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	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Charlotte	4009 Craig Avenue Charlotte, NC 28211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Family Member, facility staff, Nurse Practitioner, and Medical Director, the facility failed to resume Eliquis, an anticoagulant commonly known as blood thinner, for Resident #1. Upon admission in March 2025, Resident #1 was prescribed Eliquis due to a history of deep vein thrombosis and pulmonary embolus. The medication was temporarily discontinued on 7/2/2025, in preparation for a scheduled medical procedure performed on 7/7/2025. However, the facility did not restart Eliquis until 10/1/2025, nearly three months later, after the resident began exhibiting symptoms including shortness of breath, bilateral lower extremity (BLE) edema, and a need for supplemental oxygen. On 10/7/2025, Resident #1 was transferred to the Emergency Department, where he was diagnosed with bilateral pulmonary emboli (blood clot in the lungs), including a complete occlusion (blockage) in the right lower lobe suggestive of pulmonary infarction (death of lung tissue due to occlusion of blood flow). The resident required a heparin (a blood thinner) drip and underwent thrombectomy (a surgical procedure) to remove the clots. Resident #1 was readmitted to the nursing home on [DATE] after a nine day stay at the hospital. This deficient practice affected 1 of 3 sampled residents reviewed for quality of care (Resident #1). Immediate jeopardy began on 7/7/25 when the facility failed to restart Eliquis for Resident #1. Immediate jeopardy was removed on 10/26/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (irregular heart rhythm) and benign prostatic hyperplasia (a condition where the prostate gland enlarges, causing symptoms such as difficulty urinating and a frequent need to urinate), type 2 diabetes, urinary retention, a history of deep vein thrombosis (DVT), and a history of pulmonary embolus. On 3/19/25, the physician ordered Eliquis 5 milligrams (mg) by mouth every 12 hours. Resident #1's care plan included an anticoagulant therapy problem with the start date of 3/24/25. The goal read the resident will have no complications related to anticoagulant therapy through next review. Approaches included monitoring for signs and symptoms of bleeding and provide lab work and medications as ordered. On 6/2/25, Resident #1 was seen for a urology consultation. The progress note indicated that due to the resident's medical history and ongoing use of chronic anticoagulation therapy, medical clearance would be required to minimize bleeding risks prior to the planned procedure. The note also stated that a follow-up visit was pending based on the availability of the outpatient surgery schedule for a suprapubic catheter replacement. However, the urologist's documentation did not include a confirmed date for the procedure or any preoperative orders. Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact. He was coded for supervision, moderate assistance, and substantial assistance for activities of daily living. He was coded to have an indwelling urinary catheter and for anticoagulant medication use. Medication Administration Records (MAR) from 4/21/25 through 7/2/25 revealed Eliquis was administered as ordered. Eliquis was not administered to Resident #1 after 7/2/25. A Nurse Practitioner's (NP) progress note dated 7/2/25 indicated Resident #1 was seen, had no complaints of shortness of breath (SOB), was awake and alert and appeared comfortable in his wheelchair. Resident #1 had an indwelling catheter and would be seen on Monday (7/7/25) at the urologist for a suprapubic catheter placement procedure. Resident #1 was to be nothing by mouth on Sunday night (7/6/25) and Resident #1's Eliquis would be held per the urologist pre-operation instructions. Additionally, the progress note wrote the NP had discussed the information with nursing. A review of Resident #1's physician's orders dated 7/2/25 found Eliquis 5 mg by mouth every 12 hours was discontinued. Nurse Practitioner notes were reviewed for 7/8/25, 7/9/25, 7/15/25, 7/16/25, 7/24/25 and 7/28/25. Each note included this statement, I have reviewed the resident's medications in the facility chart (MAR). Refer to the facility's Medication Administration Record (MAR) for a complete and up to date list of active medications. The only visits with findings that were not at baseline were 7/16/25 that included a notation for catheter site intact with mild tenderness and on 7/28/25 that included a notation for redness and mucous at catheter site. Every plan in the six notes included a mention of medication, such as active medication includes a blood thinner, medications reviewed, continue Eliquis, continue current medication including blood thinner. The Medical Director's notes were reviewed for 8/18/25, 9/5/25, 9/11/25 and 9/12/25. Each note indicated the resident's medications were reviewed in the

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Nurse Practitioner, and Physician interviews, the medical providers failed to review the total plan of care and ensure the medication list on the Nurse Practitioner and Physician progress notes were accurate for 1 of 3 residents reviewed to ensure the facility is free of medication errors (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation and benign prostatic hyperplasia. Resident #1's Nurse Practitioner (NP) progress note dated 7/02/25 untimed, read that the resident's Eliquis (blood thinner medication) would be held prior to a suprapubic catheter placement procedure. The medication list included Eliquis 5 milligrams (mg) oral (by mouth) every 12 hours. An order dated 7/02/25 at 1:37 PM was created by the NP to discontinue the Eliquis. Resident #1's NP progress note dated 7/31/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's NP progress note dated 8/07/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's NP progress note dated 8/11/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's Physician (MD) progress note dated 8/18/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' There was an addendum clinical clarification electronically signed by the MD on 10/22/25 which read that the patient was not taking Eliquis on the date of the progress note. Resident #1's MD progress note dated 9/05/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' There was an addendum clinical clarification electronically signed by the MD on 10/22/25 which read that the patient was not taking Eliquis on the date of the progress note. Resident #1's MD progress note dated 9/11/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' There was an addendum clinical clarification electronically signed by the MD on 10/22/25 which read that the patient was not taking Eliquis on the date of the progress note. Resident #1's MD progress note dated 9/12/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' There was an addendum clinical clarification electronically signed by the MD on 10/22/25 which read that the patient was not taking Eliquis on the date of the progress note. Resident #1's NP progress note dated 9/17/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's NP progress note dated 9/24/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's NP progress note dated 9/30/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Consultant Pharmacist, Nurse Practitioner, Medical Director and Director of Nursing, the facility's Consultant Pharmacist failed to identify a significant lapse in anticoagulant therapy. Specifically, Eliquis (an anticoagulant, also known as a blood thinner) was discontinued on 7/2/25 for a surgical procedure and was not resumed until 10/1/25. This interruption in therapy was not addressed in the drug regimen reviews following the procedure, thereby failing to ensure the continuation of chronic anticoagulant treatment for Resident #1. This deficient practice was identified in 1 of 3 residents reviewed for unnecessary medications (Resident #1).Findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation, type 2 diabetes, and a history of pulmonary embolus. On 3/19/25, the physician ordered Eliquis 5 milligrams (mg) by mouth every 12 hours. Resident #1's physician orders for July 2025 revealed Eliquis 5 mg by mouth every 12 hours was discontinued on 7/2/25. The Consultant Pharmacist review of Resident #1 dated 7/30/25, 8/25/25, and 9/24/25 revealed no recommendations for restarting the Eliquis medication.On 10/1/25 a physician's order was written for 2 Eliquis 5 mg tablet and to administer every 12 hours for total 10 mg.The Consultant Pharmacist was interviewed via phone on 10/23/25 at 9:07 AM. He stated a pharmacy review for Resident #1 was completed on 7/30/25, 8/25/25 and on 9/24/25. The Consultant Pharmacist stated he did review NP and Medical Director's notes along with labs and it was an oversight that the Eliquis was not included on his July 2025 pharmacy review. The Consultant Pharmacist stated Eliquis was not on Resident #1's medication list for August 2025 and September 2025 because he knew Eliquis had been stopped by the physician. The pharmacist stated the Eliquis might have been stopped because of bleeding after the procedure or other reasons, but he did not remember specifics. The Medical Director was interviewed on 10/23/25 at 12:10 PM and stated the monthly pharmacy reviews should have caught the Eliquis was not restarted and brought it to her attention. An interview on 10/23/25 at 4:18 PM with the Administrator and DON revealed the Eliquis medication should have been reviewed and captured on the pharmacy reviews for Resident #1.