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	11/18/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Medical Director interviews, the facility failed to correctly transcribe a verbal physician's order for twice daily blood sugar checks resulting in no blood sugar checks being performed during a resident's admission. This affected 1 of 3 residents reviewed for services provided meet professional standards (Resident #3).The findings included:Resident #3 was admitted to the facility on [DATE] with diagnoses which included sepsis, diabetes mellitus, failure to thrive and end stage renal disease which required hemodialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are no longer able to do so) three times weekly.A review of Resident #3's electronic medical record revealed a physician verbal order dated 9/5/2025 at 9:12 PM for check blood sugar twice daily. Resident #3 was not on any diabetic medication.A care plan dated 9/10/2025 indicated Resident #3 had a diagnosis of diabetes mellitus and was at risk for complications related to the disease process with a goal that Resident #3 would not experience any complications of diabetes mellitus. Interventions included monitor for signs and symptoms of hyperglycemia (high blood sugar), monitor for signs and symptoms of hypoglycemia (low blood sugar), and obtain lab work as ordered.A review of Resident #3's electronic medical record (EMR) indicated no record of blood sugar being drawn from the date of admission 9/5/2025 to discharge 9/10/2025. An interview on 10/1/2025 at 4:40 PM with the Director of Nursing (DON) revealed that the physician's verbal order dated 9/5/2025 at 9:12 PM for check blood sugar twice a day had been provided to Nurse #2 by the Medical Director. The DON indicated when Nurse #2 entered the verbal order, Nurse #2 neglected to choose an option under the Flow Sheet box (treatment versus medication) which resulted in the order never being displayed on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). The DON stated a blood sugar was not taken while Resident #3 was a resident. The DON stated orders written within the last 24 hours are reviewed by nursing staff for accuracy and she was not sure why the transcription error was not discovered.An interview on 10/1/2025 at 5:08 PM with Nurse #2 indicated she took the verbal order for check blood sugar twice a day from the Medical Director. Nurse #2 stated she was new to entering orders and made a mistake when entering the order.An interview on 10/1/2025 at 5:43 PM with the Administrator indicated that all physician orders should be entered correctly.An interview on 10/2/2025 at 8:40 AM with the Medical Director revealed Resident #3 was a very sick individual and had an extended hospital stay prior to admission to the facility. The Medical Director stated the verbal order dated 9/5/2025 at 9:12 PM for check blood sugar twice daily was provided as Resident #3 had a history of low blood sugar episodes while in the hospital prior to admission to the facility. The Medical Director stated Resident #3 was not on any diabetic medication. The Medical Director indicated that all orders should be transcribed correctly.

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

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	11/18/2025

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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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 0925 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 observations, and resident, staff, Family Member #1, and Pest Control Representative interviews, the facility failed to effectively manage pests in 1 of 3 resident rooms (Resident #1) reviewed for pest control and for 1 of 1 observation for pest control in the conference room.Findings included: Resident #1 was admitted to the facility on [DATE] with diagnosis of peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of Resident #1's Minimum Data Set (MDS) quarterly assessment dated [DATE] indicated he had moderately impaired cognition. An interview and observation were conducted on 09/30/25 at 10:31 AM with Resident #1. During the interview he stated he had observed flies/gnats in his room, but it was in a previous room. Resident #1 stated he had been to the hospital recently but could not recall what for and told the surveyor he had the wounds on his left lower leg prior to entering the facility. During the observation there were no flies or gnats noted in Resident #1's room. An interview was conducted on 09/30/25 at 3:00 PM with Family Member #1. During the interview she stated Resident #1's room was observed with flies and gnats on multiple occasions in August 2025. She stated on 08/02/25 she had to personally go out and purchase an ultraviolet (UV) insect trap and place it into Resident #1's room. Family Member #1 explained she had received permission for the insect trap from a previous Administrator. The interview revealed the flies/gnats were so bad in Resident #1's room the family was, swatting at them. Family Member #1 stated they had told numerous facility staff members during August 2025. The interview revealed Resident #1 went to the hospital on [DATE] and had since changed rooms. An interview and observation were conducted on 09/30/25 at 3:40 PM with Resident #2. During the interview Resident #2 stated he was Resident #1's former roommate. He stated he had always experienced flies and gnats in his room and had even purchased a spray to help with the insects. No insects were observed at the time of the observation, however, snacks, bread and a small refrigerator were observed in Resident #2's room. He explained his former roommate (Resident #1) had purchased a blue light to catch insects in. He stated the facility attempted to remove his trash, but he had never seen anyone spray the room for insects. An interview conducted with the Wound Nurse on 09/30/25 at 1:53 PM revealed Resident #1 was admitted into the facility with venous ulcers (a wound on the leg or ankle caused by abnormal or damaged veins). She explained the resident had been receiving treatment to the wounds since admission and the areas were improving. The interview revealed Resident #1 was in the room with a roommate who had a refrigerator and would often leave open food in the room attracting flies and gnats. The Wound Nurse stated she had observed flies and gnats in Resident #1's room to the point Resident #1's Family Members had purchased a blue light ultraviolet (UV) insect trap and placed it in the room. She stated on 08/21/25 she went into Resident #1's room to clean and dress his wound to the left leg without any issues. She did not remember seeing flies or gnats on that date. The wound was wrapped with a bandage from the resident's toes to his left shin. The interview revealed the area to Resident #1's left leg was changed on Mondays and Thursdays. The Wound Nurse stated she saw Resident #1 on 08/22/25 and he was at his baseline, up sitting in his wheelchair with the bandage to his left leg in place. An interview conducted with Nurse Aide (NA) #1 on 09/30/25 at 11:23 AM revealed she worked in the facility on Resident #1's hall during the Monday through Friday shift 7:00 AM to 3:00 PM. NA #1 explained she had observed flies and gnats in the resident's room and administrative staff were aware of the situation because of the resident's roommate (Resident #2). An interview conducted with NA #2 on 10/01/25 at 11:30 AM revealed she had taken care of Resident #1 on 08/21/25 during the 7:00 AM to 3:00 PM shift. She stated she observed one or two flies in the resident's room due to snacks left open in the room and trash in the trash can. NA #2 stated she observed Resident #1's ultraviolent insect trap in his room with insects inside, on the trap. She explained that she removed the trash from his room and tried to clean up as much as she could but also housekeeping staff had come by to assist. Hospital records dated 08/23/25 revealed Resident #1 was admitted into the hospital on this date due to generally feeling weak and the need for increased oxygen. Upon assessment in the hospital Resident #1 was noted to have left lower extremity venous ulcers and blisters to the mid left shin. Resident #1 was admitted and treated for sepsis to chronic venous statis ulcer and returned to the facility on 9/12/25. On 09/30/25 at 4:06 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated Resident #1's wounds were always dressed and cleaned. The DON explained on 08/23/25 Resident #1 had experienced a change of condition and was sent to the hospital. The DON stated she had physically seen small flies or gnats in