) The reading was			#3s weight.		
		otation it was taken again			On 12/20/24, Unit Coordinator #1 noted	b	
		ift. Employee # 1 also			Resident #3's bruising was spreading		
		t # 3's weight was 127			from bilateral shoulders down into the		
	pounds at 6:38 AM or	n 12/18/24.			abdomen, left arm, and left side rib cag		
			1	- 1	and Resident #3 was transferred to the	!	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		5 14/110			С
	345301	B. WING _			03/31/2025
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
WHITE OAK MANOR - BURLING	TON.		323 BALDWIN ROAD		
WITTE OAK MANOK - BOKEING	ION		BURLINGTON, NC 27217		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	
assigned to care for shift which began at 5's written statemen investigative file read AM rounds, upon en noticed he had remowhich he usually doe bruising on his arm a swelling. Upon me we startled (more than usualmed down after I turning him to his left became uncomfortath his back and since he put the gown and blacame back around 5 made sure not to rol that is where his bruing forward I will aid to do a walk throwith changes. No mis if I notice ANYTHING NURSE and I will lead DON."  NA# 5 was interviewed and reported the foll 12/17/24 shift which she arrived at work, told that Resident # the 2nd shift. He was rounds and again at disturb him. Around Resident # 3 had bruisted bruise on his a reddish and turning his chest which was	sheets, NA # 5 was Resident # 3 on the night 11:00 PM on 12/17/24. NA #	F6	hospital for further evaluation thought something had happy pacemaker spontaneously, caused bleeding under the subspread downwards. The fact identify and review closely the results that revealed a large subpectoral hematoma under pacer control box measuring 5.2cm and a superficial soft contusion of the left flank and Emergency Department (EE revealed Resident #3 had exand abdominal wall ecchyminate facility did not further investic contusion of the hip that was the CT scan. It was also not the attending physicians atte CT in the ED showed a confusion of the hip that was the ct scan. It has also not the attending physicians atte CT in the ED showed a confusion to the related to the 12/18/24 incides separate event. The attending was not entirely sure but wo something would have had to cause a pacemaker to move so.  On 4/10/25, an audit of currowas completed by the Safet ensure no other residents we with bruising, discomfort and if so to ensure proper and time notification and a thorough it was completed. Also, an aureportables involving injury of sources was reviewed to en investigation was thorough widentification, clarification as prevented or corrected the approximation and a prev	pened to the which had skin and hip. The consis. The state of the stat	est  on the e as an at o one ats ed and

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	E SURVEY IPLETED
		345301	B. WING		0.	C 3/31/2025
NAME OF PE	ROVIDER OR SUPPLIER	0.000		STREET ADDRESS, CITY, STATE, ZIP CODE		0/31/2025
TO THE OT TH	TO VIDER ON OUT FILER			323 BALDWIN ROAD		
WHITE OA	K MANOR - BURLINGT	ON				
				BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	Continued From page	<b>≘</b> 68	F 61	0		
F 610	and she did not pull the extent of the bruising had happened earlier Nothing had happened tell Employee # 1, who she thought Employee # 3's room before her during the night shift Employee # 1 go into During a follow up into 3/24/25 at 1:02 PM, Nobtained Resident # 3 documented on 12/18 Review of the facility's statement from NA # Employee # 1 had claabout the bruises who approached her about time on 12/18/24, alth written statement she of them when she chelevel during the night. "On 12/18/24 I came (breakfast trays). I go soon I drop it off, I sa bruises on his right sl As soon I saw the brunurse [Employee # 1] 3's] room and showed me that this first time falls last night."	the gown down to look at the she assumed the bruising of during another shift. She did not no she thought was a nurse. He # 1 had been in Resident of (NA # 5) at some time but she did not see Resident # 3's room.  Herview with NA # 5 on NA # 5 reported she had not 3's weight that had been 3/24 at 6:38 AM.  Her in the bruises at breakfast aimed she knew nothing en Nurse Aide # 6 at the bruises at breakfast are ecked the resident's oxygen and NA # 6's statement read, to work passing the trays at [Resident # 3's] tray. As we him with no shirt on. I saw moulder, left upper quadrant. Lises I talked to 3rd shift all the bruises. She told seeing this, that they had no sterviewed on 3/25/25 at 2:57	F 61	violation of abuse, neglect, or mistreatment.  Current and newly admitted residentified areas of bruising, dis and swelling will be reported in to administration for further invand the investigation will be the they have unexplained areas.  Current facility staff were re-edreporting unexplained bruises, and discomfort at the time it is because it could be a sign of a neglect and require further inverthe re-education was completed DON, SDC, and Administrator Newly hired facility staff will receducation during their job spectorientation by the Staff Develoy Coordinator (SDC).  The Administrator, DON and Administrative staff were re-educated the Corporate Consultant on conthorough investigation such as unexplained swelling, discomfor bruising when there had not be reported incident or fall and the was not on an anticoagulant. Tre-education also included to it areas such as in hospital recorrequire further investigation, to discrepancies further when not statements and/or residents more records, and to further clarify a staff when needed as the investigation areas that are not completed in the complete contents and the contents are such as the investigation areas such as the investigation areas areas that are not completed in the contents and the contents are such as the investigation areas areas that are not completed in the contents and the contents are such as the investigation areas areas that are not completed in the contents are such as the investigation areas areas that are not completed in the contents areas that are not completed in the contents and the contents are not contents and the contents are not co	comfort nmediately estigation brough if  lucated on swelling noted buse or estigation. ed by the on 3/26/25. beive this diffic broment  ucated by brompleting a for bort, and been a be resident the dentify des that investigate led in staff edical nd question pletely	
	nurse at the facility but and had not complete	had been working as a ut had no license as a nurse ed any formal health care £1 acknowledged she had		explained, such as who and which injuries were first identified in condetermine if something had had during care. The re-education of the condetermine is such as who are also are as who are the condetermine in the condetermine is such as who are also w	order to ppened	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
		345301	B. WING _			1	C 3/ <b>31/2025</b>
NAME OF PE	ROVIDER OR SUPPLIER	1 111		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	1/3 1/2023
					23 BALDWIN ROAD		
WHITE OA	K MANOR - BURLINGT	ON					
					BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From pag	e 69	F 6	310			
	falsely provided infor	mation to the facility and			completed on 4/14/25. Newly hired fac	ility	
	given them another i	ndividual's nursing license.			staff will receive this education during t	heir	
	Employee # 1 was in				job specific orientation by the Staff		
		and reported she had called			Development Coordinator (SDC).		
	the DON at "12 some	ething" when she did the			The Corporate Consultant will monitor	5	
	oxygen level and sav	v bruising. Employee # 1			residents weekly for 12 weeks to ensur	re	
	reported she did not	know who obtained Resident			any identified unexplained bruises,		
	#3's weight which sh	ne had recorded.			discomfort and swelling is appropriatel	y	
					reported for further investigation. The		
	Interview with Unit C	oodinator # 1 revealed she			monitoring will also include that a		
		of the bruising on the morning			thorough investigation was completed,		
	of 12/18/24. She had	been stopped in the hallway			identified areas are further investigated	ť	
		told her about it. She knew			and no details are missed, the		
		ad been aware of the bruising			investigation includes further investigation		
	and had said she had	d "just seen it."			of any discrepancies with staff stateme	nts	
					and/or residents medical records, and		
		otes revealed the first entry			clarification and questioning of staff as		
	•	ident's bruising was on			needed for the investigation is complet	ed.	
		by Nurse # 1. The entry was			The results from the monitoring will be		
		rd as a late entry on the date			discussed during the morning Quality	40	
		M. The entry read, "Resident			Improvement (QI) meetings, weekly for		
		writer made aware during			weeks. Identified issues or trends will be		
		ad bruising to left side of			further discussed at the monthly Qualit	-	
	=	irms. VS 128/77 (blood			Assurance (QA) meeting with the team and recommendations made as indica		
	pressure), 97 % on					.eu.	
		emperature), 63 (pulse.) No oms) of SOB (shortness of			The DON and Administrator are responsible for the ongoing compliance	a of	
	` • .	labored breathing . Facial			F610.	<del>5</del> 01	
		n resident move his left arm.			Compliance date is 4/25/25.		
		pe repositioned" Nurse # 1			Compliance date is 4/20/25.		
		nt # 3 had an order for					
		grams) 2 tabs every 6 hours.					
		the physician was notified					
		ained for a stat x-ray on the					<b> </b>
		left arm. The DON, Unit					
	~	ial worker were also notified.					
		otes revealed on 12/20/24 at ordinator noted that Resident					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345301	B. WING		03/31/2025
	PLAN OF CORRECTION  345301  ME OF PROVIDER OR SUPPLIER  HITE OAK MANOR - BURLINGTON  K4) ID  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217	1 00.02020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 610			F 610		
	shoulders down into left side rib cage and	his abdomen, left arm, and he was being transferred to			
	notes revealed the fo documented. Reside	llowing information was nt # 3 had extensive chest			
	abdomen and pelvis The CT "impression"	with contrast was completed. read, "1) large left			
	box measuring 9.5 X tissue contusion of the other CT evidence of	5.2 cm. 2) Superficial soft the left flank and hip 3) No fracute traumatic injury to the			
	coronary artery disea discharge, the ED ph	se." Upon preparing for ysician did not note any			
	ED physician did not demonstrating hema site but otherwise su	e "CT scan obtained toma around his pacemaker perficial contusion." There			
	could have formed a	round the pacemaker site. ed to be stable for discharge			
	hematoma, left" and	•			
	3/21/25 at 3:13 PM a information. When sh 12/18/24 the bruising which included areas	nd reported the following ne evaluated Resident # 3 on was all on his upper body on his arms and chest wall			
	did not recall any bru when she examined	ising extending to his hip him on 12/18/24. He was t shoulder pain. Prior to			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG		Ι ,	С
		345301	B. WING				31/2025
	ROVIDER OR SUPPLIER	TON	•	323	EET ADDRESS, CITY, STATE, ZIP CODE  BALDWIN ROAD  RLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	had a pacemaker. It the date of 12/18/24 noticeable and appelateral position and area. The resident had was not able to occurred when she the staff he had falle could go totally by because of his confit to be reviewed also make mention of pritself. The ED physi in his notes about the which had shown upbeen brought to her ED showed a contuinsure if the contust to the 12/18/24 incident had made a referral had canceled the apphysician) was not a aware of what type when the pacemaker say 100 % for sure, something would hapacemaker to move know how far it coult to refer to a cardiological content.	been no history the resident The resident was thin and on It the pacemaker was eared to be turned more to a more towards the antecubital had poor safety awareness explain how the bruising talked to him. If he had told en, she was not sure the staff what the resident had said usion. He was sent to the ED hybician did not oblems with the pacemaker cian also had not put anything he contusion to the left hip on the CT scan. It had not reattention that the CT in the sion to the left hip was related dent or a separate event. They for a cardiologist, but the son opointment. She (the a cardiologist and was not of stiches had been placed er had originally been placed. It over time scar tissue would maker in place. She could not but would think that ave had to happen to cause a er if it had done so. She did not lid be moved. She would have	F	610			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			03/3	1/2025
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP C 323 BALDWIN ROAD BURLINGTON, NC 27217	ODE	00/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 610	information. They had investigation following bruising on 12/18/24. called on her shift to reported until the day time they did an investincident to the state. reported they witness have an accident for particular cause to the something had happed spontaneously, which the skin and had sprenot been aware that the was a contusion of the included that in their had been sent to the computer without this attention.  During a follow up into on 3/24/25 at 4:15 Photo they did not look into 3's weight on the shift to have the injury. The assumed Employee fronted it in the record.  Review of the facility' agency revealed the 12/20/24 without any that there had been a left hip identified. Also the five-day complete noted that by Employ noted the bruises where sident's oxygen levidiscrepancies in state of the st	d conducted their g the identification of the Employee # 1 had never report any injury. It was not shift on 12/18/24 and at that stigation and reported the None of the staff had sed Resident # 3 to fall or them to conclude a e bruising. They thought ened to the pacemaker in had caused bleeding under ead downwards. They had the hospital CT showed there e hip also and had not investigation. The ED report in and scanned into their is being drawn to their is being drawn to their erview with the Administrator of the Administrator reported who actually did Resident # it on which he was identified e Administrator reported he if 1 did the weight since she is five-day report to the state DON submitted the report on mention of the ED's findings in contusion to Resident # 3's in the the control of	F	510			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			1	C 31/2025	
	ROVIDER OR SUPPLIER	ON	•	3:	TREET ADDRESS, CITY, STATE, ZIP CODE 23 BALDWIN ROAD 3 BALDWIN, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 610	his oxygen level. Acc statement, Employee anything about the bipointed out to her at There was no indicat further questioned in discrepancies accound Quality of Care CFR(s): 483.25  § 483.25 Quality of Caulity of care is a function of a resist that residents receive accordance with profipractice, the compression of a resist that residents receive accordance with profipractice, the compression of a resist that residents receives accordance with profipractice, the compression of a resist that residents receives accordance with profipractice, the compression of a resist that residents receives accordance with profipractice, the compression of a resist that residents and the resident plant, and the resident positioning, swelling, chest with no known was not receiving an Resident # 3's was a	pruises when she checked cording to NA # 6's # 1 denied she knew ruises when they were breakfast time on 12/18/24. ion Employee # 1 was the five-day report and nted for.  are undamental principle that nt and care provided to sed on the comprehensive dent, the facility must ensure extreatment and care in essional standards of nensive person-centered sidents' choices.  I is not met as evidenced  iew, and interviews with Nurse Practitioner, the facility dent # 3 was initially after Nurse Aide # 5 to have discomfort with and bruises on his arm and cause and while the resident anticoagulant. When ssessed the following shift		610	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 standard practice, the comprehensive person-centered care plan, and the residents choices.	o n s of	4/25/25	
	both arms and the re broader area than ha Aide # 5. The bruisin included both red and bruises continued to	ciple bruises were found on sident's chest which was a lead been reported by Nurse g was irregular in shape and d purple bruising. The spread and two days entification of the bruises,			1.Resident # 3 was noted with discomf with positioning, swelling, and upper ar 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	rm e		

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	7. 0930 <del>-</del> 0391
· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345301	B. WING _			1	31/2025
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				32	23 BALDWIN ROAD		
WHITE OA	AK MANOR - BURLINGT	ON		В	URLINGTON, NC 27217		
0(1) 15	CUMMARY CT	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL	ID PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
					DEFICIENCY)		
F 684	Continued From page		F6	684			
		en in the ED (Emergency			shift. When evaluated by the physician	on	
	Department) where a	•			12/18/24, Resident # 3 had multiple		
		chest abdomen and pelvis			bruises on both arms and a broader ar		
	with contrast was cor	•			on the chest than initially found. The ar		
		) large left subpectoral			was irregular in shape with red and pur		
	,	on of blood, usually clotted,			bruising. Resident # 3 was transferred		
	control box measurin	ssel) underlying pacer			the Emergency Department on 12/20/2 for an evaluation and CT findings inclu-		
	I .	e contusion of the left flank			a large left subpectoral hematoma	Jeu	
		ly, the facility failed to ensure			underlying the pacer control box		
	staff communicated a	•			measuring 9.5cm X 5.2cm and a		
	I .	Resident # 9's documented			superficial soft tissue contusion of the I	eft	
		blood sugar readings and			flank and hip.		
	_	he was monitored for			On 3/26/25, an audit of current residen	ts	
		er that he receive treatment.			was completed by the Unit Coordinator		
	On three consecutive				to ensure no other residents were		
	documented finger st	tick blood sugar (FSBS)			identified with skin abnormalities such	as	
	exceeded 400 or regi				bruising, discomfort and swelling, and		
		rmittent readings had already			were not communicated to the nurse o	r	
	_	the month of January 2025.			the provider to be assessed. No new s		
		24/25 after Resident # 9's			abnormalities were identified. All identified	fied	
	_	er stick blood sugar (FSBS)			abnormalities were previously		
		24 the resident fell in the			communicated to the nurse for an initia		
		ecoming dizzy. The resident			assessment and reported to the provid	er	
		e hospital where he was			with no delay in their assessment.	ı iith	
		all subdural hematoma (type r brain that can happen after			Current and newly admitted residents videntified areas of bruising, discomfort	viui	
		acility also failed to ensure			and swelling will be reported to nurses	to	
		ed an assessment by a			be initially assessed and will be reported		
		while on an anticoagulant			to the provider for further assessment		
	_	for three of five sampled			no delay in care.		
	I .	or professional standards of			On 3/26/25 to 3/27/25, the DON, Staff	ſ	
	practice.	1			Development Coordinator (SDC) and the	ne	
					Administrator completed re-education		
	Immediate Jeopardy	began on 12/18/24 for			current staff in the process of notifying		
	1	urse Aide # 5 identified			nurse of any injuries or changes in the		
	during her shift that F	Resident # 3 had unexplained			residents condition to ensure residents	ĺ	
	_	d discomfort and there was			are initially assessed by a nurse. Newly	y	
	no assessment by a	nurse. Immediate Jeopardy			hired staff will receive this education		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345301	B. WING			C <b>03/31/2025</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<b>I</b>	00/01/2020	
				323 BALDWIN ROAD			
WHITE OA	AK MANOR - BURLINGT	ON		BURLINGTON, NC 27217			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5) COMPLETION	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	· ·	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 684	Continued From pag	e 75	F 68	4			
		9 on 1/8/25 when his FSBS		during their job specific orientation	on by the		
		ne facility failed to effectively		SDC.			
	treat his dangerously			The DON and SDC also re-educ			
		was removed on 3/28/25		licensed nurses on the importan			
		emented an acceptable		assessing the residents immedia			
	credible allegation of			injury or change in condition is r	•		
	-	will remain out of compliance		them and to report to the provide			
		severity level of E to ensure		ensure there is no delay in their			
		ed and monitoring systems tive.Example#3 was cited		assessment and care for the res This re-education was also com			
	at a scope and sever	•		3/26/25 to 3/27/25. Newly hired			
	at a scope and sever	ity level of D.		nurses will receive this education			
	The findings included	4.		their job specific orientation by the	•		
	The infangs moladed	4.		The DON or designated manage			
	1. Resident # 3 was	admitted to the facility on		nurse will monitor 5 residents we			
		nt's diagnoses in part		12 weeks to ensure any significa	-		
		ongestive heart failure,		change in condition such as idea			
	Parkinson's, atrial fib	_		bruises, discomfort and swelling			
	dysphagia.	•		reported to nursing for initial ass	essment		
				and reported to the provider to a	ssess the		
	Review of physician	orders revealed Resident # 3		residents and no delay in the res	sidents		
	was not ordered to re	eceive an anticoagulant.		care.			
				2.Resident # 9 is a diabetic and			
		l Minimum Data Set (MDS)		with multiple occurrences (1/8/2			
		0/14/24, coded the resident		finger stick blood sugar (FSBS)			
		ly impaired and as needing		1/10/25 with a FSBSs of 433 and	•		
		for bathing, dressing, and		1/18/25 with a FSBS of 413, 1/2			
		dent # 3 was coded as		a FSBSs of 453 and 456, 1/23/2			
		derate assistance to roll		FSBSs of 419 and 403, 1/24/25			
	from side to side in b	_		FSBSs of high and 524) of serio	•		
		um assistance to transfer.		elevated blood sugars (greater t			
		ded as using a manual		and the provider was not notified provide orders to address the el			
		feet after set-up assistance. coded as having falls during		blood sugars. During this time p			
	the assessment period	_		Resident # 9 did not have orders			
	uno assossinieni peni			sliding scale insulin or paramete			
	   Review of Resident ±	# 3's care plan revealed the		notifying the physician of elevate			
		. On 10/19/23 staff added the		sugars. On 1/24/25 after Reside			
		or falls. This remained part		last documented FSBS reading			
		eae. iine remaniea part	1	,st accamented i obe reading	<del></del> . ,		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		l ,	0
		345301	B. WING _				C <b>31/2025</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
W// UTE 0.4	WAANOD DUDI INOT			32	23 BALDWIN ROAD		
WHITE OF	AK MANOR - BURLINGT	ION		В	SURLINGTON, NC 27217		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From pag	ne 76	F	684			
		ve care plan. On 10/27/23			the resident fell after becoming dizzy.		
		lent picked at his skin			Resident # 9 was transferred to the		
		nd bruises at times. This			hospital and diagnosed with a small		
		the resident's active care			subdural hematoma. In January, sever	al	
		iff added that Resident # 3			nurses and nurses on subsequent shift		
	•	with care. This remained as			failed to notify the provider of the eleva		
	part of the resident's	active care plan.			blood sugars resulting in delayed		
	•	·			assessments, treatments and monitorii	ng.	
	Review of the facility	's investigative file for			On 1/24/25, Resident # 9 readmitted w	ith	
	reportable incidents	of injuries for which there			orders for sliding scale insulin and FSE	S	
	was no known cause	e revealed the following			parameters of greater than 400 to cont	act	
	information. On 12/1	8/24 the facility submitted an			the provider.		
		vas completed by Unit			On 3/26/25, an audit was completed by		
		he state agency noting that at			the DON of current residents with FSB	S	
		4 Resident # 3 had been			readings was reviewed to ensure any		
		eball size bruise on the front			noted elevated blood sugars (greater th	ıan	
	_	hematoma to his left side			400) from 3/19/25 to 3/25/25 were		
		and bruising on his left upper			communicated among the nursing staff		
		vicle. The report also noted able to lift his left arm without			and reported to the provider to obtain orders to address the elevated blood		
	pain and there was s	sweiling.			sugars and monitoring completed for hyperglycemia for proper treatment.		
	Paview of staffing sh	neets revealed on the night			Identified elevations without proper		
		11:00 PM on 12/17/24 and			physician notifications were		
		n 12/18/24, Employee # 1			communicated by the DON to the prov	der	
		e for Resident # 3 as a nurse.			on 3/25/25 and no further orders were	uo.	
	, mas assigned to sair				given for the identified residents.		
	Review of Employee	e # 1's personnel file revealed			Current and newly admitted residents v	vith	
		ired as a nurse but was not			FSBS readings will be communicated		
		and her application prior to			among nursing and the provider and		
	hire indicated no nur				monitored for hyperglycemia in order to	)	
					receive proper treatment.		
	During an interview	with the DON (Director of			On 3/26/25, the Quality Information		
	Nursing) on 3/21/25	at 9:00 AM, the DON			Manager (QIM) audited and entered th	е	
		oyee # 1 had submitted			verbiage to each blood sugar on the		
	someone else's nurs	sing license number upon hire			Medication Administration Record (MA	R)	
		ind was terminated in			with the following, blood sugar greater		
	· ·	n this had been validated. At			than 400 call the provider for		
	the time she had bee	en caring for Resident # 3 on			communication to the provider.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		l ,	0	
		345301	B. WING _				C <b>31/2025</b>	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WILLIE O	NAMES BURNING			32	23 BALDWIN ROAD			
WHITE O	AK MANOR - BURLING	ION		В	SURLINGTON, NC 27217			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 684	Continued From pag	ne 77	F	684				
		17/24, the facility had not			The Licensed Nurses and Medication			
		rsonating a nurse and was			Aides were re-educated by the DON or	1		
	-	ned to perform assessments			communicating significantly elevated	•		
	and nursing duties.	то по			blood sugars to subsequent shifts for			
					ongoing monitoring by the licensed nur	se.		
	Review of Employee	e # 1's statement read, "I was			The Licensed Nurses and Medication			
	collecting [Resident	# 3's] routine 02 (oxygen)			aides were educated on the elevated			
	when I notice he had	d some bruising to his right			blood sugar readings will be recorded	วท		
		some to his left. No fall or			the shift-to-shift report sheet to ensure			
		ed from the previous shift to			that the elevations are communicated a			
		next thought was to bring it to			addressed, and follow-up is completed			
		s attn. that he had bruising on			The re-education also included the			
		oring it to [Unit Coordinator's]			communication to the provider when			
		ght to my attention once			elevated FSBS readings that exceed 4	J0		
	more by the next shi				and the provider can provide orders to			
		, I immediately let her know lid be documented properly."			address the elevated blood sugars to prevent further issues such as dizzines			
	iny indings so it cou	ild be documented property.			or a fall. This re-education was comple			
	   Employee # 1 was ir	nterviewed on 3/25/25 at 2:57			on 3/26/25. Newly hired Licensed Nurs			
		jed she had given someone			and Medication Aides will receive this	CG		
		e number who shared a			education during their job specific			
		facility in order to work as a			orientation by the SDC.			
		Employee # 1 she completed			The DON or designated management			
		ucation or Nurse Aide			nurse will monitor all recorded blood			
		ed she had some medical			sugars from the previous day beginnir	g		
	assistant training fro	m another state but had not			on 3/27/25 to ensure all blood sugar			
	completed that eithe	r. She was interviewed			elevations above 400 are addressed a			
		#3's bruises and reported she			reported to the provider 5 days a week	for		
		at "12 something" when she			4 weeks and then 3 days a week for 8			
		00 PM to 7:00 AM shift which			weeks.			
	_	when she did the oxygen level			The DON or designated management			
		. Employee # 1 reported she			nurse will monitor all shift-to shift repor			
		otained Resident # 3's weight			to ensure that the elevated blood suga	'S		
		ded. Employee # 1 did not			are recorded on the report and			
		es occurred and reported she			communicated to the next shift. The			
	would never do anyt	hing to hurt a resident.			monitoring will be completed 5 days a			
	A review of Residen	review of Resident # 3's vital sign log revealed			week for 4 weeks, and then 3 days a week for 8 weeks.			
		nented Resident # 3's oxygen			3.Resident # 11 experienced a fall on			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		(	•	
		345301	B. WING				31/2025	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·		
W// UTE 0.4	K MANOD DUDUNOT	-0.1		3	23 BALDWIN ROAD			
WHITE OF	AK MANOR - BURLINGT	ON		В	SURLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From pag	ne 78	F	684				
	level was checked a	t 12/18/24 at 12:56 AM. The			1/9/25 and failed to ensure the residen	t		
	_	here was no notation it was			received an assessment by a nurse			
	taken again on Empl	loyee # 1's shift.			following a fall while on an anticoagular	nt		
					which increased their risk for bleeding.			
	According to staffing				On 4/9/25, an audit of current residents	,		
		Resident # 3 on the night			with falls including residents on			
	5's written statement	11:00 PM on 12/17/24. NA#			anticoagulant medications was reviewed to ensure they received an assessmen			
		d, "When I was doing my 3:00			a licensed nurse following a fall. No oth			
		tering [Resident # 3's] room I			assessments by a licensed nurse were			
		oved his gown and blanket			missing. This audit was completed by t			
		es. However, I noticed some			DON and the Safety Licensed Nurse.			
	bruising on his arm a	and chest along with some			Current and newly admitted residents v	vill		
		aking him up he seemed			receive an assessment by a licensed			
	,	usual) but he eventually			nurse following any falls including			
		talked with him. I noticed			residents on anticoagulant medication.			
	_	his left he jerked himself back			The Licensed Nurses were re-educated	ו		
		ortable so I turned him back be he had not soiled himself, I			by the DON, SDC, and management nurses on providing an assessment			
		anket back over him. When I			following falls including residents on			
		AM I did change him but			anticoagulant medication which puts th	e		
		him on his left arm since			residents at a greater risk of bleeding.			
		ise that I noticed was located.			This re-education was completed on			
	Moving forward I will	make sure to have another			4/14/25. Newly hired Licensed Nurses	will		
	aid to do a walk thro	ugh with me and/or assist			receive this education during their job			
	_	atter how minor or major it be			specific orientation by the SDC.			
		G it will be reported to the			The DON or Safety Licensed Nurse wil	I		
		ave written reports to the			monitor all fall events beginning on			
	DON."				4/10/25 weekly for 4 weeks and then u	o to		
	NΔ # 5 was intention	ved on 3/21/25 at 11:25 AM			5 falls a week for 8 weeks to ensure residents receive an assessment by a			
		owing information about her			licensed nurse following falls including			
	•	began at 11:00 PM. When			residents on anticoagulant medication.			
		she got report and had been			The results from the monitoring tools w			
		3 had been "washed up" by			be discussed during the morning Quali			
		M to 11:00 PM). He was			Improvement (QI) meetings, weekly for			
		t rounds and again at 1:00			weeks. Identified issues or trends will b			
		disturb him. Around 3:00 AM			further discussed at the monthly Qualit	y		
	she noticed Residen	t # 3 had bruising. There was			Assurance (QA) meeting with the team			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345301	B. WING				C <b>31/2025</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP CODE	1 03/	31/2025	
			323 BALDWIN ROAD		LDWIN ROAD			
WHITE OA	K MANOR - BURLINGTO	ON		BURLI	NGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	was bruising on his ch what was on his arm, covered the bruise, and down to look at the ex- assumed the bruising during another shift a were already aware of on her shift. She did r she thought was a nu # 1 had been in Resid	e on his arm which in and turning purple. There hest which was larger than but his gown partially ind she did not pull the gown ktent of the bruising. She had happened earlier ind therefore the nurses if it. Nothing had happened hot tell Employee # 1, who irse. She thought Employee lent # 3's room before her	F 6	and The	d recommendations made as indicate DON is responsible for the ongoing mpliance of F684.  Simpliance date is 4/25/25.			
	she did not see Empload's room and did not be for the resident that in the resident and the resident able to make during report that resident able to make during report that resident able to make during report that resident resident resident resident resident refused to be further noted Resident Tylenol 325 mg (millig Nurse # 1 also noted and orders were obta	otes revealed the first entry ssment of Resident #3 was M by Nurse # 1. The entry record as a late entry on the 08 AM. The entry read, we needs writer made aware dent had bruising to left side arms. VS (vital signs) re), 97 % on RA (room air), of (temperature), 63 (pulse.) reptoms) of SOB (shortness or labored breathing. Facial in resident move his left arm. e repositioned" Nurse # 1						
	Coordinator, and Soc notified.	ial Worker were also						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			C 03/31/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 323 BALDWIN ROAD BURLINGTON, NC 27217	•	313 112023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	An attempt was made 3/21/25 at 12:01 PM areached for an intervious reached for an intervious and arms. May put in DON office Sup Doctor), and DON awares # 2 was intervious and reported the date of 12/18/24 she 11:00 AM because Not that day. She had been bruises in report at 11 him and found bruises. When he talked, he may him yes and no quest simple questions. When he had fallen, I the closet area of the able to convey more are sident's physician, when the talked is the closet area of the able to convey more are sident's physician, when the more physician president's physician, when the physician president's physician, when the physician president's physician president's physician, when the physician president's physician president's physician, when the physician president's physician president	e to interview Nurse # 1 on and she could not be ew.  y was dated 12/18/24 at 2 and read, "Was informed rese that resident had chest area. Resident has chest, sides of chest, easurements obtained and pervisor, MD (Medical rare."  ewed on 3/21/25 at 10:28 following information. On the had reported to work at urse # 1 had to leave early en told about Resident # 3's :00 AM and went to assess so on his arms and chest. Sumbled but if she asked ions he would answer en asked if he had fallen, ied, "yes." When asked Resident # 3 had pointed to room. The resident was not about the incident.  Progress notes revealed the who served as the facility essed Resident # 3 on an noted, "He (Resident # ming to have bruising on his as cognitive impairment and that happened. Last BIMS ental status) 2/15. He seems en moving the left shoulder. He was given Tylenol for	F6	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45004		_			C
		345301	B. WING			03/	31/2025
	ROVIDER OR SUPPLIER	ON		3:	TREET ADDRESS, CITY, STATE, ZIP CODE  23 BALDWIN ROAD  BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Bruises were irregular measured at largest of chest upper near mid (centimeters) reddish area inferior to it. Rig (joint at the top of the abrasion. Right shoul 6 cm irregular shaped deeper purple underredown about 5 X 8 cm arm-3 circular bruises bicep mid to distal an wall- Pacemaker scan shaped purplish red to more lateral and turnerabout 7 X 3 cm redd shoulder near clavicle about 10 X 4 cm inferiarm. Left arm-irregular bicep with varying coinferior, 12 X 4 cm aram. 8 X 3 cm circular medial to elbow. Large purplish edges wraps nipple, darker purple ecchymosis (discolor caused by bruising) rebelow waist." Within the physician noted a checount would be obtain noted that she was unhad been placed or large times.	bruising as follows: "Note or shaped and were diameter. Right anterior line, about 5.5 X 3.5 cm with some faint purplish the shoulder near AC joint of shoulder) circular reddish der lateral clavicle about 7 x direddish bruise with faint neath it extending further at largest diameter. Right is about 1 cm each-2 inner did 1 lateral inferior. Left chest or with 6 small irregular bruises. Pacemaker appears ed/sticking out. Left side ish bruise with faint edges in each action on lateral upper fair shaped bruise going down lors-reddish to darker purple found to lateral aspect of or bruise purplish inferior and geleft chest wall bruise light is around chest lateral to on posterior chest. No ation of the skin, typically neck, facial area, or body the progress note, the est x-ray and complete blood ned. The physician further insure when the pacemaker ast tested. She further noted ared to be "turned/sticking"	F	684			
	Resident # 3's chest	x-ray was normal.					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION  IG		COMPLETED		
		345301	B. WING			C <b>03/31/2025</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217		03/31/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 684	Review of the 12/18/ that the pacemaker of any abnormalities with resident's heart or luthe report was "negated the resident revealed the resident (Low platelets can in bleeding.)  On 12/19/24 Resider (Nurse Practitioner) information. Resident count) did not show platelets), and the chartent had been a compacemaker had been asked for a reread of 3 denied pain at the linterview with Resident on 3/24/25 at 5:15 Plaware of how the brureported she attemp who performed the could determine if so resident's pacemaker determine.  Review of nursing not 2:21 PM Unit Coordiff 3's bruising was specified and the hospital for further linterview with Unit Coordiff and the could determine was specified and the hospital for further linterview with Unit Coordiff and the hospital for further linterview with Unit Coordiff and the could determine was specified and the hospital for further linterview with Unit Coordiff and the could be specified and the hospital for further linterview with Unit Coordiff and the could be specified and the linterview with Unit Coordiff and the could be specified and the linterview with Unit Coordiff and the	24 Chest x-ray result showed was present but did not note the the pacemaker or with the ngs. The radiologist noted ative."  2 # 3's 12/18/24 CBC result the place to complete the chance of the the	F6	84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER:  A. BUILDING			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345301	B. WING				C 31/2025	
	ROVIDER OR SUPPLIER	ON		323	REET ADDRESS, CITY, STATE, ZIP CODE  BALDWIN ROAD  RLINGTON, NC 27217	1 03/	31/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 83	F	684				
F 004	bruising on the morni been stopped in the half told her about it. She to be on the resident's spread downwards.  Review of 12/20/24 Enotes revealed the form documented. Resider and abdominal wall end Tomography) of the cowith contrast was considered, "1" hematoma (a collection outside of a blood vestion to box measuring Superficial soft tissue and hip 3) No other Contraumatic injury to the 4) emphysema, 5) co	ang of 12/18/24. She had hallway but did not recall who initially recalled the bruising is shoulder and over time it.  ED (Emergency Department) Illowing information was in # 3 had extensive chest occhymosis. A CT (Computed thest abdomen and pelvis inpleted. The CT.) large left subpectoral on of blood, usually clotted, issel) underlying pacer in g. 9.5 X 5.2 cm. 2) is contusion of the left flank incompleted. The left flank incompleted in the left flank		584				
	preparing for discharge note any further commonte any further commonte any further contusion. The ED probtained demonstration pacemaker site but of contusion." There was the hematoma could pacemaker site. The stable for discharge fidiagnosis of "chest w" superficial bruising of ED discharge orders.  On 12/20/24 at 10:55 Resident # 3 returned distress, no pain, and	ge, the ED physician did not ments about the hip hysician did note "CT scan ng hematoma around his therwise superficial s no notation regarding how have formed around the resident was noted to be rom the ED with a final all hematoma, left" and of back, left." There were no PM Nurse # 1 documented a from the hospital in no I no new orders.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		IDENTIFICATION NI IMBED		) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345301	B. WING _			1	C <b>31/2025</b>	
	ROVIDER OR SUPPLIER	ON		323 I	EET ADDRESS, CITY, STATE, ZIP CODE BALDWIN ROAD RLINGTON, NC 27217	1 00/	01/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 684	and trained to do an when she was caring injury was first observed.  2. Record review revadmitted to the facilit diagnoses which in palzheimer's dementia cardiomyopathy, and Review of physician was ordered to receive every 12 hours for at on 11/8/24. (Eliquis is increases the chance Review of Resident # Data Set assessment Resident #9 as sever resident was also comoderate assistance ambulatory with superincontinent of urine.  Resident # 9's care put that Resident # 9's care put the care plan on 1 the Resident # 9's addirected on the care levels as ordered and any signs and symptohypoglycemia.  Review of physician January 2025 MAR (record) revealed the	loyee # 1 was not licensed assessment of Resident # 3 for him during the time the wed on her shift.  ealed Resident # 9 was y on 11/7/24 and had art included diabetes, a, atrial flutter, congestive heart failure.  orders revealed Resident # 9 we Eliquis 5 mg (milligrams) rial flutter. This order began is an anticoagulant and	F	584				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
		345301	B. WING _			C 03/31/2025
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP COD 323 BALDWIN ROAD BURLINGTON, NC 27217	•	00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag		F 6	684		
		per day. This order originated in effect until discontinuation				
	were scheduled for 6 were no orders for paregarding results and	uary 2025 MAR, the FSBS's 6:30 AM and 4:30 PM. There arameters to call the provider d there was no order for coverage based on FSBS				
	dates of 1/1/25 and insulin Resident # 3 acting insulin given a order change in Res medication dosages.	orders revealed between the 1/24/25, the only type of was prescribed was a longat night and there was one ident # 9's diabetic Specific medications and ange were as follows:				
		lligram) tablet once per day. ect from 12/7/24 until its /27/25.				
		blet twice per day. This order 2/13/24 until discontinuation				
	once per week on M	r; 0.5 mg; subcutaneous onday. This order was in until discontinuation on				
	insulin pen; 100 units units subcutaneous a effect from 12/31/202 on 01/06/2025. (Lant	00 Insulin (insulin glargine) (mL (3 mL); Administer 15 at bedtime. This order was in 24 until the discontinuation tus is a long acting insulin 24 hours but does not have a ).				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345301	B. WING _			C <b>03/31/2025</b>
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CO 323 BALDWIN ROAD BURLINGTON, NC 27217	DE	03/3/1/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA	
F 684	mL); Administer 15 u bedtime. This order wiscontinuation on 1/1 is a biosimilar interchinsulin glargine which receiving. There were According to the recoveresident on 1/18/25 at HgbA1c (hemoglobin 9.2 and she would in acting insulin from 18 A1c is a blood test the blood sugar result in A result of 6.5% and The date of 1/18/25 wincrease in insulin dochart from 1/1/25 to insulin glargine-yfgn mL); Administer 18 u bedtime. This order windiscontinuation on 1/1 Review of Resident and following FSBS result On 1/8/25 at 6:30 AN unlicensed employed MAR. On 1/10/25 at 6:30 A 433 on the MAR.	insulin pen; 100 unit/mL (3 nits subcutaneous at was in effect from 1/6/25 until 18/25. (Insulin glargine-yfgn tangeable insulin product to a the resident was already e no dosage changes).  ord, the physician saw the and noted his hemoglobin a A1C) on 12/24/24 had been crease the resident's longto to 18 units. (Hemoglobin at measures the average the last two to three months. above reflects diabetes.)  was the only date where an esage order was noted in the 1/24/25. The order was for insulin pen; 100 unit/mL (3 nits subcutaneous at was in effect until 27/25.  # 9's MAR revealed the ts documented.  # Employee # 1 (an e) documented where # 6 documented.  M Nurse # 6 documented.	F6			
	423 on the MAR. On 1/18/25 at 4:30 P 413 on the MAR.	M Nurse # 7 documented  M Nurse # 8 documented  M Medication Aide (MA) # 1 the MAR.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	\ , ,	(X3) DATE SURVEY COMPLETED		
	345301	B. WING		0.5	C 3/31/2025		
NAME OF PROVIDER OR SUPPLIER  WHITE OAK MANOR - BURLINGT	ON		STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217		10112020		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
on the MAR. On 1/23/25 at 6:30 A 419 on the MAR. On 1/23/25 at 4:30 P on the MAR. On 1/24/25 at 6:30 A on the MAR. On 1/24/25 at 4:30 P 524 on the MAR.  There was no docum with an assessment or resident's blood suga 1/24/25 at 6:30 AM. entered into the reco  MA # 4 was interview and reported the follor recalled Resident #9' "high" on the morning was to be reporting to thought was a nurse Employee # 1 about Employee # 1 about Employee # 1 stated for sliding scale orde She saw Employee # talk to someone, but she was talking to. A asked to look in her ( obtain an insulin pen room. She did not kn Employee # 1 had ob when she went into to checked the FSBS, F okay.  Employee # 1 was in	M MA # 2 documented 456  M Nurse # 9 documented  M MA # 3 documented 403  M MA # 4 documented "high"  M Nurse # 5 documented  Mented nursing progress note of Resident # 9 when the ar registered "high" on There were no orders rd.  Med on 3/25/25 at 10:28 PM owing information. She is blood sugar registering go of 1/24/25. At the time she is Employee # 1, who she at the time. She told the "high" blood sugar and she would check the record rs and call the physician.  Med 1 make a phone call and she did not know to whom fterwards Employee # 1 [MA # 4's) medication cart, and go into Resident # 9's	F 68	4				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE COMP	
		345301	B. WING _			03/:	31/2025
	ROVIDER OR SUPPLIER	ON	STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		<u>'</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 684	facility as a nurse. She license to the facility as education nor a license nurse. She had taken members and had so medication assistant morning of 1/24/25 we sugar registered "high and gotten an order for given the insulin. Who issue that Resident # acting insulin ordered for him, Employee # acting insulin for newly ordered insul	a accepted to work at the e had provided a false and had no nursing se to perform job duties of a care of diabetic family me partial training as a in another state. On the hen Resident # 9's blood " she had called the doctor or some insulin. She had en interviewed about the 3 did not have any short and filled for her to access I replied they kept some on for times such as this.  se # 9, who had worked on vealed the facility did not stored on medication carts ulin.  nt # 9's NP (Nurse 25 at 5:15 PM and with the at 1:42 PM revealed they ployee # 1 had called on the ecause there was no history e on-call provider.  sheets, Unit Coordinator #1 se on the day shift on	F 6	84			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345301	B. WING			C
	ROVIDER OR SUPPLIER		D. WING	STREET ADDRESS, CITY, STATE, ZIP C 323 BALDWIN ROAD BURLINGTON, NC 27217	:ODE	03/31/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO 1  DEFICIENCE	TION SHOULD BI THE APPROPRIA	DATE
F 684	According to the Med record, the next time was checked again for AM was on 1/24/25 a result was 524. There resident at that time or reading.  Nurse # 5 was interviand reported the follonever received inform # 9's blood sugar had the glucometer earlied cared for him on the 11:00 PM) on 1/24/25 on 1/24/25 when Res 524. She was walking physician when she satisfinger better and much time between the fore she then went She then obtained a recall what it was. Not documented the repetition.	revealed no nursing yshift showing the blood I and the resident was	F	584		
	first time and respond	ident # 9's finger well the ded that she thought she had rther stated during her shift ed to be okay.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345301	B. WING _			C <b>03/31/2025</b>
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZI 323 BALDWIN ROAD BURLINGTON, NC 27217	P CODE	33/01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI O THE APPROPRIA	DATE
F 684	nursing progress note 1/24/25 at 7:16 PM at 10. Nurse # 10 docur Resident # 9 was in to The resident became sustained a laceration bleeding. Nurse # 10 given the resident was resident was transfer Medical Services) to a linterview with Nurse revealed she had note 9 at the time he fell of the shower room who cut to his head, so he Aide held pressure to and she called 911.  Interview with Nurse PM revealed the follocared for Resident # 1/24/25. It seemed to feel well. He "barely a was usually continent bathroom on his own soaked from urine. To him to the shower rook Resident # 9 initially and struggled to remarks able to walk him	sing notes revealed the only e on 1/24/25 was dated nd was written by Nurse # nented at this time that he shower with staff present. dizzy and fell. Resident # 9 n to his head with minimal further documented that is on an anticoagulant, the red by EMS (Emergency	F	584		
	stand, and as she wa suddenly "went blank	ng. Then she helped him to is pulling down his pants he " and just fell over. She e nurse, and they called 911.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345301	B. WING				31/ <b>2025</b>
	ROVIDER OR SUPPLIER	DN		323	REET ADDRESS, CITY, STATE, ZIP CODE  B BALDWIN ROAD  JRLINGTON, NC 27217	1 03/	31/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page Review of EMS recor		F	684			
	paramedics arrived a Resident # 9 was ale blurred vision or dizzi arrival. The paramedi 9's blood pressure was respirations, 20, and paramedics did not reserved. Review of the hospital 1/24/25 to 1/30/25 resinformation. Resident small subdural hemati 305 at 8:40 PM on 1/2 lab. The hospital physical hemore and short acting insult the facility. Also, the fincluded information hypotensive when he his Toprol (used for hwhile hospitalized, neand recommended heanticoagulant medical repeat CT scan was president's subdural hed Discharge orders included should be placed on scoverage and in addiscale insulin, when the 400, the primary physical states are subdurated and the primary physical states are subdurated and the placed on scoverage and in addiscale insulin, when the 400, the primary physical states are subdurated and the primary physical states are subdurated and the placed on scoverage and in addiscale insulin, when the 400, the primary physical states are subdurated and the primary physical states	trict 7:23 PM on 1/24/25 and trict and did not complain of ness at the time of their cs documented Resident # as 101/55, pulse 61, oxygen saturation 99%. The ecord a blood sugar check.  If records for the date of vealed the following # 9 was diagnosed with a soma. His blood sugar was 24/25 when drawn by the sician noted Resident # 9's 2. The hospital physician ould receive both long acting in upon discharge back to nospital discharge summary that the resident had been arrived to the hospital and eart failure) was held. Also, urosurgery was consulted olding the resident's tion. Prior to discharge, a performed to ensure the ematoma had not worsened. Unded that the resident sliding scale insulin tion to the prescribed sliding e FSBS was greater than sician should be contacted.					
		M the Administrator was e Jeopardy and provided					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345301	B. WING _			C		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI 323 BALDWIN ROAD BURLINGTON, NC 27217		3/31/2025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 684	Continued From pag	e 92	F 6	84				
	the following Credible Jeopardy Removal P	e Allegation of Immediate lan.						
		nts who have suffered, or serious adverse outcome as mpliance:						
	upper arm bruising o notify any nurse of th positioning, and swel she first saw the brui bruising to the nurse	ed with significant chest and n 12/18/24. NA #5 failed to be bruising, discomfort with lling of the bruised area when ses. Her failure to report the delayed the assessment and the with #3 by any nurse and the						
	experienced multiple elevated blood sugar this time period resid for sliding scale insul physician of blood su January several nurs and nurse #5 failed to nurses on subsequentigh blood sugars reassessment, treatme	ary 2025 Resident # 9 instances of seriously is (greater than 400). During ent # 9 did not have orders in or parameters for notifying agar elevations. During ies, including employee #1 io notify the provider or int shifts of these seriously sulting in the delayed ent, and monitoring. And, as resident # 9 experienced						
	resident # 9 was perf "high" was recorded administration record a.m. MA # 5 witnesse go into the resident # although there were that time and no reco	n a blood sugar check for formed and the reading of on the medication I. Per her statement at 6:30 ed unlicensed Employee # 1 49's room with an insulin pen no orders for any insulin at ord of the physician giving ne unit manager was working						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) M A. BU		TIPLE C		(X3) DATE SURVEY COMPLETED		
		345301	B. WING				C / <b>31/2025</b>	
	ROVIDER OR SUPPLIER			323	EET ADDRESS, CITY, STATE, ZIP CODE  BALDWIN ROAD  RLINGTON, NC 27217	1 03/	31/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	shift, and in her state not recall the specific she had been told in blood sugar was "hig sure the resident was done. The unit mana, had been aware of the sugar, she would have provider and entered her actions. No new of were entered for days.  A statement from the 1/24/25 indicated that to her that the resident the 6:30 a.m. blood seperformed the 4:30 performed the 4:30 performed the 4:30 performed the nurse reagain and received at the evening shift on a dizziness and did sushyperglycemia expershows that the Employeresident, notify provide elevated blood sugar this resulting in the resident, notify provide elevated blood sugar that evening.  On 3/26/25 body audicoordinators for all 3 abnormalities that we nurse or the provider were identified. All ice	ment the unit manager could so of 1/24/25 but stated that if report that the resident's h" she would have made a monitored and follow up ger also indicated that if she re seriously elevated blood re requested orders from the a nursing progress note of orders or progress notes shift on 1/24/25.  Evening shift nurse for the tit was never communicated int's blood sugar was high at ugar check. When she is meaning in the 300s. Later in 1/24/25 resident #9 reported stain a fall in the shower. The fienced by Resident #9 sident a fall in the shower. The stain a fall in the shower is the communicate the to the oncoming shift with resident experiencing a fall in the shower with the sident experiencing as a sident experien	F	584				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345301	B. WING				C <b>31/2025</b>
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 684	the Vital Signs (Blood elevated blood glucos physician notification sugars greater than 4 subsequent shifts. It proper physician notifiby the DON to the profurther orders were gidentified residents.  Specify the action the process or system fair adverse outcome from when the action will be to a system fair adverse outcome from when the action will be to a system fair adverse outcome from when the process of not injuries or changes in The DON and SDC a importance of assess if an injury or change them. The education either face to face or The facility does not a contracts. Any new and education from the Sinotifying the nurse of the resident's condition.  On 3/26/25 the DON nurses and Med Aide significantly elevated shifts for ongoing mo Elevated blood sugar on the shift-to-shift resident's conditions.	om 3/19/2025-3/25/2025 of displayed Glucose Values) for se levels over 400 for proper and communication of blood 400 to the nurse on dentified elevations without fication were communicated ovider on 3/25/2025. No even by the provider for entity will take to alter the flure to prevent a serious of an occurring or recurring, and the education with all staff ifying the nurse of any of the resident's condition. Iso educated nurses on the ing the resident immediately of condition is reported to was performed verbally by via phone communication.  Currently have any agency gency staff will receive DC on the process of any injuries or changes in on.  completed education with all so n communicating blood sugars to subsequent	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345301	B. WING _				31/ <b>2025</b>		
	ROVIDER OR SUPPLIER	ON		323 BA	T ADDRESS, CITY, STATE, ZIP CODE ALDWIN ROAD INGTON, NC 27217	1 00/	0172020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 684		e 95 pleted. The education was y either face to face or via	F	584					
	phone communication All newly hired nurse the SDC on commun blood sugars to subsimonitoring by the nurse readings will be recorreport sheet to ensur communicated and a completed. The SDC completed as part of process.  All newly hired staff with the SDC on notifying changes in the reside orientation.  Date of Immediate Jeg 3/28/25.  On 3/31/25 the facilit Immediate Jeopardy by the following action  The facility presented their action plan and	es will receive education from sicating significantly elevated sequent shifts for ongoing rese. The education will also at all elevated blood sugar reded on the shift-to-shift re that elevations are addressed, and follow-up is will ensure that education is the facility orientation  will receive education form the nurse of any injuries or ent's condition during facility eopardy removal will be  cy's Credible Allegation of Removal Plan was validated ons:  d evidence of body audits per progress note audits.							
	their action plan.  Interviews were done	n pian.  d evidence of education per  e to validate training. Staff te training ponts. Although							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		ATE SURVEY OMPLETED
		345301	B. WING _			C <b>03/31/2025</b>
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217		00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684		nat staff reported, some	F 6	84		
	training were to alwa resident was having	zed they recalled from the ys report any problem a to other staff members and ion going" to other staff.				
	The facility's date of was validated to be 3	immediate jeopardy removal 8/28/25.				
	12/10/24. Resident #	admitted to the facility on 11's diagnoses in part and a history of pulmonary				
	Set) assessment, dar # 11 as severely cog resident was also com maximum assistance requiring total staff as	ission MDS (Minimum Data ted 12/16/24 coded Resident nitively impaired. The ded as needing substantial to with his hygiene needs, ssistance to turn in bed, not e assessment period, and as				
	prescribed Eliquis 5 i	(Eliquis is an anticoagulant				
	the bed sitting on the side, head propped u obvious injury or brui given and vitals reco	M Employee # 1 ent slipped of the left side of e floor, laid down on his left up against the nightstand. No sing. Head trauma protocol rd at the time of the fall. , Resp. 20 B/P (blood				
	There was no docum	nented assessment by a				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	COMPLETED
		345301	B. WING		C 03/31/2025
	ROVIDER OR SUPPLIER	TON	3	TREET ADDRESS, CITY, STATE, ZIP CODE 23 BALDWIN ROAD BURLINGTON, NC 27217	00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 684	licensed nurse when 12/28/25 at 12:30 A Employee # 1 was PM and reported the was not a licensed completed any form care. She had taken members, and she Resident # 11 did not 12/28/24 and 1/9/25  NA # 8 had cared for shift which had beg NA # 8 was intervie and reported she did Resident # 11 that is had fallen.  Interview with the E at 9:00 AM revealed the facility under fall November 2024 un 2025. She had not caring for Resident been aware of that Review of nursing rot reveal any document 12/28/24 fall.  On 1/9/25 at 7:27 A "[Resident # 11] was room beside his bemake sure he did in head. T-94.6 P 64 B	n Resident # 11 fell on MM.  interviewed on 3/25/25 at 3:30 e following information. She nurse and had never nal training program in health in care of bedridden family thought she knew what to do. ot seem hurt to her on	F 684		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345301	B. WING		C 03/31/2025
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217	1 00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 684	Continued From page	e 98	F 68	4	
F 726 SS=K	when Resident # 11 t	ent # 11 by a licensed nurse fell on 1/9/25. Staff	F 72	6	4/25/25
	the appropriate comp provide nursing and a resident safety and a practicable physical, well-being of each re resident assessment and considering the r diagnoses of the faci	e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care			
	licensed nurses have and skill sets necess needs, as identified t	cility must ensure that the specific competencies ary to care for residents' hrough resident escribed in the plan of care.			
	limited to assessing,	ing care includes but is not evaluating, planning and nt care plans and responding			
	to demonstrate comp techniques necessar needs, as identified t assessments, and de	ure that nurse aides are able betency in skills and y to care for residents'			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDII	_	<del></del>	Ι,	
		345301	B. WING				31/2025
NAME OF PI	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	31/2023
					23 BALDWIN ROAD		
WHITE OA	AK MANOR - BURLINGT	ON			SURLINGTON, NC 27217		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 726	Continued From page	e 99	F 7	726			
	by:						
	•	riew and staff and Physician			White Oak Manor Burlington will ensu	re	
		failed to have a system in			quality nursing services by providing		
	-	who were hired as nurses			sufficient nursing staff with the appropr	iate	
		npetent to perform their job			competencies and skills sets to provide		
	duties. Employee #1	, who was not licensed as a			nursing and related services to assure		
		cumented nursing education,			resident safety and attain or maintain t	ne	
	worked at the facility	in the role of a licensed			highest practicable physical, mental, a	nd	
	nurse from 11/5/24 u	ntil her termination on			psychosocial well-being of each reside	nt.	
	2/6/25. Her job duties	s included, but were not			Employee #1 was hired as a nurse on		
	limited to: insulin administration, blood sugar				11/5/2024 without qualifications. A		
	monitoring, medication				timecard report in the Paycom payroll		
		sident who sustained falls			system indicated that Employee #1		
	_	ulant (blood thinner), and			attended and completed 3 out of 4 day		
		ement to make decisions.			scheduled orientation. The facility did r	ot	
	These job duties requ				ensure that Employee #1 completed a		
		safely. There was no			formal nursing competency form to ma	ke	
		ency evaluation completed			sure the employee was competent to		
		o duties or nursing skills. On			perform job duties and using nursing		
		ch began at 11:00 PM on			judgements to make decisions. During		
		1 was assigned to Resident			this time, unlicensed Employee #1		
		an anticoagulant, when she			performed multiple job duties which		
		the resident's shoulders with			required education and training to perfe		
		ployee #1 was responsible			correctly to ensure residents are safe a not neglected. This included, but is not		
	_	ident and utilizing nursing			limited to, blood sugar checks,		
	, ,	ons on when to notify the 5 Employee #1 was informed			neurological checks following falls, inst	ılin	
	' '	(MA) that Resident #9's			administration and other medication	41111	
	finger stick blood sug				administration, and oxygen saturation		
	•	s highest measurable range			level. Unlicensed Employee #1 through	1	
	indicating a dangerou				the actions of falsifying a nursing licens		
		#1 was responsible for			had the high likelihood of failing to ider		
		nt, providing insulin, and			changes in resident conditions, and the	•	
	utilizing nursing judge				high likelihood of providing inadequate		
	, , ,	otify the physician for blood			care to any resident in the facility. Allow		
		2/8/24 and 1/9/25 Resident			Employee #1 to work in the capacity of	-	
		cognitive impairment and			licensed nurse with no verification of th		
	· ·	lant, experienced falls.			competencies placed all resident that		
		signed to Resident #11 on			Employee #1 was assigned to care for	in	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345301	B. WING				31/2025
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	31/2023
					23 BALDWIN ROAD		
WHITE OA	AK MANOR - BURLINGT	ON			BURLINGTON, NC 27217		
	OUR MARRY OF	TELEVIT OF DEFICIENCIES					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From page	e 100	F	726			
		responsible for assessing the			the capacity of licensed nurse had a hi	ah	
		nursing judgement for			likelihood of a serious adverse outcom	-	
	_	when to call the physician.			harm to the residents. Employee #1 wa		
		1 to work in the capacity of a			terminated on 2/6/25 when discovered		
	licensed nurse with n	o verification of her			employee falsified as a licensed nurse.		
	competencies affecte	ed Resident #3, Resident #9,			Employee #1 was responsible as a nur	se	
	and Resident #11 in a	addition to placing all			for Resident #3 on the night shift when		
	residents Employee #	#1 was assigned to care for			Nursing Assistant # 5 (NA #5) noted		
	in the capacity of lice				Resident #3 to have bruises, swelling a		
		s adverse outcome or harm.			discomfort with positioning. There was	no	
	Additionally, the facili				documentation of an assessment by		
		se #13 and Nurse #14. This			Employee #1 and there was no		
		e staff (Employee #1, Nurse			documentation that Employee #1 had		
	1	whose personnel files were			been evaluated to be competent in		
	reviewed for compete	ency.			assessment skills in the personnel file.	1	
	Immodiato iconordy k	aggan on 11/5/24 when the			Resident #9 did experience an untreate		
		pegan on 11/5/24 when the pyee #1, who fraudulently			elevated blood sugar of 409 on 1/8/25 6:30 AM and a high blood sugar on	สเ	
		the facility as a licensed			1/24/25 at 6:30 A.M. The unlicensed		
	I -	capacity of a licensed nurse			Employee #1 failed to notify the provide	≏r	
		was trained and competent			of the hyperglycemic event and Reside		
		urse skills and duties.			#9 was not treated for hyperglycemia.		
	-	was removed on 3/28/25			Resident #11 had severe cognitive		
		emented an acceptable			impairment and was on an anticoagula	nt	
	credible allegation of				with recurrent falls. Employee #1 was		
	~	will remain out of compliance			assigned to Resident #11 on 12/8/24 a	nd	
	at a lower scope and	severity E to ensure			1/9/25 and was responsible for assess	ng	
	education is complete	ed and monitoring systems			the resident and utilizing nursing		
	put in place are effec	tive. Example 1b. and 1c.			judgement for decisions regarding whe	n	
	were cited at a scope	and severity of E.			to call the physician without the nursing	j	
					skills to do so.		
	The findings included	l:			Current and newly admitted residents \	vill	
					be provided with verified, qualified and		
		yee # 1's personnel file			competent licensed nurses to ensure the	ıе	
		he state surveyor revealed			residents are safe and cared for		
	the following information				appropriately in order to maintain the		
	application for emplo				highest practicable physical, mental, a		
		4 for a position as a licensed			psychological well-being of each reside	:nt.	
	⊢practical nurse/regist	ered nurse on third shift from	1		The facility also did not verify the		1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	PLE CONSTRUCTION  G		E SURVEY IPLETED
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		345301	B. WING _			3/31/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
WHITE O	K MANOR - BURLINGTO	ON		323 BALDWIN ROAD		
WHILE OF	IN MANUR - BURLING I	ON		BURLINGTON, NC 27217		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	(X5) COMPLETION	
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F 726	Continued From page		F 7	26		
	11:00 PM to 7:00 AM history included on the	. The only employment eapplication noted		competencies of Licensed Licensed Nurse #14.	Nurse #13 and	
		ended an out-of-state high		An audit was conducted on	3/26/25 by the	
		ucation experience was		Staff Development Coordin		
		stion, "Please indicate		identify all newly hired nurs	` '	
		ining which you believe		2/6/2025 to ensure that all		
		position you are applying,"		the current nurse orientatio	•	
		I response was, "CNA		completed. No discrepand	•	
		and 5 years of home health."		identified.		
	,	,		On 3/27/25, the Director of	Nursing (DON)	
	The Administrator and	d DON (Director of Nursing)		and SDC were educated by		
		ether on 3/21/25 at 9:00 AM		Regional Nurse Consultant		
	and a follow up interv	riew was conducted with the		implemented nursing comp	etency form.	
	DON again on 3/21/2	5 at 9:45 AM revealing the		The education also include	d a system in	
	following information.	Employee # 1 presented		place to ensure staff who w	ere hired as	
	herself falsely as a lic	ensed nurse when she		nurses were trained and co	mpetent to	
	applied for employme	ent and provided the facility		perform their nursing job du	uties and	
	with another individua	al's nursing license. The		competencies are verified i	n the nurses	
		license, which was provided		personnel file (education, li	cense and	
	to the facility, was sin	nilar to Employee # 1's		employment history). The r	newly hired	
	name. She was hired	on 11/5/24 and continued to		nurses will have 4 days of i		
	work until her termina	ation on 2/6/25.		orientation and then will be	•	
				a seasoned licensed nurse		
		residents, who were cared		performing nursing job duti		
		while she worked as a		independently. This will be	verified on the	
		d. Although not all inclusive		competency form.		
	_	performed and judgements		On 3/27/25, the Assistant F	_	
		1 while employed at the		Consultant educated the D		
	_	cords revealed some of the		of the following process: Th		
		f nursing duties performed		initiate the nursing compete		
	or required of Employ	ree # 1 to be done safely.		orientation for all newly hire		
	Francisco # 4 h - 11	an the mean and the ending of		newly hired nurse will be pa		
		en the responsible assigned		an experienced nurse and		
		3 on the night shift which		experienced nurse will observe as a semple to the to	-	
		: 11:00 PM. Review of a		hired nurse complete the ta		
	, ,	eport revealed during this		competency form. Any uns		
		ent # 3 was identified by		demonstrations will be com		
		Aide to have unexplained		the SDC for further training		
	bruises to his chest a	na arm wnich were		hired nurse. The newly hire	a nurse will	

<u> </u>	C . C	· · · · · · · · · · · · · · · · · · ·					2. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345301	B. WING				31/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE OA	AK MANOR - BURLINGT	ON		32	23 BALDWIN ROAD		
Willia Or	AT IIIATOR - BOTEINOT			В	SURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page accompanied by swe positioning during this have been responsib notification of the phy and per her statement was aware of the bruich She noted in her state on his shoulders. The on 3/21/25 at 3:13 PM provider had not been and this should have interview with the phy reported the bruising upper body which incompanies that was a cognitively not report what had he Resident # 3's nursin hospital ED (Emergen revealed Resident # 3's nursin hospital ED (Emergen revealed Resident # 3's showed the resident hematoma underlying measuring 9.5 X 5.2 c superficial soft tissue left flank and hip.	el 102  Illing and discomfort with a shift. Employee # 1 would be for the assessment and resician during the night shift, at in the investigative file she ises during the night shift. Ement she had seen bruises a interview with the physician of revealed she or another in notified by Employee # 1, been done. During the resician, the physician was all on the resident's cluded areas on his arms and oped around some on his aving some left shoulder curther reported that Resident impaired resident and could pappened. Further review of g notes and 12/20/24 and not populate incompany (2/20/24) at the hospital had a large left subpectoral g his pacer control box cm. (centimeters) and contusion (bruising) of the	TAG		CROSS-REFERENCED TO THE APPROPRIA	rm ne rse re will by the tity ne se	DATE
	for performing FSBS Checks) for Resident about when to call the readings. There was 9's record that Emplo to Resident # 9 accor (Medication Administr	# 9 and making judgements be physician for blood sugar documentation in Resident # eyee # 1 administered Insulin rding to Resident # 9's MAR rator Record). On 1/8/25 documented on the MAR			validated with education, license and employment history in nurse skills provided by the SDC to record and enst that the new nurse is paired and works with an experienced nurse for the first shifts after facility orientation. The monitoring will be completed weekly fo weeks.	sure Four	

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				OIVID INC	7. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345301	B. WING _			03/	/31/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
		•••		32	23 BALDWIN ROAD		
WHITE OF	AK MANOR - BURLINGT	ON		В	URLINGTON, NC 27217		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 726	Continued From page	e 103	F 7	26			
		was 409, there was no		_	The DON will also monitor by reviewir	na	
		hysician was notified and			weekly of newly hired nurses maintain	-	
	· ·	ough the resident had no			by the SDC to record when the new	<b>J</b> u	
		coverage ordered at the time.			nurses competency form is completed		
	_	/25/25 interview at 10:28 AM			and returned to the SDC (must be by t	he	
		(MA) #4, MA # 4 reported			90th day). The SDC will then follow-up		
		tion. She (MA # 4) had			any areas the newly hired nurse may r		
	_	FSBS on 1/24/25 when it			additional training on. The monitoring		
	was due to be check	ed at 6:30 AM. The result			be completed weekly for 12 weeks.		
	was "high" and did no			The results from the monitoring tools w	/ill		
	She reported the res			be discussed during the morning Qual			
		eved to be a nurse. She (MA			Improvement (QI) meetings, weekly fo	vill be	
		yee # 1 call someone. She			weeks. Identified issues or trends will be		
		nployee # 1 called and did			further discussed at the monthly Qualit	-	
		aid to them. Later Employee			Assurance (QA) meeting with the team		
		that someone was on the			and recommendations made as indica		
	·	ne (MA#4) again saw someone but did not hear			The DON is responsible for the ongoin compliance of F726.	g	
	the conversation. After				Compliance date is 4/25/25.		
		hrough the insulin pens on			Compilance date is 4/20/20.		
		emoved one, and walked					
		om. MA # 4 did not know					
		en was removed or to whom					
		of the chart revealed no					
	documentation or ord	ders for any insulin					
	administration to add	ress Resident # 9's 1/24/25					
	6:30 AM FSBS readi	ng of "high." Resident # 9's					
		ck was performed next when					
		e completed at 4:30 PM,					
		ocumented as 524. During an					
	interview with Reside	•					
	,	25 at 9:00 AM, the NP					
		t been called on the morning					
		urther reported she had					
		og for that date, and there					
		all being placed to the on-call					
		ing of 1/24/25 regarding					
	** *	olver before Employee # 1					
	⊨ ⊏mpioyee # ⊤nad sp	ooken before Employee # 1					1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345301	B. WING _		-	C 03/31/2025
	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STA 323 BALDWIN ROAD BURLINGTON, NC 27217		33.0 112320
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	( (EACH CORRECTION CROSS-REFERENCE CROSS-REFER	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	DATE
F 726	The interview with R revealed she only had to the Unit Managers know how the employed She did not usually a AM when she was maractice, and she did Employee # 1 had sp.  According to Reside resident's 12/16/24 Massessment coded to cognitively impaired, orders revealed he may a compare the complete of 1/9/25, Employed and the formulation she compared to the compared	9's room with an insulin pen. esident # 9's physician ad given her personal number is and therefore she did not yee could have reached her. answer her phone before 7:00 of on call for the medical I not know to whom boken.  Int # 11's record, the Minimum Data Set the resident as severely and a review of physician esceived an anticoagulant. Inotes, Employee # 1 Int # 1 was on the floor on the d 1/9/25. Within her nursing byee # 1 documented she did sment to make sure the ain any "blows" to the head. esponsible for making a garding whether to call the and there was no did so although a review of rs revealed he was receiving ulant) when the falls were  # 1's personnel file and aled there was a "Nursing cklist" in the file. The	F	726		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345301	B. WING		<del></del>	03/	31/2025
NAME OF P	ROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		-		3	323 BALDWIN ROAD		
WHITE OA	AK MANOR - BURLINGT	ON		E	BURLINGTON, NC 27217		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 726	Continued From pag	e 105	F	726			
	· -	e Nurse Aide skills listed.		. 20			
	There was no similar						
		competency for tasks and					
		vas responsible for while					
		The file also contained:					
		perform the Heimlich					
		Coding Quiz;" a "check-off					
		echanical lift and safe					
		; the facility's electronic					
	medical system "Nur						
	•	of nursing assistants" (which					
	included resident rights and abuse and neglect);						
		klist; a "hand hygiene quiz;"					
		E (personal protective					
		ng home infection prevention					
		tation checklist; education					
		a licensed nurse as it relates					
		n aide and Nurse Aide II can					
	do; a checklist for the	e facility's electronic medical					
		py of instructions on how to					
		unsigned job description for					
	a "NC licensed Pract	ical Nurse/Charge Nurse;"					
	and a multiple choice						
	Orientation Program	Evaluation Questions,"					
	which included some	medication questions. The					
	last page of the evalu	uation form was the only					
	page that indicated the	he evaluation was completed					
	by Employee # 1 by i	requiring a signature and					
	date. Employee # 1's	s signature with the date of					
	11/8/24 was on this la	ast page. The last two					
		s were marked through and				ĺ	
		were a total of 40 questions				ĺ	
	on the evaluation for	m. One example on the					
		the question, "Before				ĺ	
		s medication, the nurse					
	should A) take a dee	p breath or B) check to be					
	sure the resident is in	n his/her room." Employee #					
	1 had circled both A	and B. Another question					
	read, "Correct medic	ation administration time for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	COMPL	
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	ROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217		00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 726	Continued From page		F 7	26		
	the scheduled dose If of the scheduled dos of the scheduled dos Employee # 1 had ar incorrectly thought the	A) plus or minus 1 hour of B) plus or minus 30 minutes e C) plus or minus 2 hours e or D) all but "A." aswered, "D" indicating she at she could administer as plus or minus 2 hours.				
	and on 3/21/25 at 4:0 following information they went through a forientation. The first education with all new fourth day included Naides, and Nurses to nurses off on Nurse Awould be overseeing Nurse Aide checklist The nurses were also instructional videos a form with questions.	two days were general wemployees. The third and lurse Aides, Medication gether. She checked the Aide duties which nurses. She then included the in the Nurse's personnel file.				
	orientation. They wer putting on and taking protective equipment and handwashing. No show they could use no sign off on that duthe SDC she had dor Employee # 1. Follow orientation, then the another experienced The Scheduler would # 1 was partnered aft the four-day orientation interviewed regarding	e: a glucometer check, off of PPE (personal ), use of mechanical lifts, urses were also required to an insulin pen but there was ring orientation. According to ne these tasks with ving their four-day nurse was partnered with nurse for at least three days. I know with whom Employee ter Employee # 1 completed on. The SDC was g competencies and training s which there was no				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER	DN		323	REET ADDRESS, CITY, STATE, ZIP CODE  BALDWIN ROAD  RLINGTON, NC 27217	1 00/	01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	were also required to videos on their own a indicated the last two 1's form, which were required of the group  The Nurse Staffing C on 3/21/25 at 3:05 PN information. Employe with Nurse # 11, Nurse following her classroop partnered a new nurse for a week and the neif they needed more to nurse. Employee # 1 time. The interview for used to have a compand validate a new nursed to have a compand validate a new nurse for Employee # anymore for newly his Staffing Coordinator prompetency form was Nurse # 7, who was considered.	The SDC reported nurses watch a library of further and take quizzes. The SDC questions on Employee # blank, had not been when the test was taken.  oordinator was interviewed # and reported the following e # 1 had been partnered se # 12, and Nurse # 7 om orientation. She typically we with an experienced nurse ew nurse could let her know ime with an experienced did not request any further arther revealed the facility etency form used to check curse's skills, but that was not 1 and was not being utilized red nurses. The Nursing provided no reason a se not being used.		726	DEFICIENCY)		
	6:50 AM and reported She had only been partial for orientation purpose had "acted disinterese #7) around as she ca # 1 watched Nurse # she (Nurse #7) did not perform tasks and du Employee # 1 routine (Nurse # 7) did not with 1 but she (Nurse # 7) would receive a nursi	ras interviewed on 3/24/25 at a the following information. For artnered with Employee # 1 tees one night. Employee # 1 teed" and followed her (Nurse red for residents. Employee 7 do tasks and duties, but not observe Employee # 1 ties. It was more of showing as. Following that night, she nork directly with Employee # 1 was aware that Nurse # 9 ng report from Employee # 1 tes and Nurse # 9 had some					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 726	from Employee # 1, at 7:18 AM and repoinformation. She thorogen information. She thorogen information. She thorogen information. She thorogen information. She thorogen in shift change report oxygen level had been in shift change report oxygen level had been in shift change report oxygen level had been in shift change report oxygen level was now as done about it. So resident's room and oxygen level was oktook Employee # 1 to showed her what to open it was low. Nurse # of this resident, who harmed or experience it was low. Nurse # of this resident, who harmed or experience Employee # 1 taking.  Nurse # 11, who was with Employee # 1 "struct (Nurse # 11) had may with paperwork. The followed her (Nurse # 11) had may with paperwork. The followed her (Nurse # 11) had her own assigniterviewed regarding interviewed regarding intervie	d at times receive report was interviewed on 3/24/25 rted the following ught Employee # 1 was not received a good ple was regarding checking vels. Employee # 1 reported t a particular resident's en around 86% or 87% and ot able to say in report what he (Nurse # 7) went to that checked it herself and the ay when she checked it. She to this resident's room and do, while thinking that she ucated well about checking vels and measures to take if reported she was not aware utilized oxygen, ever being sing difficulty due to care of him.  so one of the nurses partnered was interviewed on 3/24/25 at d the following information. Is one of the ployee # 1 first few nights Employee # 1 first few nights Employee # 1 # 11) and she showed es. Then she told Employee gnment. Nurse # 11 was g what tasks and duties she	F 72	26		
	#1 had her own assignment interviewed regarding observed Employee that tube feedings "v #1. Employee # 1 di	gnment. Nurse # 11 was				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
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	HITE OAK MANOR - BURLINGTON   X4) ID  REFIX TAG  Continued From page 109 because Employee # 1 was a new graduate. She (Nurse # 11) had therefore showed Employee # 1 how to administer a tube feeding and afterwards			STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217		3/31/2025
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 726	because Employee (Nurse # 11) had the how to administer a watched her do it. A 1 what to do, she do 11) watched her adnever watched Employee changes or a physical which would entail lungs or a neurolog # 11) only worked winights. She (Nurse been six or seven to She was not aware was hurt while under (Nurse #11) never sobserved Employee to she was the control of th	# 1 was a new graduate. She erefore showed Employee # 1	F 72	26		
	Coordinator had we partnering nurses we interviewed on 3/25 the following informmany days she had When she worked we Employee # 1 first we Employee # 1 aske appropriate to Nurse that Employee # 1's questioned. There we (11:00 PM to 7:00 A and night shift was	coording to the Nurse Staffing brked as one of the three with Employee # 1, was 5/25 at 9:37 AM and reported faction. She did not recall how did worked with Employee # 1. with Employee # 1, she let watch her and follow along. In did questions which seemed the # 12, and it did not stand out is abilities should be were not a lot of night shift family medications to be given when she worked with also watched Employee # 1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		NSTRUCTION		E SURVEY IPLETED
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NAME OF PROVIDER OR SUPPLIER  WHITE OAK MANOR - BURLINGTON			323 B	ET ADDRESS, CITY, STATE, ZIP CODE  ALDWIN ROAD  LINGTON, NC 27217	03/31/2025 CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOPEL DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 726	showing all the tas Employee # 1 to po Employee # 1 check insulin. She had not neurological assess instructed Employer assessment would resident fell but need in the character of the character	s but there was no off list that was completed ks that she had observed erform. She had watched k a blood sugar and give ever watched her do a sment of a resident. She had ee # 1 that a neurological need to be done after a ver watched her do one and ake sure she knew how to do ecall how many days she had eyee # 1 before Employee # 1 lependently. The only thing that ematic was that one time it was is 12's attention that Employee # inting in a professional manner	F	726			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, , ,	ATE SURVEY DMPLETED
		345301	B. WING			C
	ROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 323 BALDWIN ROAD BURLINGTON, NC 27217		03/31/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 726	resident to get a urine recall the specific res not aware of anything resident that needed did not know how the obtained.  NA # 5 was interview and reported the followho had a catheter, wet during the night. have the nurse checked Employee # 1 and eversident's brief was seen done. She did in had occurred.  Employee # 1 was interview and reported the knew it was a "shot infor a nurse job at the that the facility would submitted the applicate she had never finished care training, she had school in another staff health care to some of care of family member diabetics and reporte. She told the facility dihealth care experience a license. She was so call her and offer her texted her to come to already started. There days of orientation, a two days of the scheet	e 111  I know how to catheterize a e specimen. NA # 4 did not ident. She reported she was a bad that happened to the a urine specimen, and she specimen was finally  ed on 3/21/25 at 11:25 AM wing. There was a resident but his brief would become He would ask her (NA # 5) to a it. She would report it to the en after she reported it, the still wet as if nothing had not recall specific dates this enterviewed on 3/25/25 at 3:30 following information. She in the dark" when she applied facility. She never thought reach out to her after she stion, but they did. Although and any type of formal health and gone to medical assistant the, and she did know about degree. She also had taken the swho were "bedridden" or and herself to be a fast learner. They never asked her for arprised when the facility did a job. They called and training and the training had the was supposed to be four and she started on the last duled orientation. Then they on night shift for about two or	F7	26		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	' '	OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217	<u> </u>	03/31/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 726	working for about two asked her about a lice name on a website a similar name to her to and she decided to go did not think the facion was "baffled myself" never questioned it a work. Her intent was was her perception to other nurses who had to go back to school she was working at the Administrator was PM of Immediate Je.  The Administrator proceedible Allegation of Removal Plan.  Identify those recipies are likely to suffer, a a result of the noncompanyous payroll syst #1 attended and conscheduled orientation ensure that employed nursing competency competent to perform unlicensed Employed duties which require perform correctly to and not neglected. To	went to work. She had been of weeks before they even beense. She looked up her and found someone with a hat had a nursing license, give that to the facility. She lity would accept it and she when they did, but they and let her come back to never to hurt anyone, and it hat she did just as well as the did a license. She was trying to actually get a license while he facility.  The sent of the following of Immediate Jeopardy  The serious adverse outcome as	F 72	26		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED	
		345301	B. WING _			C <b>3/31/2025</b>
NAME OF PROVIDER OR SUPPLIER  WHITE OAK MANOR - BURLINGTON			STREET ADDRESS, CITY, STATE, ZIP CO 323 BALDWIN ROAD BURLINGTON, NC 27217	•	3/3 1/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 726	medication administra level. Unlicensed emplactions of falsifying he high likelihood of failing resident conditions, a providing inadequate facility.  Resident #9 did expect blood sugar of 409 or "high" blood sugar on unlicensed employee provider of the hyperof #9 was not treated for Employee #1 was resident.	administration and other ation, and oxygen saturation ployee #1 through her er nursing license had the ang to identify changes in and the high likelihood of care to any resident in the rience an untreated elevated a 1/8/25 at 6:30 AM and a 1/24/25 at 6:30 A.M. The #1 failed to notify the glycemic event and Resident r hyperglycemia.	F 7	726		
	and there was no dod #1 had been evaluate assessment skills in t  An audit was conduct Development Coordin newly hired nurses si all components of the process were comple identified.  Specify the action the process or system fail	the personnel file.  The don 3/26/25 by the Staff factor (SDC) to identify all fince 2/6/2025 to ensure that it current nurse orientation fited. No discrepancies were the entity will take to alter the flure to prevent a serous in occurring or recurring, and the complete.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE	SURVEY
		345301	B. WING				C
NAME OF PROVIDER OR SUPPLIER  WHITE OAK MANOR - BURLINGTON				32	TREET ADDRESS, CITY, STATE, ZIP CODE 23 BALDWIN ROAD URLINGTON, NC 27217	1 03/	31/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 726	On 3/27/25 the Direct SDC were educated nurse consultant on a On 3/27/25 the Assist consultant notified the Coordinator (SDC) of SDC will initiate the norientation for all new hired nurse will be panurse and the experience and the experience of the competency form. And demonstrations will be Development nurse for newly hired nurse. The have 90 days to composite of the competency form. The hired nursing competency form. The hired nursing competency form and areas the newly be complete on the computed the sistent Regional nursing training manner. On 3/27/25 the SDC Assistant Regional nursing training the competency with the new educated on the competency work with the newly hor 3/27/25 the Assisted the Staffing educated the Staffing educated the Staffing	tor of Nursing (DON) and by the Assistant Regional a nursing competency form.  Itant Regional nurse as Staff Development if the following process: The nursing competency form in the high process in the nurse will observe the molete the tasks on the nurse will observe the mustisfactory are communicated to the Staff for further training with the ne newly hired nurse will plete the nursing are SDC will review the newly ency form after 90 days and nired nurse could not petency (i.e. nasogastric s) will be performed on the nequin for competency.  Was educated by the curse that nurses who are why hired nurse will be petency form by the Staff nator prior to being early hired nurse and their k the newly hired nurse off then they are scheduled to hired nurse.  Itant Regional Nurse a coordinator that she will be ing the SDC which nurses	F	726			

NAME OF F				·	COMPLETED
NAME OF F		345301	B. WING		03/31/2025
WHITE O	ROVIDER OR SUPPLIER AK MANOR - BURLINGT	ON		STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 726	Immediate jeopardy On 3/31/25 the facilit Immediate Jeopardy by the following action. The facility presented which they had devision nursing staff. The microvered multiple task to demonstrate as existed to demonstrate as existed to demonstrate as existed pevelopment Nurse competency evaluating A nurse, who had reported the facility began using with her and she had checked off on 3/28/2 another nurse.  The facility's date of was validated to be 3/2 another nurse.  The facility's date of was validated to be 3/2 another nurse.  The facility's date of was validated to be 3/2 another nurse.  The facility's date of was validated to be 3/2 another nurse.  The facility's date of was validated to be 3/2 another nurse and training records surveyor revealed No. 2/25/25.  Nurse # 14 was inter PM and reported she employee at an earlier	removal will be 3/28/2025  ry's Credible Allegation of Removal Plan was validated ons:  d a nursing competency form sed to utilize for newly hired altipage competency form as that nurses were required vidence of competency.  d evidence the Staff had been educated about ons for nurses.  cently been hired within the interviewed and reported and the new competency form I started having her skills 25 as being observed by  immediate jeopardy removal 3/28/25.  at # 14's personnel records provided to the state curse # 14 was hired on  viewed on 3/24/25 at 3:27 as had already been an er time period and was	F 72	6	
	covered multiple task to demonstrate as ex The facility presented Development Nurse competency evaluation A nurse, who had recepted from the facility began using with her and she had checked off on 3/28/2 another nurse.  The facility's date of was validated to be 3/28/2 another nurse and training records surveyor revealed Novel 2/25/25.  Nurse # 14 was inter PM and reported she employee at an earlifamiliar with the facility Upon her rehire she test. She was then pon the floor who did so	d evidence the Staff had been educated about ons for nurses.  cently been hired within the interviewed and reported ng the new competency form I started having her skills 25 as being observed by immediate jeopardy removal 3/28/25.  e # 14's personnel records provided to the state urse # 14 was hired on			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED	
	345301	B. WING		03/31/2025	
ROVIDER OR SUPPLIER	TON	3	23 BALDWIN ROAD	1 33/01/2020	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
record system.  A review of training competency validation skills for which Nurse Staffing on 3/21/25 at 3:05 Finformation. She type with an experience new nurse could let time with an experience have a competency validate a new nurse being utilized anymomorphisms. Coordinator did not competency form which was and training records surveyor revealed Now 2/25/25.  An attempt was mad 3/24/25 at 1:33 PM reached.  A review of training competency validation skills for which Nurse Staffing on 3/21/25 at 3:05 Finformation. She types in the skills for which She types in the staffing on 3/21/25 at 3:05 Finformation. She types in the skills for which She	records did not reveal a on form for all the nursing se # 14 would be responsible.  Coordinator was interviewed PM and reported the following sically partnered a new nurse I nurse for a week and the her know if they needed more enced nurse. They used to form used to check and e's skills, but that was not ore. The Nursing Staffing provide a reason why the as not being used anymore.  Let # 13's personnel records a provided to the state lurse # 13 was hired on  The the transport of the state lurse # 13 was hired on  The transport of the state lurse # 14 would be responsible.  Coordinator was interviewed PM and reported the following pically partnered a new nurse	F 726			
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIEN REGULATORY OF	ROVIDER OR SUPPLIER  K MANOR - BURLINGTON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 116 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 with an experienced nurse for a week and the new nurse could let her know if they needed more	ROVIDER OR SUPPLIER  K MANOR - BURLINGTON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 116  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	A BUILDING  345301  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  323 BALDWIN ROAD  BURLINGTON, NC 27217  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 116 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. 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 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	

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PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 726 Continued From page 117 F 726 being utilized anymore. The Nursing Staffing Coordinator did not provide a reason why the	NAME OF PROVIDER OR SUPPLIER  WHITE OAK MANOR - BURLINGTON				323 BALDWIN ROAD	<u> </u>	3/3 1/2029
being utilized anymore. The Nursing Staffing Coordinator did not provide a reason why the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SECTION SECTIO	HOULD BE	COMPLETION
		being utilized anymor Coordinator did not p	re. The Nursing Staffing rovide a reason why the	F 72	26		