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	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 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 [DATE] with diagnoses including chronic obstructive pulmonary disease and type 2 diabetes. The admission Minimum Data Set (MDS) assessment dated [DATE] 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 on to 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. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 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 [DATE]. 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 [DATE] revealed Resident #41 was cognitively intact. The MDS also indicated Resident #41 was receiving oxygen. 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE]. 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 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 [DATE] 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 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 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 with the Director of Nursing (DON). The observation revealed an unopened bottle of Red [NAME] Oil (omega 3 vitamin) containing 60 soft gel tablets available for use. The expired bottle of Red [NAME] Oil was located in the top cabinet of the medication storage room. A review of the pharmacy label affixed to the bottle of Red [NAME] 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 [NAME] 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 [NAME] 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. 40476 2. Resident #126 was admitted to the facility on [DATE] with diagnoses including generalized weakness and diabetic neuropathy. The annual Minimum Data Set (MDS) dated [DATE] 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 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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 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 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 [NAME] 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. 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37019 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: 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.