STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING _____ B. WING _____	C 03/27/2025

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

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E 000	Initial Comments An unannounced onsite recertification and complaint survey was conducted on 3/24/25 through 3/27/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PJWE11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification and complaint survey was conducted on 3/24/25 through 3/27/25. Event ID #PJWE11. The following intakes were investigated: NC00220904, NC00227502, NC00218087, NC00214340, NC00212370. 1 of 13 complaint allegations resulted in deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to provide a safe transfer for 1 of 6 residents reviewed for accidents (Resident #51). The findings included: Resident #51 was admitted to the facility on	F 689	White Oak Manor Charlotte will ensure all residents are transferred appropriately according to their plan of care and assessments in order to prevent accidents. Corrective action for the resident found to be affected: Resident #51 was	4/24/25

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

Electronically Signed | 04/17/2025

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F 689	Continued From page 1 11/07/24 with diagnoses including chronic obstructive pulmonary disease and type 2 diabetes. The admission Minimum Data Set (MDS) assessment dated 11/13/24 indicated Resident #51 was cognitively intact and dependent on staff for transfers. The care plan dated 12/02/24 revealed Resident #51 required 2-person assistance using the sit-to-stand lift for all transfers. An incident report dated 1/29/25 at 8:00 PM written by Nursing Supervisor #1 indicated Nurse Aide (NA) #3 was assisting Resident #51 to stand, pivot and transfer from the wheelchair to the bed and they both fell onto the bed. Resident #51 was assessed, and no injuries were noted. NA #3's written statement dated 1/29/25 indicated at approximately 8:00 PM she entered Resident #51's room to assist her into bed. Resident #51 stated she had been working with therapy, was feeling stronger and wanted to stand and pivot to transfer without using the sit-to-stand lift. NA #3 agreed to assist Resident # 51 with a stand and pivot transfer and positioned her close to the bed in the wheelchair. Resident #51 used the bedrail and pulled herself up to a standing position, but her legs were weak, and she started lowering down to the floor. NA #3 was able to pivot Resident #51 and they both landed in a seated position on the bed. An interview with NA #3 on 3/26/25 at 2:24 PM revealed she was Resident #51's assigned NA on 2nd shift (3pm-11pm) on 1/29/25. She stated Resident #51 required 2-person assistance with	F 689	immediately assessed after the incident and no injuries were identified. The staff member involved in the transfer, NA#3, was immediately re-educated by the Staff Development Coordinator RN on proper transfer techniques, including the required sit to stand transfer method per the care plan. NA#3 was also educated to follow the care planned transfer method even if a resident requests a different method of transfer. The method of transfer must be deemed safe through a nursing assessment prior to execution of the transfer. Resident #51's transfer status and care plan were reviewed and verified for accuracy. Identification of other residents who have the potential to be affected: A review of all residents requiring assistance with transfers was completed by the Director of Nursing and the Safety Nurse on 3/27/25 to identify others who may be at risk of unsafe transfer techniques. Resident with similar transfer needs were assessed to ensure appropriate care plans and transfer methods are in place with no issues noted. Systemic changes to ensure practice does not recur: Starting on 3/28/25, the Staff Development Nurse RN and Safety Nurse provided education to all direct care staff on safe transfer techniques, including facility policy and the review of the care plan indicators of lift or transfer status. Staff were educated to not transfer residents per the preference if that differs	

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F 689	Continued From page 2 the sit-to-stand lift for all transfers. NA #3 indicated on 1/29/25 at approximately 8:00 PM Resident #51 was ready to lay down in bed. She revealed Resident #51 told her she was feeling stronger and instead of using the sit-to-stand lift she requested NA #3 assisted her to stand and pivot to the bed. NA #3 stated she wanted to honor Resident #51's choice, so she positioned her close to the bed Resident #51 used the bed rail to pull up into a standing position. She stated Resident #51 was able to pull up to a standing position, but her legs started shaking and she started lowering down to the floor. NA #3 indicated she pushed the wheelchair out of the way, put her arms around Resident #51, turned her around, and they both landed in a seated position on the bed. NA #3 revealed she then assisted Resident #51 to lay down and asked her if she was injured. She indicated Resident #51 stated she was not injured and that her legs must have been weak from sitting in the wheelchair too long. NA #3 stated she went out into the hall and notified a staff member that she needed the nurse. She revealed Nurse #4 responded to Resident #51's room, completed an assessment and no injuries were noted. NA #3 stated assisting Resident #51 to stand, pivot and transfer to the bed was not safe and she should have used the sit-to-stand lift. A phone interview with Nurse #4 on 3/27/25 at 1:41 PM revealed she was the 2nd shift nurse assigned to Resident #51 on 1/29/25. Nurse #4 stated she responded to Resident #51's room per NA #3's request and observed Resident #51 lying comfortably in bed. She stated NA #3 reported to her that Resident #51 requested to stand and pivot to transfer to the bed and did not want to use the sit-to-stand lift. Nurse #4 stated during	F 689	from the care plan, even if they are alert and oriented, before they are properly assessed for a change in transfer status. This education will be complete for all nursing staff on or before 4/24/25 and has been added to the orientation materials for all new hires in nursing to ensure compliance. Charge nurses will ensure that any transfer method changes are communicated during shift change report and huddles. Monitoring to ensure plan is effective: The Staff Development Nurse RN or designee will conduct 5 random transfer observations per week for a total of 4 weeks to ensure staff are following the appropriate transfer method per each resident's care plan and assessments. Any discrepancies will result in immediate re-education and documentation of corrective action. After 4 weeks, the SDC or designee will continue to monitor 3 transfers a week for an additional 8 weeks, for a total of 12 weeks of monitoring. The results of these audits will be reviewed by the Director of Nursing or designee weekly in the facility's morning Quality Improvement (QI) meetings for 12 weeks. Additionally, the audit findings will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) meetings and any trends or identified issues will be discussed and recommendations made as indicated to ensure compliance is achieved and sustained.	

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F 689	Continued From page 3 the transfer Resident #51's legs became weak, and NA #3 had to put her arms around Resident #51 to turn her body and they both landed in a seated position on the bed. Nurse #4 revealed Resident #51 was not in any distress, her vital signs were stable, and no injuries were noted. An interview conducted with Resident #51 on 3/26/25 at 12:24 PM revealed staff used a mechanical lift to transfer her in and out of the bed. Resident #51 stated she was unsure if a NA had ever assisted her with a stand/pivot transfer and she did not recall the incident that occurred on 1/29/25. During an interview with the Director of Nursing (DON) on 3/27/25 at 12:13 PM she stated she was aware of the incident that occurred on 1/29/25. The DON indicated NA #3 assisting Resident #51 with a stand and pivot transfer was unsafe and she should have used the sit-to-stand lift. An interview conducted with the Administrator on 3/27/25 at 1:50 PM revealed Resident #51 required 2-person assistance and the sit-to-stand lift for all transfers. She indicated NA #3 wanted to honor Resident #51's request but should have used the sit-to-stand lift to ensure the transfer was safe.	F 689	The Director of Nursing is responsible for the ongoing compliance of F689 and safe resident transfers. Date of compliance is 4/24/25.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		4/24/25

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F 695	Continued From page 4 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, and Physician Assistant (PA) interviews, the facility failed to ensure oxygen was delivered at the prescribed rate (Resident #41 & Resident #101). These deficient practices occurred for 2 of 2 residents reviewed for respiratory care and services. The findings included: 1. Resident #41 was admitted to the facility on 06/13/2017. Resident #41 had diagnoses which included chronic respiratory failure with hypoxia. Review of the care plan dated 03/26/2024 and revised on 02/25/2025 revealed Resident #41 was at risk for respiratory complications secondary to chronic respiratory failure with hypoxia requiring supplemental oxygen. The interventions included administer oxygen as ordered and observed for signs and symptoms of respiratory complications. Review of Resident #41's electronic medical record (EMR) revealed a physician's orders dated 07/29/2024 for oxygen at 3 liters per minute (LPM) via nasal cannula continuous. Review of Resident #41's annual Minimum Data Set (MDS) assessment dated 02/21/2025 revealed Resident #41 was cognitively intact. The MDS also indicated Resident #41 was receiving oxygen.	F 695	White Oak Manor Charlotte will ensure all residents receiving oxygen therapy are provided the correct oxygen flow rate per physician's orders. Corrective action for residents found to be affected: On March 27th, 2025, it was identified that Residents #41 and #101 were not receiving oxygen at the from rate as ordered by their physicians. Nurse #2 and Nurse #3 were immediately re-educated by the staff development coordinator (SDC) RN on the importance of ensuring oxygen therapy is administered according to physician orders and to monitor the flow rate every shift and every medication pass. The oxygen flow rate was promptly adjusted to reflect the active physician orders. Both residents were assessed by a provider and no adverse effects were noted. Identification of other residents who have the potential to be affected: All residents receiving oxygen therapy have the ability to be affected by the alleged deficient practice. A facility-wide audit was conducted on 3/27/25 by the Director of Nursing to identify other residents with physician-ordered oxygen therapy. All current oxygen orders were reviewed for accuracy, and bedside oxygen was	

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F 695	Continued From page 5 Observations of Resident #41 were completed on 03/24/2025 at 2:16 PM, 03/25/2025 at 10:53 PM, 03/26/2025 at 8:53 AM, and 03/27/2025 at 8:24 AM. During each of the observations Resident #41 was observed in bed with her nasal cannula in her nostrils and the oxygen concentrator set at 4 liters per minute. An interview was completed on 03/27/2025 at 10:01 AM with Nursing Assistant (NA) #1 who was assigned to Resident #41. NA #1 stated she did not do anything with oxygen settings. NA #1 further stated she did make sure the nasal cannula was in place and applied correctly for residents receiving oxygen. An interview was conducted on 03/27/2025 at 10:06 AM with Nurse #2 who was assigned to Resident #41 on 03/27/2025 from 7:00 AM to 3:00 PM. Nurse #2 stated that all residents receiving oxygen should have a physician's order for oxygen which would include the flow rate. Nurse #2 also stated the flow rate should be set as ordered by the physician. Nurse #2 further stated she reviewed Resident #41's physician's orders and stated that Resident #41 should be on 3 liters per minute of continuous oxygen via nasal cannula. An interview was completed with Resident #41 on 03/27/2025 at 10:20 AM. Resident #41 stated that she used to be able to manage her oxygen, but her health had gotten so bad over the years that she could no longer do that. Resident #41 also stated that she did not touch her oxygen concentrator or adjust the flow rate. Resident #41 further explained that she did not know what her oxygen should have been set at.	F 695	verified to be in compliance with those orders. any discrepancies were corrected immediately. Systemic changes to ensure practice does not recur: The Staff Development Coordinator RN provided an in-service education, starting on 3/28/25, to all licensed nursing staff on the importance of verifying and maintaining oxygen flow rates as per physician orders. Nursing staff were educated to verify oxygen settings and flow rate during every shift change and medication pass. This education is provided to all new hires and is added to the orientation material for the facility as well. Physician orders for oxygen therapy will be reviewed upon admission, readmission and with any change in condition. Monitoring to ensure plan is effective; Licensed nurses now use an Oxygen Therapy Verification audit tool for shift-by-shift flow rate verification daily. This is reviewed by the charge nurse daily, and the tool was implemented on 4/3/25. It includes all residents receiving oxygen therapy and will be updated with any residents with new or discontinued orders. The staff development coordinator RN will audit oxygen flow rates for 5 residents a week receiving continuous oxygen therapy for 4 weeks. Additionally, the staff development coordinator or designee will continue monitoring 3 oxygen flow rates a week for a further 8 weeks, for a total of	

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F 695	Continued From page 6 An interview was completed on 03/27/2025 at 10:39 AM with the Director of Nursing (DON). The DON stated Resident #41 did get up to the chair with assistance and Resident #41 could have changed the flow rate on the concentrator. The DON stated she expected the nursing staff to check the physician's order for the prescribed oxygen flow rate and check to make sure residents were receiving the correct oxygen flow rate. The DON further explained that three days of observations for an incorrect oxygen flow rate was not acceptable nursing practice. An interview was conducted on 03/27/2025 at 10:58 AM with the Administrator. The Administrator stated she expected all staff to follow the physician's order for oxygen settings. A telephone interview was conducted with the Physician Assistant (PA) on 03/27/2025 at 2:15 PM. The PA stated all residents receiving oxygen required an active physician's order for the prescribed liters per minute of oxygen they were to receive. The PA further stated nursing staff should follow the physician's orders for providing oxygen including the prescribed flow rate. 2. Resident #101 was admitted to the facility on 04/02/2024. Resident #101 had diagnoses which included congestive heart failure (CHF), respiratory failure with dependence on supplemental oxygen, and atrial fibrillation (AF). Review of the care plan dated 08/27/2024 and updated 02/05/2025 revealed Resident #101 was at risk for respiratory complications secondary to congestive heart failure and respiratory failure requiring supplementary oxygen. The	F 695	12 weeks of monitoring to ensure proper oxygen flow rates are used. The audit tools are reviewed by the Director of Nursing weekly in the morning stand up Quality Improvement (QI) meetings for 12 weeks, and additionally for 3 months in the monthly Quality Assurance and Performance Improvement (QAPI) meetings. Any identified trends will be discussed and recommendations made to ensure compliance is achieved and sustained. The Director of Nursing is responsible for ensuring ongoing compliance with F695 and proper oxygen flow rate usage. Compliance date is 4/24/25.	

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F 695	Continued From page 7	F 695		

interventions included to administer oxygen as ordered, encourage rest periods as appropriate, and observed for signs and symptoms of respiratory complications.

Review of the electronic medical record (EMR) revealed a physician order for Resident #101 dated 08/28/2024 for oxygen at 3 liters per minute via nasal cannula (NC) continuous for shortness of breath related to CHF.

A review of Resident #101's quarterly Minimum Data Set (MDS) assessment dated 11/24/2024 revealed Resident #101 had severely impaired cognition. The MDS also indicated Resident #101 was receiving oxygen.

Observations were completed of Resident #101 on 03/24/2025 at 3:16 PM, 03/25/2025 at 10:58 AM, 03/26/2025 at 8:58 AM, and 03/27/2025 at 8:28 AM. During each of the observations Resident #101 was observed resting in bed with her nasal cannula in her nostrils, the oxygen concentrator was set at 1.5 liters per minute, and Resident #101 was observed to not be in distress.

An interview was completed on 03/27/2025 at 10:01 AM with NA #2 who was assigned to Resident #101. NA #2 stated she did not do anything with oxygen settings. NA #2 further stated she did make sure the nasal cannula was in place and applied correctly for residents receiving oxygen. NA #2 also stated she also checked to make sure the oxygen concentrator was plugged up correctly into the electrical outlet.

An interview was conducted on 03/27/2025 at 10:27 with Nurse #3. Nurse #3 was assigned to

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F 695	Continued From page 8 Resident #101 from 7:00 AM to 3:00 PM on 03/24/2025, 03/25/2024, and 03/26/2025. Nurse #3 stated Resident #101 could not change her oxygen settings independently. Nurse #3 also stated she did not check Resident #101's oxygen flow rate on 03/24/2025, 03/25/2025, or on 03/26/2025. An interview was completed on 03/27/2025 at 10:39 AM with the Director of Nursing (DON). The DON stated Resident #101 could not change her oxygen setting independently. The DON stated she expected the nursing staff to check the physician's order for the prescribed oxygen flow rate and check to make sure residents were receiving the correct oxygen flow rate. The DON further explained she expected the nursing staff to provide oxygen at the prescribed flow rate. An interview was conducted on 03/27/2025 at 10:58 AM with the Administrator. The Administrator stated that she expected all staff to follow the physician's order for oxygen settings. A telephone interview was conducted with the Physician Assistant (PA) on 03/27/2025 at 2:15 PM. The PA stated all residents receiving oxygen required an active physician's order for the prescribed liters per minute of oxygen they were to receive. The PA further stated nursing staff should follow the physician's orders for providing oxygen to all residents including the prescribed flow rate.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		4/24/25

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F 761	Continued From page 9 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to discard expired medications in 1 of 2 medication rooms (South Hall Medication Room) and failed to store a lidded container of prescription topical medicated cream that treats fungal infections in a secure locked storage area for 1 of 1 resident observed with medicated cream at the bedside (Resident #126). The findings included: 1. An observation of the South Hall Medication Room was conducted on 03/25/2025 at 3:19 PM	F 761	White Oak Manor Charlotte will ensure medications are stored in a secure manner, and that all expired medications are discarded appropriately. Corrective Action for Resident Found to be Affected: On March 26th, 2025, Resident #126 was found with medication at the bedside. The medication was immediately removed and discarded per facility protocol. The Physician Assistant (PA) assessed the resident for the continued need of the topical cream, and the order was updated to reflect	

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F 761	Continued From page 10	F 761		

with the Director of Nursing (DON). The observation revealed an unopened bottle of Red Krill Oil (omega 3 vitamin) containing 60 soft gel tablets available for use. The expired bottle of Red Krill Oil was located in the top cabinet of the medication storage room. A review of the pharmacy label affixed to the bottle of Red Krill Oil indicated the expiration date was 07/16/2024. The printed manufacturer's expiration date was illegible. During the observation, an interview with the DON was conducted. The DON confirmed the expiration date and stated there should be no expired medications in the medication storage room or in the medication carts. She also stated the bottle of Red Krill Oil tablets should have been discarded. The DON further explained that all nursing staff were responsible for checking the medication rooms weekly for expired medications and the bottle of Red Krill Oil should have been discarded.

An interview was conducted with the Administrator on 03/27/2025 at 8:23 AM. The Administrator stated that she expected all expired medications be discarded and not available for use.

2. Resident #126 was admitted to the facility on 02/27/24 with diagnoses including generalized weakness and diabetic neuropathy.

The annual Minimum Data Set (MDS) dated 02/08/25 revealed Resident #126 cognitively intact requiring extensive assistant of one staff member for most activities of daily living (ADL). Resident #126 was assessed as having no skin conditions during the assessment period.

On 03/24/25 at 12:25 PM Resident #126 was

appropriate treatment. The resident was assessed and no adverse outcomes were noted. In addition, one unopened, expired bottle of vitamins was discovered in the South Hall medication room. The expired item was promptly removed and discarded in accordance with pharmaceutical waste procedures.

Identification of other residents who have the potential to be affected:
All residents have the ability to be affected by the alleged deficient practice. A facility-wide audit was conducted by the Director of Nursing and Administrative nurses on 3/25/25 to ensure no other medications were at resident beside, and the med rooms were checked for expired medications on all units. No additional expired medications or improperly stored medications were identified during the audit.

Systemic changes to ensure practice does not recur:
Re-education of nursing staff began on 3/25/25 regarding medication storage per facility policy, emphasizing that medications are not to be left at the bedside unless specifically ordered and approved by the physician, and an assessment is completed for the resident to safely self-administer. It also included emphasis on the regular inspection of medication carts and medication rooms for proper storage and monitoring of expiration dates. This education will be complete for all nursing staff on or before 4/24/25, and will be added to orientation

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F 761	Continued From page 11 observed to have a lidded container of prescription topical medicated cream that treats fungal infections on his bedside table. Resident #126 stated, "I put it on my legs and use it for itching." Resident #126 explained he had the cream prior to admission into the facility and had always applied it as he wanted. Resident #126 did not recall where the cream came from. He stated he left it sitting at his bedside and no staff member had ever said anything to him. During an observation of Resident #126's room on 03/25/25 at 2:26 PM the lidded container of prescription topical medicated cream that treats fungal infections remained on his bedside table. During an observation of Resident #126's room on 03/26/25 at 10:27 AM the lidded container of prescription topical medicated cream that treats fungal infections remained on his bedside table. An interview conducted on 03/26/25 at 10:35 AM with Unit Manager #1 revealed she was not aware of any medication on Resident #126's bedside table. She stated no residents in the facility were allowed to keep medications at the bedside. On 03/26/25 at 10:42 AM Unit Manager #1 was accompanied to Resident #126's room and observed the lidded container of prescription topical medicated cream that treats fungal infections located on Resident #126's bedside table. Resident #126 stated to Unit Manager #1, "I put it on my groin". Unit Manager #1 removed the container of medicated cream from Resident #126's room. The container had an expiration date of January/2024.	F 761	for all nursing staff newly hired to ensure continued compliance. Monitoring to ensure the plan is effective: Unit managers or designees will conduct audits twice a week for 4 weeks of resident rooms to observe for medications at the bedside. After 4 weeks, monitoring by unit managers will be completed once a week to ensure continued compliance, for a total of 12 weeks of monitoring. These audits began on 3/28/25. Administrative team members will complete weekly room rounding for 12 weeks to include ensuring no medications or treatments are at the bedside in resident rooms. These rounds began on 4/7/24. Additionally, licensed nurses will complete weekly audits of the facility's medication storage rooms for 12 weeks to ensure no items are present that should be discarded due to expiration or any other reason. These audits began on 3/25/25. The results of these audits will be submitted to the Director of Nursing and reviewed weekly during the morning Quality Improvement (QI) meetings weekly for 12 weeks. Any identified issue or trend will be further discussed at the monthly Quality Assurance and Performance Improvement (QAPI) meetings with the team and any recommendations made as indicated. The Director of Nursing is responsible for the ongoing compliance of F761 and proper drug storage.	

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F 761	Continued From page 12 On 03/26/25 at 2:55 PM an interview was conducted with Nurse #1. During the interview she stated she was Resident #126's nurse during the 7:00 AM to 3:00 PM shift on 03/24/25, 03/25/25 and 03/26/25. She stated she had not noticed the container of medicated cream on the resident's bedside table. The interview revealed she felt the container was missed because the resident had a lot of items on his bedside table, and it was "just missed". On 03/27/25 at 10:00 AM an interview was conducted with the Medical Director. During the interview she stated the medicated cream was appropriate but not for the resident to apply himself. The facility did not know Resident #126 had the container of medicated cream in his room. The Medical Director indicated Resident #126 was alert and oriented but had intermittent confusion and was not assessed to administer his own medications. She stated she had evaluated him on 03/26/25 and there was no harm caused by using the medicated cream. However, it was removed, and he received a new order for a cream to be administered by nursing staff. The Medical Director stated the label on the container indicated the medicated cream had been originally prescribed for application to the resident's groin. On 03/27/25 at 9:55 AM an interview was conducted with the Director of Nursing (DON). She stated a physician's order was required to have any medication at a resident's bedside. The DON stated the facility was unaware Resident #126 had the medicated cream at his bedside otherwise it would have been removed. The medicated cream was not prescribed in-house by the Medical Director.	F 761	Date of compliance is 4/24/25.	

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F 761	Continued From page 13 On 03/27/25 at 9:50 AM an interview was conducted with the Administrator. She stated the medicated cream was immediately removed from the resident's room when it was brought to Unit Manager #1's attention. Resident #126 kept it at his bedside without staff knowing. She stated she expected the nurses to be observant of medication at bedside.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure dishware (divided plates and bowls) were clean for use for 1 of 1 meal service observation and failed to ensure the plate warmer was free of food debris. This practice had	F 812	White Oak Manor Charlotte will ensure the dietary department follows proper sanitation protocols to create a safe and orderly environment for food service production in service to our residents.	4/24/25

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F 812	Continued From page 14 the potential to affect food served to residents. The findings included: On 03/26/25 at 11:30 AM observations of the lunch meal tray line revealed there were divided plates stacked on a cart to the side of the steam table in preparation for the lunch service. Seven of the divided plates were noted to have dried egg particles on the plates. There were also dried egg particles noted on the plate warmer that contained the regular plates for lunch meal service. In addition, there were plastic bowls stacked for meal service and two of the bowls were noted to have dried food particles inside the bowls and around the outside of the bowls. On 03/26/24 at 11:41 AM the food particles on the plate warmer, crumbs and dried egg particles on the divided plates and the food particles on and in the bowls were shown to the Registered Dietitian (RD) and the Regional Dietary Manager. The RD started examining the divided plates and confirmed most of the divided plates had crumbs or dried egg particles on them. An interview on 03/26/25 at 3:00 PM with the Dietary Manager and the Regional Dietary Manager revealed the procedure for assuring dishes were clean before using was a three-step process. The first check occurred when dishes were removed from the dishwasher, the second check occurred when the dishes were put on drying racks or in storage and then a third check when dishes were moved to the tray line for use. The Dietary Manager and Reginal Dietary Manager stated the Dietary Aides had not paid close attention to the dishes prior to putting them on the tray line for meal service.	F 812	Corrective Action to those found to be affected: An on-site inspection on 3/26/25 identified several divided plates, bowls, and the plate warmer machine as having alleged dried food debris present. All affected items and surfaces were immediately re-washed, sanitized, and verified to be clean before reuse in food service. No residents were served with unclean dishware. System changes to ensure practice does not recur: On March 26th, all dietary staff on both shifts that day received re-education on proper dishwashing procedures, including the importance of visual inspection of dishware and equipment for food debris prior to use. Staff were also educated during this in-service on proper cleaning and sanitation protocols for the kitchen surfaces and food equipment such as the plate warmer. This education will be complete for all dietary partners on or before 4/24/25 and will extend to all new hires upon orientation. Signage outlining dishwashing procedures and sanitation steps were posted at the dishwashing station as a visual reminder. The Dietary Manager enforced the requirement that all dishware be inspected for cleanliness after completing the wash cycle before food service and that all equipment be cleaned according to the facility's sanitation schedule to ensure compliance with regulation and	

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F 812	Continued From page 15 An interview on 03/27/25 at 3:11 PM with the Administrator revealed she would have expected the dishes and the equipment to have been clean and free of debris and food particles prior to the meal service.	F 812	facility policy to provide residents with a high quality dining experience. Monitoring to ensure the plan is effective: The Dietary Manager or designee will conduct daily audits of dishwashing and sanitation on both shifts daily for a period of 4 weeks to ensure no plates or bowls with food debris are used in food service and all kitchen surfaces and equipment, including the plate warmer, are free from food debris. After the initial daily monitoring for 4 weeks, the dietary manager or designee will continue to monitor dishwashing and sanitation audits 3 times a week for 8 weeks, for a total of 12 weeks of monitoring. The Registered Dietitian will complete a weekly sanitation audit during the same 12 week period to ensure compliance with sanitation guidelines. Audit findings will be reviewed weekly in the morning Quality Improvement (QI) meetings for 12 weeks. Any identified issues or trends will be discussed further at the monthly Quality Assurance and Performance Improvement meetings with the team and recommendations made as indicated to ensure compliance is achieved and sustained. The Dietary Manager is responsible for ensuring the ongoing compliance of F812. The compliance date is 4/24/25.	
F 880 SS=D	Infection Prevention & Control	F 880		4/24/25

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F 880	Continued From page 16 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 17 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow their Hand Hygiene policy when the Treatment Nurse did not perform hand hygiene before each donning of clean gloves while providing wound care to Resident #63. This deficient practice occurred for 1 of 5 staff members observed for infection control practices (Treatment Nurse). The findings included:	F 880	White Oak Manor Charlotte will ensure appropriate infection control standards are met for all residents, including hand washing per policy, in order to maintain a a safe, sanitary and comfortable environment. Corrective Action for the resident(s) found to have been affected: On March 25th, 2025, it was observed	

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F 880	Continued From page 18 Review of the facility's policy and procedure entitled Hand Hygiene read in part: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: - Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident) - After contact with a resident's mucous membranes and body fluids or excretions; - After handling soiled or used linens, dressings, bedpans, catheters, and urinals; - After removing gloves or aprons; and - After completing duty. A wound observation was made on 03/25/25 at 2:13 PM on Resident #63 with the Treatment Nurse. The Treatment Nurse was observed cleaning the bedside table with disinfectant wipe and placed her wound supplies on wax paper on the table after it dried. The treatment nurse donned a clean gown and sanitized her hands and donned clean gloves and removed the old dressing from the resident's right lateral leg and measured the wound with a disposable paper measuring tape. The Treatment Nurse then doffed her gloves and without sanitizing her hands, donned a clean pair of gloves and proceeded to rub cream on the resident's right leg and foot. She then doffed her gloves and without sanitizing her hands, donned clean gloves and cleansed the wound with normal saline soaked gauze from the inside of the wound outward. The Treatment Nurse then doffed her gloves, sanitized her hands and donned clean gloves and patted the wound dry with gauze, doffed her gloves, sanitized her hands and donned clean	F 880	that a treatment nurse failed to sanitize her hands properly during a wound care treatment. The treatment nurse was immediately re-educated on appropriate hand hygiene practices as outlined in the facility policy that includes following CDC infection prevention practices, including sanitizing her hands each time removed gloves, before putting another pair of gloves on. The resident (#63) was monitored after treatment and no adverse effects were identified. Identification of Other Residents Who Have the Potential to be Affected: Since proper hand hygiene is essential to prevent infection, all residents have the potential to be affected by the deficient practice. A review of the recent treatments and infection control logs revealed no additional concerns. Staff interactions with residents were evaluated to ensure adherence to current infection control standards. This observation was conducted on 3/26/25 by the Director of Nursing and all proper hand hygiene procedures were followed during wound care observations following re-education. Systemic Changes to Ensure Practice does not Recur: All nursing staff will be educated by 4/24/25 on hand hygiene policy, a part of the Infection Control procedures - this in-service began on March 25th, 2025. This includes when and how to perform	

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F 880	Continued From page 19 gloves and applied silver alginate to the wound bed and covered it with bordered gauze and then covered the resident's leg with his sheet. She then proceeded to Resident #63's left leg posterior skin tear for treatment. The Treatment Nurse doffed her gloves, sanitized her hands and donned clean gloves and rubbed cream on the resident's left lower leg and foot. She doffed her gloves, sanitized her hands and donned clean gloves and removed the old dressing from the resident's left posterior lower leg skin tear. The Treatment Nurse doffed her gloves and without sanitizing her hands, donned clean gloves and cleansed the wound with normal saline soaked gauze from inside of the wound outward, doffed her gloves, and without sanitizing her hands, donned clean gloves and patted the wound dry with gauze. She doffed her gloves, sanitized her hands and donned clean gloves and applied xeroform to the wound bed and covered with a bordered gauze dressing. The Treatment Nurse doffed her gloves, sanitized her hands and donned clean gloves and cleaned her scissors she had used to cut the xeroform with soap and water and then placed them in her pants pocket. She then doffed her gown, washed her hands with soap and water, collected her supplies and trash and wiped down the table and left the resident's room. An interview on 03/25/25 at 2:47 PM with the Treatment Nurse revealed she was not aware that she had not sanitized her hands each time she had doffed her gloves. She stated she had to change gloves so much during the wound care that she must have forgotten to always sanitize her hands when she removed her gloves. The Treatment Nurse further stated she knew she was supposed to always sanitize her hands when	F 880	handwashing or use alcohol-based hand rubs in accordance with CDC guidelines and facility policy, with a focus on hand hygiene during direct care, wound care, and medication or treatment administration. The facility reinforced the expectation that hand hygiene must be performed before and after all applicable resident contact and care procedures, particularly during wound care. Hand hygiene signage and reminders were posted at sinks and hand sanitizer stations at each unit. This education has been added to the orientation process for all new hires as well. Monitoring to ensure the plan is effective: The staff development nurse or designee will perform 5 random observations per week for 4 weeks, with 2 observations being wound care focused. After the initial 4 weeks, the staff development coordinator or designee will complete 3 observations of hand hygiene per week, with one of the observations being wound care focused, for 8 additional weeks, for a total of 12 weeks of monitoring. Observations with any required interventions or re-education will be completed and documented by the staff development coordinator to ensure compliance with infection control standards. The findings of the observations of hand hygiene will be reviewed at least monthly by the Infection Preventionist and Director of Nursing during the monthly Quality Assurance and Performance	

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F 880	Continued From page 20 she removed her gloves each time and before putting on clean gloves. An interview on 03/27/25 at 11:38 AM with the Infection Preventionist (IP) revealed he was aware of the errors made by the Treatment Nurse during wound care. He stated his expectation was that she would sanitize her hands every time that she removed her gloves and before putting on clean gloves during wound care. The IP further stated staff received education on infection control annually and multiple times during the year. An interview on 03/27/25 at 11:54 AM with the Director of Nursing (DON) revealed she was aware of the Treatment Nurse's errors during wound care and said she had been provided with additional education regarding doffing and donning and sanitizing in between glove changes. The DON stated it was her expectation that the Treatment Nurse follow infection control best practices to avoid introducing microorganisms into the wounds. She further stated there was a lot of donning and doffing and in the Treatment Nurse's mind she thought she had done the appropriate practice. An interview on 03/27/25 at 3:14 PM with the Administrator revealed she would expect the Treatment Nurse to follow the Hand Hygiene policy for wound care. The Administrator stated it was her understanding that the Treatment Nurse did do another dressing change in which she didn't make any errors in the procedure.	F 880	Improvement (QAPI) meetings to ensure compliance is achieved and sustained without the need for further corrective action. The findings from the monitoring tools will be reviewed weekly in the morning Quality Improvement (QI) meetings weekly for 12 weeks. Any identified issues or trends will be further discussed at the monthly Quality Assurance and Performance Improvement (QAPI) meetings with the team and recommendations made as indicated. The Director of Nursing is responsible for the ongoing compliance for F880. Compliance date is 4/24/2025.	