

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2025
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Burlington		STREET ADDRESS, CITY, STATE, ZIP CODE 323 Baldwin Road Burlington, NC 27217	

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)
<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289</p> <p>Based on record review, and interviews with staff, Physician, and Nurse Practitioner, the facility failed to ensure the physician was notified when Resident # 3 was initially identified by Nurse Aide # 5 to have discomfort with positioning, swelling, and bruises on his arm and chest with no known cause and while the resident was not receiving an anticoagulant. The physician was not notified until the following shift. When Resident # 3's physician was notified and a complete assessment was conducted, multiple bruises were found on both arms and the resident's chest which was a broader area than had been reported by Nurse Aide # 5 when she identified bruising. The bruising was irregular in shape and included both red and purple bruising. Two days following the initial identification of the bruises, the resident was transferred to the hospital ED (Emergency Department) where A CT (computerized tomography) of the chest abdomen and pelvis with contrast was completed. The CT impression read, 1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip. Unexplained bruises could be a sign of abuse or neglect and require an investigation. According to an interview with Resident # 3's physician, the provider should have been notified on the shift the bruises, discomfort, and swelling were identified because of the extent of the unexplained bruises. Additionally, for another resident (Resident #9), the facility failed to notify the physician on multiple occurrences when Resident # 9's documented elevated FSBS (finger stick blood sugar) readings exceeded 400 and both the Nurse Practitioner and Physician reported they should have been notified so that orders could be given. (Normal blood sugar values for nondiabetic individuals typically do not exceed 125). On the evening of 1/24/25 after Resident # 9's last documented finger stick blood sugar (FSBS) reading registered 524 the resident fell after becoming dizzy. The resident was transferred to the hospital where he was diagnosed with a small subdural hematoma (type of bleeding near your brain that can happen after a head injury). For a third resident (Resident # 11), the facility also failed to ensure the physician was notified following falls while the resident was receiving anticoagulant medication which placed him at greater risk of bleeding. This was for three of five sampled residents reviewed for physician notification.</p> <p>Immediate Jeopardy began on 12/18/24 for Resident # 3 when Nurse Aide # 5 identified during her shift that Resident # 3 had unexplained bruises, swelling, and discomfort and there was no physician notification. Immediate Jeopardy began for Resident # 9 on 1/8/25 when his FSBS registered 409 and there was no physician notification. Immediate Jeopardy was removed on 3/28/25 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 E to ensure education is completed and monitoring systems put in place are effective. Example # 3 was cited at a scope and severity level of D.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 345301
		If continuation sheet Page 1 of 55

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The findings included:</p> <p>1. Resident # 3 was admitted to the facility on [DATE]. The resident's diagnoses in part included dementia, congestive heart failure, Parkinson's, atrial fibrillation, anxiety, and dysphagia.</p> <p>Resident # 3's annual Minimum Data Set (MDS) assessment, dated 10/14/24, coded the resident as severely cognitively impaired and as needing total staff assistance for bathing, dressing, and hygiene needs. Resident # 3 was coded as needing partial to moderate assistance to roll from side to side in bed and as needing substantial to maximum assistance to transfer.</p> <p>Review of Resident # 3's medication regimen for December 2024 revealed Resident # 3 was not on an anticoagulant.</p> <p>Review of staffing sheets revealed on the night shift which began at 11:00 PM on 12/17/24 and ended at 7:00 AM on 12/18/24, Employee # 1 was assigned to care for Resident # 3 as a nurse.</p> <p>Review of Employee # 1's statement revealed it was dated on 12/19/24 and read, I was collecting [Resident # 3's] routine 02 when I notice he had some bruising to his right shoulder as well as some to his left. No fall or bruising was reported from the previous shift to me in report so my next thought was to bring it to our unit coordinators attn. that he had bruising on him. Before I could bring it to [Unit Coordinator's] attention it was brought to my attention once more by the next shift and when the unit coordinator got here I immediately let her know my findings so it could be documented properly.</p> <p>Employee # 1 was interviewed on 3/25/25 at 2:57 PM. This interview revealed Employee # 1 was not a nurse, she did not know how the bruises had occurred, and she had not notified the physician about Resident # 3's bruises.</p> <p>According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However I notice some bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I notice while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aid to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been washed up by the 2nd shift. He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was a golf ball sized bruise on his arm which appeared light reddish and turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise, and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift and staff were already aware it was there. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse.</p> <p>A review of nursing notes revealed the first entry documenting the resident's bruising and that the physician was notified was on 12/18/24 at 7:32 AM by Nurse # 1. The entry was entered into the record as a late entry on the date of 12/19/24 at 8:08 AM. The entry read, Resident able to make needs writer made aware during report that resident had bruising to left side of chest, armpits, and arms. VS 128/77 (blood pressure), 97 % on RA (room air), 18 (respirations), 97.9 (temperature), 63 (pulse.) No s/s (signs and symptoms) of SOB (shortness of breath), wheezing or labored breathing. Facial grimacing noted when resident move his left arm. Resident refused to be repositioned . Nurse # 1 further noted Resident # 3 had an order for Tylenol 325 mg (milligrams) 2 tabs every 6 hours. Nurse # 1 also noted the physician was notified and orders were obtained for a stat x-ray on the chest, right arm and left arm. The Director of Nursing (DON), Unit Coordinator, and Social Worker were also notified.</p> <p>Review of physician progress notes revealed the resident's physician, who served as the facility medical director, assessed Resident # 3 on 12/18/24. The physician noted, He (Resident # 3) was noted this morning to have bruising on his upper body. Patient has cognitive impairment and is not able to tell us what happened. Last BIMS (brief interview for mental status) 2/15. He seems to only have pain when moving the left shoulder. No documented falls. He was given Tylenol for pain. The physician further documented measurements of the bruising as follows: Note Bruises were irregular shaped and were measured at largest diameter. Right anterior chest upper near midline, about 5.5 X 3.5 cm (centimeters) reddish with some faint purplish area inferior to it. Right shoulder near AC joint circular reddish abrasion. Right shoulder lateral clavicle about 7 x 6 cm irregular shaped reddish bruise with faint deeper purple underneath it extending further down about 5 X 8 cm at largest diameter. Right arm-3 circular bruises about 1 cm each-2 inner bicep mid to distal and 1 lateral inferior. Left chest wall- Pacemaker scar with 6 small irregular shaped purplish red bruises. Pacemaker appears more lateral and turned/sticking out. Left side -about 7 X 3 cm reddish bruise with faint edges in shoulder near clavicle. Large reddish purple about 10 X 4 cm inferior to tattoo on lateral upper arm. Left arm-irregular shaped bruise going down bicep with varying colors-reddish to darker purple inferior, 12 X 4 cm around to lateral aspect of arm. 8 X 3 cm circular bruise purplish inferior and medial to elbow. Large left chest wall bruise light purplish edges wraps around chest lateral to nipple, darker purple on posterior chest. No ecchymosis (discoloration of the skin, typically caused by bruising) neck, facial area, or body below waist. Within the progress note, the physician noted a chest x-ray and complete blood count would be obtained. The physician further noted that she was unsure when the pacemaker had been placed or last tested . She further noted the pacemaker appeared to be turned/sticking out more.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident # 3's Physician, who serves as the facility's medical director, was interviewed on 3/21/25 at 3:13 PM and reported the following information. When she evaluated Resident # 3 on 12/18/24 the bruising was all on his upper body which included areas on his arms and chest wall which wrapped around some on his trunk. According to the Physician the provider should have been called during the night when the bruising was found due to the extent of the bruising. She learned of the bruising when she arrived at the facility during the dayshift of 12/18/24.</p> <p>2. Record review revealed Resident # 9 was admitted to the facility on [DATE] and had diagnoses which in part included diabetes and Alzheimer's dementia.</p> <p>Review of Resident # 9's admission Minimum Data Set assessment, dated 11/13/24, coded Resident #9 as severely cognitively impaired and as receiving Insulin.</p> <p>Review of physician orders revealed Resident # 9 was ordered to receive Eliquis 5 mg (milligrams) every 12 hours for atrial flutter. This order began on 11/8/24. (Eliquis is an anticoagulant and increases the chances of bleeding).</p> <p>Resident # 9's care plan included the information that Resident # 9 was a diabetic. This was added to the care plan on 11/8/24 and remained part of the resident's active care plan. Staff were directed on the care plan to monitor blood sugar levels as ordered and both observe and report any signs and symptoms of hyperglycemia or hypoglycemia.</p> <p>Review of physician orders and Resident # 9's January 2025 MAR (medication administration record) revealed the following information.</p> <p>Resident # 9 had an order for FSBS (fingerstick blood sugars) twice per day. This order had originated on 11/8/24 and was in effect until discontinuation on 1/27/25. There were no physician orders regarding what parameters the physician should be notified when the FSBSs were obtained.</p> <p>According to the January 2025 MAR, the FSBS were scheduled for 6:30 AM and 4:30 PM. There were no orders for parameters to call the provider regarding results and there was no order for sliding scale insulin coverage based on FSBS results.</p> <p>Review of physician orders revealed between the dates of 1/1/25 and 1/24/25, the only type of insulin Resident # 3 was prescribed was a long acting insulin given at night and there was one order change in Resident # 9's diabetic medication dosages. Specific medications and the dosage order change were as follows:</p> <p>Jardiance 25 mg (milligram tablet once per day. This order was in effect from 12/7/24 until its discontinuation on 1/27/25.</p> <p>Metformin 500 mg tablet twice per day. This order was in effect from 12/13/24 until discontinuation on 1/27/25.</p> <p>Ozempic pen injector; 0.5 mg; subcutaneous once per week on Monday. This order was in effect from 11/11/24 until discontinuation on 1/27/25.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); Administer 15 units subcutaneous at bedtime. This order was in effect from 12/31/2024 until the discontinuation on 01/06/2025. (Lantus is a long- acting insulin which can last up to 24 hours but does not have a rapid onset of action).</p> <p>Insulin glargine-yfgn insulin pen; 100 unit/mL (3 mL); Administer 15 units subcutaneous at bedtime. This order was in effect from 1/6/25 until discontinuation on 1/18/25. (Insulin glargine-yfgn is a biosimilar interchangeable insulin product to insulin glargine which the resident was already receiving. There were no dosage changes).</p> <p>The date of 1/18/25 was the only date where an increase in insulin dosage order was noted in the chart from 1/1/25 to 1/24/25. The order was for insulin glargine-yfgn insulin pen; 100 unit/mL (3 mL); Administer 18 units subcutaneous at bedtime. This order was in effect until discontinuation on 1/27/25.</p> <p>According to the record, the physician entered a progress note on 1/18/25 and noted his hemoglobin HgbA1c on 12/24/24 had been 9.2 and she would increase the resident's long-acting insulin from 15 to 18 units. (Hemoglobin A1c is a blood test that measures the average blood sugar result in the last two to three months. A result of 6.5% and above reflects diabetes.)</p> <p>Review of Resident # 9's MAR revealed multiple times Resident # 9's FSBS exceeded 400 from 1/1/25 to 1/24/25 without any documentation the physician was notified in the record. Specifics are as follows</p> <p>On 1/8/25 at 6:30 AM Employee # 1 documented 409 on the MAR.</p> <p>On 1/10/25 at 6:30 AM Nurse # 6 documented 433 on the MAR.</p> <p>On 1/10/25 at 4:30 PM Nurse # 7 documented 423 on the MAR.</p> <p>On 1/18/25 at 4:30 PM Nurse # 8 documented 413 on the MAR.</p> <p>On 1/22/5 at 6:30 AM Medication Aide (MA) # 1 documented 453 on the MAR.</p> <p>On 1/22/25 at 4:30 PM MA # 2 documented 456 on the MAR.</p> <p>On 1/23/25 at 6:30 AM Nurse # 9 documented 419 on the MAR.</p> <p>On 1/23/25 at 4:30 PM MA # 3 documented 403 on the MAR.</p> <p>On 1/24/25 at 6:30 AM MA # 4 documented high on the MAR.</p> <p>On 1/24/25 at 4:30 PM Nurse # 5 documented 524 on the MAR.</p> <p>Nurse # 6 was interviewed on 3/25/25 at 1:45 PM and reported she did not recall details of the date of 1/10/25 but she would normally call the physician and make a note she had done so for elevated blood sugars.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Nurse # 7 was interviewed on 3/26/25 at 9:48 AM and reported she wasn't aware she was to call for blood sugars over 400 but would have done so if the blood sugars went over 500.</p> <p>An attempt was made to talk to Nurse # 8 on 3/25/25 at 1:21 PM and the nurse could not be reached by phone.</p> <p>MA # 1 was interviewed on 3/25/25 at 6:30 AM and reported she would have reported to a nurse the FSBS on 1/22/25 but did not recall who the nurse was. MA # 1 reported she always did so, and that Resident # 9 would often eat sugary items brought in by the family.</p> <p>MA # 2 was interviewed on 3/25/25 at 12:38 PM and reported she could not recall specific details of 1/22/25 but she would have told a nurse about an elevated blood sugar over 400, rechecked it in an hour and put it on the 24-hour nursing report.</p> <p>Nurse # 9 was interviewed on 3/25/25 at 12:10 PM and reported she had not worked on the night shift on 1/23/25 at 6:30 AM to have obtained a FSBS of 419 and did not know why her initials were signed off on the MAR as obtaining the result. The nurse reported she was a day shift nurse.</p> <p>An attempt was made to interview MA # 3 on 3/25/25 at 11:29 AM and she could not be reached.</p> <p>MA # 4 was interviewed on 3/25/25 at 10:28 PM and reported the following information. She recalled Resident #9's blood sugar registering high on the morning of 1/24/25. At the time she was to be reporting to Employee # 1, who she thought was a nurse at the time. She told Employee # 1 about the high blood sugar and Employee # 1 stated she would check the record for sliding scale orders and call the physician. She saw Employee # 1 make a phone call and talk to someone, but she did not know to whom she was talking to. Afterwards Employee # 1 asked to look in her (MA # 4's) medication cart, obtain an insulin pen, and go into Resident # 9's room. She did not know what insulin pen Employee # 1 had obtained or what she had done when she went into the room. When she had checked the FSBS, Resident # 9 had appeared okay.</p> <p>Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She had applied and been accepted to work at the facility as a nurse. She had provided a false license to the facility and had no nursing education nor a license to perform job duties of a nurse. She had taken care of diabetic family members and had some partial training as a medication assistant in another state. On the morning of 1/24/25 when Resident # 9's blood sugar registered high she had called the doctor and gotten an order for some insulin. She had given the insulin. When interviewed about the issue that Resident # 9 did not have any short acting insulin ordered and filled for her to access for him, Employee # 1 replied they kept some on the cart or in back up for times such as this.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Nurse # 5 was interviewed on 3/25/25 at 1:26 PM and reported the following information. She was new at the time on 1/24/25 when Resident # 9's FSBS registered 524. She was walking to the desk when she saw MA # 1. She asked MA # 1 if Resident # 9's FSBS usually ran high, and MA # 1 told her that Resident # 9 would get sugary things on his hands and recommended to clean his finger better and recheck it. There was not much time between Nurse # 5 talking to MA # 1 before she then went back to recheck the FSBS. She then obtained a result in the 300s but did not recall what it was. She thought she had documented the FSBS but had not done so. Nurse # 5 was interviewed regarding whether she had cleaned Resident # 9's finger well the first time and responded that she thought she had done so. She had not communicated with the physician following either FSBS check. Nurse #5 further stated during her shift Resident # 9 appeared to be okay.</p> <p>Interview with Unit Coordinator # 1 on 3/25/25 at 12:46 PM revealed the facility kept a communication book that the provider could reference when they arrived at the facility. She had looked through the physician communication book and found no record of communication left for the provider between the dates of 1/1/25 to 1/24/25 about Resident # 9's elevated blood sugar readings.</p> <p>Further review of nursing notes revealed the only note on 1/24/25 was dated 1/24/25 at 7:16 PM and was written by Nurse # 10. Nurse # 10 documented at this time that Resident # 9 was in the shower with staff present and became dizzy and fell . Resident # 9 sustained a laceration to his head with minimal bleeding. Nurse # 10 further documented that given the resident was on an anticoagulant the resident was transferred by EMS services to the hospital.</p> <p>Interview with Nurse # 10 on 3/25/25 at 10:44 AM revealed she had not been caring for Resident # 9 at the time of the fall, but was closet to the shower room when the resident fell .</p> <p>Review of EMS records dated 1/24/25 revealed the EMS paramedics arrived at 7:23 PM on 1/24/25 and Resident # 9 did not complain of blurred vision or dizziness at the time of their arrival.</p> <p>Review of the hospital records for the date of 1/24/25 to 1/30/25 revealed the following information. Resident # 9 was diagnosed with a small subdural hematoma. His blood sugar was 305 at 8:40 PM on 1/24/25 when drawn by the lab. The hospital physician noted Resident # 9's last HgbA1C was 10.2. The hospital physician noted the resident should receive both long acting and short acting insulin upon discharge back to the facility. Also, the hospital discharge summary included information that the resident had been hypotensive when he arrived to the hospital and his Toprol (used for heart failure) was held. Also, while hospitalized , neurosurgery was consulted and recommended holding the resident's anticoagulant medication. Prior to discharge, a repeat CT scan was performed to ensure the resident's subdural hematoma had not worsened. Discharge orders included that the resident should be placed on sliding scale insulin coverage and in addition to the prescribed sliding scale insulin, when the FSBS was greater than 400, the primary physician should be contacted.</p> <p>On 1/30/25 Resident # 9 returned to the facility with the new insulin orders and designated parameters to call the physician.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with Resident # 9's NP (Nurse Practitioner) on 3/24/25 at 5:15 PM and again on 3/26/25 at 11:21 AM revealed the following information. She was at the facility three days per week. She also took call during the day. She had not been notified of blood sugar results greater than 400 from 1/1/25 to 1/24/25. If she had been, then she would have left orders for the resident. During the night if the resident's blood sugar registered over 400, the facility staff could call an on-call provider. She had reviewed the on-call provider log and found no documentation of calls that came into the on-call provider between the dates of 1/1/25 and 1/24/25 related to Resident # 9's blood sugars being above 400. The NP also validated that the change made on 1/6/25 in Resident # 9's long-acting insulin was a substitution and was probably due to insurance covering one form of insulin. The order change had not been due to notification of elevated blood sugar readings.</p> <p>The facility's Medical Director, who also was Resident # 9's physician, was interviewed on 3/21/25 at 3:13 PM and again on 3/27/25 at 1:42 PM. The physician reported the following information. The staff should call the provider about blood sugars which were greater than 400 unless there are specific instructions in the orders and a different parameter is set for a specific resident based on their individual history. If she had been notified of a blood sugar greater than 400 then she would have given an order to address it. She did not typically answer her phone before 7:00 AM unless she was on call and did not know to whom Employee # 1 had talked to on 1/24/25. The Physician was further interviewed about whether residue on an individual's finger could affect a FSBS result and reported that it sounded strange that by just cleaning someone's finger that such a large difference in a result would occur as reported by Nurse # 5 unless something was wrong with the glucometer itself. The Physician reported even if the FSBS was in the 300s that also needed to be addressed.</p> <p>On 3/25/25 at 8:55 PM the Administrator was notified of Immediate Jeopardy.</p> <p>The Administrator presented the following Credible Allegation of Immediate Jeopardy Removal Plan.</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and</p> <p>Resident #3 was noted with significant Chest and upper arm bruising initially by a Certified Nursing Assistant (CNA) on 12/18/2024. The CNA failed to notify any nurse of the bruising. Her failure to report the bruising to the nurse delayed assessment and treatment of Resident # 9 by the provider.</p> <p>In the month of January 2025 resident # 9 experienced multiple instances of seriously elevated blood sugars (greater than 400). During this time period resident # 9 did not have orders for sliding scale insulin or parameters for notifying physician of blood sugar elevations. During January several nurses including employee #1 and nurse #5 failed to notify the provider or nurses on subsequent shifts of these seriously high blood sugars resulting in the delayed assessment, treatment, and monitoring. And as a result of the failure resident # 9 experienced hyperglycemia.</p> <p>On 3/26/25 The DON conducted an audit of all nursing progress notes from 3/19/25-3/25/25 to ensure that the provider had been notified of any residents with a significant change in condition. The audit revealed that there were no changes in condition that were not communicated to the provider.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER White Oak Manor - Burlington		STREET ADDRESS, CITY, STATE, ZIP CODE 323 Baldwin Road Burlington, NC 27217	

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A complete audit from 3/19/2025-3/25/2025 of the Vital Signs (Blood Glucose Values) for elevated blood glucose levels over 400 with proper physician notification was completed by the DON on 3/25/2025. Identified elevations without proper physician notification were communicated by the DON to the provider on 3/25/2025. No further orders were given by the provider for identified residents.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>On 3/26/25 The Director of Nursing (DON) conducted education with all licensed nurses and Medication Aides on blood glucose parameters and the necessity of notifying the provider of any reading above 400. All nurses and Medication Aides were contacted either face to face or via phone communication on 3/26/25. Education was provided to prevent any further failures of nurses to notify providers and to prevent uncontrolled hyperglycemia in facility residents.</p> <p>On 3/27/25 the Staff Development Coordinator was educated by the DON that all Newly hired nurses, medication aides and agency nurses will receive this training in orientation by the Staff Development Coordinator.</p> <p>On 3/26/2025 the Quality information manager (QIM) audited and entered the verbiage to each blood sugar order on the MAR: blood sugar greater than 400 call provider.</p> <p>On 3/25/25 the Director of nursing educated licensed nurse to add blood sugar greater than 400 call provider to newly admitted resident with finger stick blood sugar orders for proper notification to the provider.</p> <p>On 3/27/25 the QIM was educated by the Director of Nursing to include in the current QIM admission order review process to ensure blood sugar greater than 400 call provider has been added by the nurse to those residents with finger stick blood sugar orders for proper notification to the provider.</p> <p>On 3/26 & 3/27/2025 the DON and Staff Development Coordinator (SDC) completed education with all nurses, CNAs, activities (life enrichment), social services and therapy staff on recognition and reporting of significant changes, and proper chain of communication to the provider for reporting bruising or other resident changes in condition. Education was completed either by face to face or phone communication. The SDC will also educate all newly hired nurses, CNAs, Activities (Life enrichment) staff, therapy and social services staff on the recognition and reporting of significant changes, and proper chain of communication to the provider for reporting bruising or other resident changes in condition as part of the facility orientation process.</p> <p>Date of Immediate Jeopardy removal will be 3/28/25.</p> <p>On 3/31/25 the facility's Credible Allegation of Immediate Jeopardy Removal Plan was validated by the following actions:</p> <p>The facility presented an audit of all resident's records in which the Director of Nursing had reviewed progress notes and vital signs to identify changes in condition. Recent progress notes were printed by the DON. The DON had made written notations regarding the physician was aware on any progress note which indicated a resident was experiencing an acute medical condition.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility presented evidence of blood sugar checks to ensure the physician was being informed of elevated levels.</p> <p>Review of a random diabetic resident's record revealed the information had been added to the resident's record that the physician should be contacted for blood sugars greater than 400.</p> <p>Interview with nurses revealed they were aware they were to immediately call for blood sugars greater than 400 unless otherwise specified in the physician's orders.</p> <p>The facility presented evidence of education as outlined in their removal plan.</p> <p>The facility's date of immediate jeopardy removal was validated to be 3/28/25.</p> <p>3. Resident # 11 was admitted to the facility on [DATE]. Resident # 11's diagnoses in part included dementia and a history of pulmonary embolus.</p> <p>Resident # 11's admission MDS (Minimum Data Set) assessment, dated 12/16/24 coded Resident # 11 as severely cognitively impaired. The resident was also coded as needing substantial to maximum assistance with his hygiene needs, requiring total staff assistance to turn in bed, not ambulatory during the assessment period, and as having no falls.</p> <p>Review of orders revealed Resident # 11 was prescribed Eliquis 5 mg (milligrams) from 12/17/24 to 1/30/25. (Eliquis is an anticoagulant which places a resident at greater risk for bleeding).</p> <p>On 12/28/24 12:30 AM Employee # 1 documented, Resident slipped of the left side of the bed sitting on the floor, laid down on his left side, head propped up against the nightstand. No obvious injury or bruising. Head trauma protocol given and vitals record at the time of the fall. Temp-97.9, Pulse-71, Resp. 20 B/P (blood pressure) 115/64.</p> <p>Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She was not a licensed nurse and had never completed any formal training program in health care. She had taken care of bedridden family members, and she thought she knew what to do. Resident # 11 did not seem hurt to her on 12/28/24 and 1/9/25 and she had not called the physician.</p> <p>There was no record the physician was called regarding the resident's fall he sustained while on Eliquis.</p> <p>Review of nursing notes following 12/28/24 did not reveal any documented injury from the 12/28/24 fall.</p> <p>NA # 8 had cared for Resident # 11 on the night shift which had begun on 12/27/24 at 11:00 PM. NA # 8 was interviewed on 3/25/25 at 6:45 AM and reported she did not recall taking care of Resident # 11 that night and did not know how he had fallen.</p> <p>Interview with the Director of Nursing on 3/21/25 at 9:00 AM revealed Employee # 1 had worked at the facility from November 2024 until her termination in February 2025 under false pretenses as a nurse. She had not been a licensed nurse while caring for Resident # 11.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 1/9/25 at 7:27 AM Employee # 1 documented, [Resident # 11] was laying on the floor in the room beside his bed and neuro assessment to make sure he did not sustain any blows to the head. T-94.6 P 64 R 20 B/P 126/83. He was alert and oriented. (A temperature reading of 94.6 would indicate a hypothermic reading which is a lower than normal body temperature).</p> <p>Review of the nursing notes revealed no notification to the physician was documented.</p> <p>Interview with Resident # 11's Physician on 3/21/25 at 3:13 PM revealed the provider should be contacted when a cognitively impaired resident, who was on Eliquis, falls and it is not known if the resident hit their head. In those cases, the resident would be sent out to the hospital to be checked.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289</p> <p>Based on observation, record review, and interview with residents, staff, Physician, and Nurse Practitioner the facility failed to protect Resident #3's right to be free of an injury of unknown source; and abuse/neglect. Resident # 3, who was a cognitively impaired resident, was identified to have significant bruises on his arm and chest which wrapped around his torso on 12/18/24. The bruises were also accompanied by swelling and discomfort with positioning when initially found. Staff reported they had not observed any incident which had caused the bruises. The resident could not provide detailed information about how the bruises occurred, and the extent of the bruising without a known cause indicated a suspicion of neglect or abuse. Also, Resident # 3 was under the care of a non-licensed employee (Employee # 1), who was working at the facility under the false pretense she was a nurse when the bruises were found. The bruises continued to spread and on 12/20/24 Resident # 3 was evaluated at the local hospital ED (Emergency Department) where it was noted Resident # 3 had extensive chest and abdominal wall ecchymosis (discoloration of the skin, typically caused by bruising). A CT (computerized tomography) of the chest abdomen and pelvis with contrast was completed. The CT impression read, 1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip. This was for one (Resident # 3) of three residents reviewed for abuse, neglect, and injuries of unknown origin.</p> <p>Immediate jeopardy began on 12/18/24 when Nurse Aide # 3 identified during her shift that Resident # 3 had unexplained bruises, swelling, and discomfort. Immediate Jeopardy was removed on 3/28/25 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 to ensure education is completed and monitoring systems put in place are effective.</p> <p>The findings included:</p> <p>Resident # 3 was admitted to the facility on [DATE]. The resident's diagnoses in part included dementia, congestive heart failure, Parkinson's, atrial fibrillation, anxiety, and dysphagia.</p> <p>Resident # 3's annual Minimum Data Set (MDS) assessment, dated 10/14/24, coded the resident as severely cognitively impaired and as needing total staff assistance for bathing, dressing, and hygiene needs. Resident # 3 was coded as needing partial to moderate assistance to roll from side to side in bed and as needing substantial to maximum assistance to transfer. The resident was coded as using a manual wheelchair to roll 50 feet after set-up assistance. The resident was not coded as having falls during the assessment period.</p> <p>Review of Resident # 3's care plan revealed the following information. On 10/19/23 staff added the resident was at risk for falls. This remained part of the resident's active care plan. On 10/27/23 staff added the resident picked at his skin causing skin tears and bruises at times. This also remained as part of the resident's active care plan. On 2/10/24 staff added that Resident # 3 could be combative with care. This remained as part of the resident's active care plan.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of November 2024 nursing notes revealed Resident # 3 sustained one fall which was on the date of 11/2/24 at 6:15 PM. According to a nursing note, Resident # 3 had attempted to try to transfer himself from the chair to the bed before staff could assist him. His upper body had landed on the bed and then his body had slid to the floor. According to the nursing note at 6:15 PM on 11/2/24, the resident's range of motion was at his baseline. A later nursing note on 11/2/24 at 9:57 PM noted the resident had some discoloration but no swelling to his left knee, and orders were given for an x-ray. Review of x-ray results reported on 11/3/24 revealed Resident # 3 had sustained no fractures from the 11/2/24 fall.</p> <p>Review of Resident # 3's medical record revealed no falls in December 2024 were documented.</p> <p>Review of Resident # 3's medication regimen for December 2024 revealed Resident # 3 was not on an anticoagulant.</p> <p>Review of nursing progress notes revealed no entry for the date of 12/17/24, which was the date prior to Resident # 3's injury being identified.</p> <p>Review of staffing sheets revealed NA (Nurse Aide) # 1 had cared for Resident # 3 on the 12/17/24 dayshift (7:00 AM to 3:00 PM) prior to the bruising being identified on 12/18/24. A statement written by NA # 1 read, I [Nurse Aide # 1] had [Resident # 3] from 7 AM 3 PM. No bruising or swelling at the time me and coworker [name of coworker] use [mechanical] lift to get resident up on 12/17/2024 and resident was dressed by me on 12/17/2024 around 11 AM.</p> <p>NA # 1 was interviewed on 3/21/25 at 12:25 PM and reported the following information. She routinely cared for Resident # 3. On 12/17/24 there had been no problems with his care or transfer and there had been no bruising on his body. She and another staff member used a lift to transfer the resident, and he was still up when she left at the end of her shift.</p> <p>Review of the investigative file revealed a statement by NA # 2 noting that she (NA # 2) had assisted NA # 1 on 12/17/24 with Resident # 3's transfer to the chair and there had been no incident or bruising on the resident.</p> <p>Review of the facility's investigative file revealed Nurse # 1 had been assigned to care for Resident # 3 on 12/17/24 during both the day shift and the evening shift (3:00 PM to 11:00 PM). Nurse # 1's statement within the facility's investigative file read, On 12/17/24 I [Nurse # 1] worked 1st (7:00 AM to 3:00 PM) and 2nd shift (3:00 PM to 11:00 PM) as [Resident # 3's] nurse. I did not observe any bruising or swelling on resident body. No one reported any swelling or bruising. I [Nurse # 1] last seen [Resident # 3] approximately around 9:25 PM with no shirt on while giving him his night meds. No bruising or swelling noted.</p> <p>An attempt was made to interview Nurse # 1 on 3/21/25 at 12:01 PM and she could not be reached for an interview.</p> <p>Review of staffing sheets revealed NA # 3 had cared for Resident # 3 on the 12/17/24 evening shift. A review of the investigative file provided to the surveyor did not include a statement from NA # 3.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>NA # 3 was interviewed on 3/21/25 at 12:34 PM and reported the following information regarding the evening shift of 12/17/24. Resident # 3 had not fallen and there had been no incidents. He had no bruises. She (NA # 3) had placed Resident # 3 back in bed with the mechanical lift with the help of NA # 4. After she placed Resident # 3 back in bed on the evening shift, she had checked on him every two hours and he had been fine. She had submitted a statement during the facility's investigation and did not know what had happened to it.</p> <p>NA # 4 was interviewed on 3/24/25 at 3:21 PM and corroborated NA # 3's statement. NA # 4 reported she did assist NA # 3 with transferring Resident # 3 on the evening shift of 12/17/24. NA # 4 reported Resident # 3 was okay at the time, and she had not observed any injuries.</p> <p>Review of the facility's investigative file for reportable incidents of injuries for which there was no known cause revealed the following information. On 12/18/24 the facility submitted an initial report, which was completed by Unit Coordinator # 1, to the state agency noting that at 7:20 AM on 12/18/24 Resident # 3 had been identified with a baseball size bruise on the front right shoulder, large hematoma to his left side under arm, swelling and bruising on his left upper chest and below clavicle. The report also noted the resident was unable to lift his left arm without pain and there was swelling.</p> <p>Review of staffing sheets revealed on the night shift which began at 11:00 PM on 12/17/24 and ended at 7:00 AM on 12/18/24, Employee # 1 was assigned to care for Resident # 3 as a nurse.</p> <p>Review of Employee # 1's personnel file revealed Employee # 1 was hired as a nurse but was not licensed as a nurse and her application prior to hire indicated no nursing education.</p> <p>During an interview with the DON (Director of Nursing) on 3/21/25 at 9:00 AM, the DON confirmed that Employee # 1 had submitted someone else's nursing license upon hire in November 2024 and was terminated in February 2025 when this had been validated. At the time she had been caring for Resident # 3 on the night shift of 12/17/24, the facility had not noted she was impersonating a nurse and was not licensed.</p> <p>A review of Resident # 3's vital sign log revealed Employee # 1 documented Resident # 3's oxygen level was checked at 12/18/24 at 12:56 AM. (According to Employee # 1's statement this was when she noticed the bruises.) The reading was 94%. There was no notation it was taken again on Employee # 1's shift. Employee # 1 also documented Resident # 3's weight was 127 pounds at 6:38 AM on 12/18/24.</p> <p>Review of Employee # 1's statement read, I was collecting [Resident # 3's] routine 02 (oxygen) when I notice he had some bruising to his right shoulder as well as some to his left. No fall or bruising was reported from the previous shift to me in report, so my next thought was to bring it to our unit coordinators attn. (attention) that he had bruising on him. Before I could bring it to [Unit Coordinator's] attention it was brought to my attention once more by the next shift and when the unit coordinator got here, I immediately let her know my findings so it could be documented properly.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However I notice some bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I notice while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aide to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON.</p> <p>NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been washed up by the 2nd shift. He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was a golf ball sized bruise on his arm which appeared light reddish and was turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise, and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift and therefore the nurses were already aware of it. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse. She thought Employee # 1 had been in Resident # 3's room before her (NA # 5) at some time during the night shift but she did not see Employee # 1 go into Resident # 3's room.</p> <p>During a follow up interview with NA # 5 on 3/24/25 at 1:02 PM, NA # 5 reported she had not obtained Resident # 5's weight that had been documented on 12/18/24 at 6:38 AM.</p> <p>Review of the facility's investigative file revealed a statement from NA # 6 which showed discrepancies in what Employee # 1 had written in her statement. According to Employee # 1's statement she had seen the bruises when she checked Resident # 3's oxygen level and this had been recorded in Resident # 3's record by Employee # 1 at 12/18/24 at 12:56 AM. NA # 6's statement read, On 12/18/24 I came to work passing the trays (breakfast trays). I got [Resident # 3's] tray. As soon I drop it off, I saw him with no shirt on. I saw bruises on his right shoulder, left upper quadrant. As soon I saw the bruises I talked to 3rd shift (11:00 PM to 7:00 AM) nurse [Employee # 1]. I saw her go to [Resident # 3's] room and showed her the bruises. She told me that this first time seeing this, that they had no falls last night.</p> <p>Employee # 1 was interviewed on 3/25/25 at 2:57 PM and acknowledged she had given someone else's nursing certificate number who shared a similar name to the facility in order to work as a nurse. According to Employee # 1 she completed no type of Nursing Education or Nurse Aide training. She reported she had some medical assistant training from another state but had not completed that either. She was interviewed regarding Resident #3's bruises and reported she had called the DON at 12 something when she saw them on the 11:00 PM to 7:00 AM shift which began on 12/17/24 when she did the oxygen level and saw the bruises. Employee # 1 reported she did not know who obtained Resident # 3's weight which she had recorded. Employee # 1 did not know how the bruises occurred and reported she would never do anything to hurt a resident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of nursing notes revealed the first entry documenting the resident's bruising was on 12/18/24 at 7:32 AM by Nurse # 1. The entry was entered into the record as a late entry on the date of 12/19/24 at 8:08 AM. The entry read, Resident able to make needs writer made aware during report that resident had bruising to left side of chest, armpits, and arms. VS 128/77 (blood pressure), 97 % on RA (room air), 18 (respirations), 97.9 (temperature), 63 (pulse.) No s/s (signs and symptoms) of SOB (shortness of breath), wheezing or labored breathing. Facial grimacing noted when resident move his left arm. Resident refused to be repositioned . Nurse # 1 further noted Resident # 3 had an order for Tylenol 325 mg (milligrams) 2 tabs every 6 hours. Nurse # 1 also noted the physician was notified and orders were obtained for a stat x-ray on the chest, right arm and left arm. The DON, Unit Coordinator, and Social Worker were also notified.</p> <p>An attempt was made to interview Nurse # 1 on 3/21/25 at 12:01 PM and she could not be reached for an interview.</p> <p>The next nursing entry was dated 12/18/24 at 7:36 PM by Nurse # 2 and read, Was informed from previous shift nurse that resident had discoloration noted to chest area. Resident has discoloration noted to chest, sides of chest, armpits and arms. Measurements obtained and put in DON office Supervisor, MD, and DON aware.</p> <p>Review of Nurse # 2's written statement which was located in the facility's investigative file read, Came into my shift and was made aware by [Nurse # 1] about [Resident # 3] having bruising. Went to go see [Resident # 3] and noted bruising to chest, arms, armpits, sides of chest. I asked [Resident # 3] what happened he just mumbled. I asked [Resident # 3] did he fall. He said yes the other night. I asked where did he fall. He then pointed to the closet area. I asked [Resident # 3] did anyone hurt him and he stated no. I then obtained measurements of bruising and placed them in DON office.</p> <p>Nurse # 2 was interviewed on 3/21/25 at 10:28 AM and reported the following information. On the date of 12/18/24 she had reported to work at 11:00 AM because Nurse # 1 had to leave early that day. She had been told about Resident # 3's bruises in report at 11:00 AM and went to assess him and found bruises on his arms and chest. When he talked, he mumbled but if she asked him yes and no questions he would answer simple questions. When asked if he had fallen, Resident # 3 had replied, yes. When asked where he had fallen, Resident # 3 had pointed to the closet area of the room. The resident was not able to convey more about the incident.</p> <p>The facility Social Worker was interviewed on 3/24/25 at 10:56 AM and reported the following information. She had interviewed Resident # 3 on 12/18/24 after the bruises were brought to her attention. Resident # 3 was not able to convey what happened. She also interviewed Resident # 3's roommate (Resident # 12), who also had cognitive impairment. Resident # 12 had reported someone pushed a machine into their room during the night and it was not used for his roommate. Resident # 12 did not report Resident # 3 had fallen. He was not able to say what the machine was that was pushed into the room.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER White Oak Manor - Burlington		STREET ADDRESS, CITY, STATE, ZIP CODE 323 Baldwin Road Burlington, NC 27217	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of physician progress notes revealed Resident # 3's physician, who served as the facility medical director, assessed Resident # 3 on 12/18/24 and in addition to documenting the bruises also documented the resident had an abrasion to his skin. The physician noted, He (Resident # 3) was noted this morning to have bruising on his upper body. Patient has cognitive impairment and is not able to tell us what happened. Last BIMS (brief interview for mental status) 2/15. He seems to only have pain when moving the left shoulder. No documented falls. He was given Tylenol for pain. The physician further documented measurements of the bruising as follows: Note Bruises were irregular shaped and were measured at largest diameter. Right anterior chest upper near midline, about 5.5 X 3.5 cm (centimeters) reddish with some faint purplish area inferior to it. Right shoulder near AC joint (where the collar bone meets the shoulder blade) circular reddish abrasion. Right shoulder lateral clavicle about 7 x 6 cm irregular shaped reddish bruise with faint deeper purple underneath it extending further down about 5 X 8 cm at largest diameter. Right arm-3 circular bruises about 1 cm each-2 inner bicep mid to distal and 1 lateral inferior. Left chest wall- Pacemaker scar with 6 small irregular shaped purplish red bruises. Pacemaker appears more lateral and turned/sticking out. Left side about 7 X 3 cm reddish bruise with faint edges in shoulder near clavicle. Large reddish purple about 10 X 4 cm inferior to tattoo on lateral upper arm. Left arm-irregular shaped bruise going down bicep with varying colors-reddish to darker purple inferior, 12 X 4 cm around to lateral aspect of arm. 8 X 3 cm circular bruise purplish inferior and medial to elbow. Large left chest wall bruise light purplish edges wraps around chest lateral to nipple, darker purple on posterior chest. No ecchymosis (discoloration of the skin, typically caused by bruising) neck, facial area, or body below waist. Within the progress note, the physician noted a chest x-ray and complete blood count would be obtained. The physician further noted that she was unsure when the pacemaker had been placed or last tested . She further noted the pacemaker appeared to be turned/sticking out more.</p> <p>On 12/18/24 at 7:38 PM Nurse # 2 noted Resident # 3's chest x-ray was normal.</p> <p>Review of the 12/18/24 Chest x-ray result showed that the pacemaker was present but did not note any abnormalities with the pacemaker or with the resident's heart or lungs. The radiologist noted the report was negative.</p> <p>A review of Resident # 3's 12/18/24 CBC result revealed the resident's platelet count was normal. (Low platelets can increase the chance of bleeding.)</p> <p>On 12/19/24 Resident # 3 was seen by the NP (Nurse Practitioner) who noted the following information. Resident # 3's CBC did not show thrombocytopenia (low platelets), and the chest x-ray had been normal. There had been a concern that the resident's pacemaker had been dislodged, and she had asked for a reread of the chest x-ray. Resident # 3 denied pain at the time.</p> <p>Review of nursing notes revealed on 12/20/24 at 2:21 PM Unit Coordinator # 1 noted that Resident # 3's bruising was spreading from his bilateral shoulders down into his abdomen, left arm, and left side rib cage and he was being transferred to the hospital for further evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of 12/20/24 ED (Emergency Department) notes revealed the following information was documented. Resident # 3 had extensive chest and abdominal wall ecchymosis. A CT (computerized tomography) of the chest abdomen and pelvis with contrast was completed. The CT impression read, 1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip 3) No other CT evidence of acute traumatic injury to the chest, abdomen, or pelvis. 4) emphysema, 5) coronary artery disease. Upon preparing for discharge, the ED physician did not note any further comments about the hip contusion. The ED physician did note CT scan obtained demonstrating hematoma around his pacemaker site but otherwise superficial contusion. There was no notation regarding how the hematoma could have formed around the pacemaker site. The resident was noted to be stable for discharge from the ED with a final diagnosis of chest wall hematoma, left and superficial bruising of back, left. There were no ED discharge orders.</p> <p>On 12/20/24 Nurse # 1 documented Resident # 3 returned from the hospital in no distress, no pain, and no new orders.</p> <p>Interview with Resident # 3's Nurse Practitioner on 3/24/25 at 5:15 PM revealed she was not aware of how the bruising had occurred. The NP reported she attempted to see if the radiologist, who performed the chest x-ray at the facility, could determine if something occurred to the resident's pacemaker, but they were not able to determine. It had not been brought to her attention that the hospital's CT showed a contusion on the resident's hip.</p> <p>Resident # 3's physician was interviewed on 3/21/25 at 3:13 PM and reported the following information. When she evaluated Resident # 3 on 12/18/24 the bruising was all on his upper body which included areas on his arms and chest wall which wrapped around some on his torso. She did not recall any bruising extending to his hip when she examined him on 12/18/24. He was also having some left shoulder pain. Prior to 12/18/24 there had been no history the resident had a pacemaker. The resident was thin and on the date of 12/18/24 the pacemaker was noticeable and appeared to be turned more to a lateral position and more towards the antecubital area. The resident had poor safety awareness and was not able to explain how the bruising occurred when she talked to him. If he had told the staff he had fallen, she was not sure the staff could go totally by what the resident had said because of his confusion. He was sent to the ED to be reviewed also, but the ED physician did not make mention of problems with the pacemaker itself. The ED physician also had not put anything in her notes about the contusion to the left hip which had shown up on the CT scan. It had not been brought to her attention that the CT in the ED showed a contusion to the left hip. She was unsure if the contusion to the left hip was related to the 12/18/24 incident or a separate event. They had made a referral for a cardiologist, but the son had canceled the appointment. The physician was further interviewed regarding whether the pacemaker could have moved causing the resident's injuries. The physician reported the following information. She (the physician) was not a cardiologist and was not aware of what type of stitches had been placed when the pacemaker had originally been placed. She would think that over time scar tissue would help hold the pacemaker in place. She could not say 100 % for sure but would think that something would have had to happen to cause a pacemaker to move if it had done so. She did not know how far it could be moved. She would have to refer to a cardiologist's opinion.</p> <p>Interview with the facility appointment scheduler on 3/21/25 at 2:55 PM revealed Resident # 3 had a cardiology appointment scheduled after the 12/18/24 incident but the son canceled the appointment. Due to the resident's payment sources, he was to be seen at a particular provider. They had talked to the son and arranged for the appointment to be rescheduled and it was rescheduled for 4/7/25.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident # 3 was interviewed on 3/20/25 at 2:45 PM. During the interview Resident # 3 mumbled and his words could not be understood. Following the interview, Resident # 3 was observed to roll himself out of his room and into the hallway independently. He was not observed to use his feet to propel the wheelchair, only his arms. Several times he would run his wheelchair into the wall or objects as he propelled himself and would readjust the wheelchair himself to continue to move forward.</p> <p>Resident # 3's roommate (Resident # 12) was interviewed on 3/20/25 at 3:00 PM. A review of Resident # 12's record revealed his BIMS (Brief Interview for Mental Status) score on a 2/18/25 MDS assessment was a 6, indicating severe cognitive impairment. Resident # 12 reported he had never witnessed anyone mistreat him or his roommate. Resident # 12, who was aware it was March during the interview, stated Resident # 3 had two falls he had recalled. One seemed to him (Resident # 12) about a month ago and then another one prior to that. One had happened in the hallway near the doorway and the other had happened in the room. The staff had helped the resident off the floor both times. Resident # 12 reported at times Resident # 3 had problems moving his wheelchair in the room.</p> <p>Interview with Unit Coordinator # 1 on 3/21/25 at 11:10 AM revealed she first became aware of the bruising on the morning of 12/18/24. She had been stopped in the hallway but did not recall who told her about it. She knew that Employee # 1 had been aware of the bruising and had said she had just seen it. When she (Unit Manager # 1) was made aware on the morning of 12/18/24, she notified the DON, and the DON informed her they needed to complete a reportable injury of unknown origin to the state agency.</p> <p>During an interview on 3/20/25 at 3:20 PM with Nurse # 3, who oversaw safety reports in the facility, Nurse # 3 reported Resident # 3's last recorded fall was 11/2/24. Nurse # 3 also reported that Resident # 3's roommate (Resident # 12) was confused and was not a reliable source to report falls.</p> <p>On 3/24/25 at 11:12 AM during a follow up interview, Nurse # 3 reported Resident # 3's 11/2/24 fall was the only time the facility had on record that the resident had fallen since he had resided at the facility.</p> <p>Interview with the DON and Administrator on 3/21/25 at 5:30 PM revealed the following information. They had conducted their investigation following the identification of the bruising on 12/18/24. Employee # 1 had never called on her shift to report any injury. It was not reported until the dayshift on 12/18/24 and at that time they did an investigation and reported the incident to the state. None of the staff had reported they witnessed Resident # 3 to fall or have an accident for them to conclude a particular cause of the bruising. They thought something had happened to the pacemaker spontaneously, which had caused bleeding under the skin and had spread downwards. According to the DON, she had read of this occurring for other individuals. They had not been aware that the hospital CT showed there was a contusion of the hip also and had not included that in their investigation. The ED report had been sent to them and scanned into their computer without this being drawn to their attention.</p> <p>A Device Nurse at the cardiology clinic, where Resident # 3 had been historically seen, was interviewed on 3/24/25 at 11:55 AM and reported the following information. She had been a device nurse for [AGE] years and had never known a pacemaker to spontaneously move. The pacemakers are sutured in place and then scar tissue formed around them to hold them in place. Resident # 3 had not been seen by the cardiologist since 2021. Their records showed he had a pacemaker and not an implanted defibrillator.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The hospital ED (emergency department) physician, who evaluated Resident # 3 on 12/20/24, was interviewed on 3/31/25 at 10:11 AM. Prior to the interview the ED physician had been sent a message that one of the questions which the surveyor would like to discuss was whether a pacemaker could spontaneously move. During the interview, the ED physician reported the following information. She had never heard of a pacemaker moving. After receiving the surveyor's question, she had reviewed studies and case reports and found one case in which an individual with an implanted defibrillator had an electrode lead to migrate causing some external bruising on the patient's left side. This had been a very rare case. She did not recall anything being wrong with Resident # 3's pacemaker when she saw him on 12/20/24. A chest CT would have shown a problem with any lead or displacement. She also did not think a problem with a pacemaker could lead to a hip contusion as well. It was her medical opinion that Resident # 3's injuries were more consistent with some sort of trauma that had occurred to him.</p> <p>On 3/24/25 at 8:55 PM the Administrator was notified of Immediate Jeopardy. The Administrator submitted the following Credible Allegation of Immediate Jeopardy Removal Plan.</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance</p> <p>While under the care of employee #1 (non- licensed employee) resident # 3 was found to have an injury of unknown origin. Resident #3 was noted with significant bruising to his chest and arms. The bruises were reddish with faint deeper purple, located over the right clavicle extending to the upper chest over the pacemaker site. The bruising was noted to be an irregular shape measuring 7cmx 6cm in the largest area. In addition to the bruising to the chest, a night shift NA (NA #5) wrote in her statement in the facility's investigative file that she saw that the resident had swelling and appeared uncomfortable with positioning. NA #5 failed to notify any nurse of the significant bruising and the resident's discomfort. This failure of notification resulted in a delay in assessment and treatment of Resident #3's bruising and discomfort by the provider.</p> <p>On 12/18/24 at 7:20am the unit coordinator noted the bruising to resident #3's chest and arm area. The unit coordinator then reported the bruising to the DON. The DON then instructed the unit coordinator to complete and send two-hour initial report of injury of unknown origin to North Carolina Department of Health and Human Services (NCDHHS). The DON began the investigation into Resident #3's injury of unknown origin. The investigation revealed that the resident had not had any injury that would have contributed to the bruising.</p> <p>On 2/6/2025 the unit 300 nurse coordinator and wound care nurse conducted body audits on all residents who received care from employee #1 on unit 300. No signs or symptoms of injuries or new skin abnormalities were noted in any resident on the 300 unit.</p> <p>On 2/6/25-2/7/25 a review of all resident hospital transfers and recorded incidents/events (events include reported falls, skin tears, and infections) to ensure completeness of the documentation, proper notification of the resident representative and provider, and follow-up interventions were implemented. Audit included the timeframes/shifts employee #1 worked from 11/5/24 to 2/6/25 was conducted by the nurse consultant to identify any care concerns. The review of hospital transfers and reported falls, skin tears, or infections did not reveal any obvious care concerns.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 3/26/25 and 3/27/25 The Director of Nursing, SDC, and Administrator completed education with all staff on recognizing and reporting injuries or changes in resident condition; including the chain of reporting. All st [TRUNCATED]</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289</p> <p>Based on record review and staff interviews, the facility failed to implement their abuse policy for employees who worked in the capacity of a licensed nurse by not screening and verifying Employee #1's credentials prior to hiring her as a licensed nurse and allowing her to perform licensed nurse duties for which she had no documented education or nursing license. Employee #1 provided the facility nurse license information for an individual she found online with a name that was similar to her own and she worked at the facility in the role of a licensed nurse from 11/5/24 until her termination on 2/6/25. During this timeframe, Employee #1 had resident assignments and performed licensed nurse responsibilities that she was not qualified to provide. On the shift that started on 11:00 PM on 12/17/24 Employee #1 was assigned to Resident #3, who was not on an anticoagulant (blood thinner) when she identified bruising to the resident's shoulders with no known cause. Employee #1 was responsible for assessing the resident and notifying the physician of significant changes. Employee #1 did not notify the physician and there was no evidence of an assessment or interventions implemented for Resident #3 until he was assessed the following shift by the physician. The bruises continued to spread and on 12/20/24 Resident #3 was seen in the Emergency Department (ED) where a Computed Tomography (CT) scan revealed a large (9.5 centimeters [cm] by 5.2 cm) left subpectoral (situated under the chest muscles) hematoma (a collection of blood, usually clotted, outside of a blood vessel) and a superficial soft tissue contusion (bruising) of the left flank and hip. On 1/24/25 Medication Aide (MA) #4 reported to Employee #1, who she believed to be a nurse, that Resident #9's finger stick blood sugar (FSBS) registered outside of the meter's highest measurable range indicating a dangerously high blood sugar reading (normal blood sugar levels are between 70 and 100). There was no evidence Resident #9 was provided with treatment to address the high blood sugar level, and the physician was not notified. On 12/8/24 and 1/9/25 Employee #1 was assigned to Resident #11, who had severe cognitive impairment and was on an anticoagulant, in the role of a licensed nurse when he experienced falls. The assigned nurse was responsible for completing a comprehensive assessment and utilizing nursing judgment regarding whether to call the physician. Employee #1 was not qualified to complete a comprehensive assessment of Resident #11 nor was she qualified to use nursing judgement to make decisions. Additionally, Nurse Aide (NA) #5 did not implement the abuse policy related to reporting injuries of unknown source when she identified that Resident #3 had discomfort with positioning, swelling, and bruises on his arm and chest with no known cause. These deficient practices affected Resident #3, Resident #9, and Resident #11 in addition to placing all residents Employee #1 was assigned to care for in the capacity of licensed nurse for the high likelihood of a serious adverse outcome or harm. This occurred for 1 of 3 employees whose personnel records were reviewed for credentials (Employee #1) and 1 of 3 nurse aides reviewed for reporting an injury of unknown source or allegation of abuse (Nurse Aide # 5).</p> <p>Immediate jeopardy began on 11/5/24 when the facility failed to screen and verify credentials for Employee #1, who fraudulently presented herself to the facility as a licensed nurse, prior to hiring her and allowing her to perform licensed nurse duties. Immediate Jeopardy was removed on 3/28/25 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 E to ensure education is completed and monitoring systems put in place are effective. Example 2 is being cited at a scope and severity level severity of E.</p> <p>The findings included:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Plan for the Prevention of Elder Abuse, which was undated and provided to the surveyor as the facility's current policy, included the following information. A thorough preemployment screening would be conducted in efforts to prevent negligence or abuse. This included a pre-employment interview, reference checks, and licensure verification.</p> <p>1. Review of Employee # 1's personnel file records provided to the state surveyor revealed the following information. Employee # 1's application for employment was signed as submitted on 10/21/24 for a position as a licensed practical nurse/registered nurse on third shift from 11:00 PM to 7:00 AM. The only employment history included on the application noted Employee # 1 had attended an out-of-state high school. No further education experience was listed. There was one record of employment history listed. This was from the dates of 2/1/2016 until 5/1/2017 for an employer located in the USA. Employee # 1 listed chat support agent as her job duty for this employer. There was one person listed as a reference whose relationship to Employee # 1 was noted to be her employer. This individual, who was listed as Employee # 1's work reference, was noted to share the same last name as Employee # 1. Under Reference Entry # 2 on the application form, Employee # 1 had submitted, I do not have a # 2 Reference Entry. Under the question, Please indicate education or skills training which you believe qualifies you for the position you are applying, Employee # 1's typed response was, CNA (Certified Nurse Aide) and 5 years of home health. At the bottom of the application there were some scribbled notes which read, In home care currently dementia 2 yrs-Nurse for 4 1/2 years 3rd shifts M-F FT. There was no documentation of who had made the notes on the application. There was no documentation in the personnel file showing Employee # 1's one reference was checked and there was no resume.</p> <p>Also located in the personnel file, there was an employment notice record for Employee # 1 which did not note for which employment position she was being hired. It did note the hours would be from 11 PM to 7:00 AM as a full-time employee. It was signed by a corporate Human Resources Consultant on the date of 11/5/24.</p> <p>There was no evidence of nursing license verification prior to 11/5/24 in the personnel records provided to the surveyor.</p> <p>Within the personnel file were different records provided by the Staff Development Coordinator and signed by Employee # 1 on dates which included 11/7/24 and 11/8/24 indicating she had reported to work for training on those days.</p> <p>The first license verification in Employee # 1's personnel file was a copy of an email from Employee # 1 to the DON (Director of Nursing). The email, dated 11/19/24, only contained a picture of a QuickConfirm License Verification Report from QNursys. (QNursys is an online national nurse licensure and disciplinary database.) The picture within the email noted that the individual on the license was licensed in the compact state of Georgia with a multistate license as a practical nurse. Within the personnel file were copies of Employee # 1's social security card and driver's license. The name on the nursing license in the 11/19/24 email varied from the name on Employee # 1's copies of her social security card and her driver's license. They varied in the following ways. The first name of Employee # 1 had an extra a letter in it than the first name on the nursing license. The middle name was totally different. The last name was the same. According to Employee # 1's driver's license, she was born in 1996. The original nursing license issue date was 4/5/2006 on the license provided in the email to the DON, which indicated that Employee # 1 would have been nine years old when she was licensed.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Administrator and DON (Director of Nursing) were interviewed together on 3/21/25 at 9:00 AM and a follow up interview was conducted with the DON again on 3/21/25 at 9:45 AM revealing the following information. During the interviews the Administrator reported Employee # 1 would have been interviewed by the DON and the former Human Resources Manager (HRM #1). HRM # 1 would have been responsible for checking the nursing license of Employee # 1. The DON reported the following information during the interviews. Employee # 1's original hire date was 11/5/24. The DON did not recall any details of the interview or what was discussed. The DON recalled that it was called to her attention after hire, that Employee # 1's license was single state in Georgia only and therefore there was no reciprocity on the license for her to practice in North Carolina. She had contacted Employee # 1 and explained she needed to verify her license was for multi-state. After doing so, Employee # 1 sent the email (which was in the personnel file) with the license information to her (the DON) noting the license was multistate. At the time the license was submitted by email on 11/19/24 there had been no red flags that Employee # 1 was not really a nurse. Therefore, the DON looked at the license that Employee # 1 emailed her, noted that it did document she had a multistate license from Georgia, and it was placed in the personnel file without further questions. Employee # 1 continued to work through 2/6/25 as a licensed nurse on third shift until her termination. At some point prior to 2/6/25 it had been brought to the DON's attention that Employee # 1's documentation skills were not professional. Therefore, she looked at Employee # 1's notes and started to question things. On 2/6/25 she (the DON) pulled Employee # 1's license again herself. At that time the license came up in Georgia as a single state again and she (the DON) noted during that check that the nursing license issue date was in 2006, which would have meant that Employee # 1 would have been nine years old when licensed. She (the DON) then noted Employee # 1's first name varied very slightly and that the middle name was not the same. Employee # 1 was confronted by her and terminated. When confronted, Employee # 1 maintained she did have a nursing license and would get it to the DON, which she never did. The State Board of Nursing was contacted on 2/6/25 and a report was filed with them. After the State Board of Nursing's investigation, they were also unable to verify any nursing license for Employee # 1 and directed the facility to call the police which they did.</p> <p>A review of a police report revealed the Administrator called the police on 3/18/25 to notify them of Employee # 1 impersonating a nurse. The responding officer noted in the 3/18/25 police report that there was evidence of fraudulent documentation provided by Employee # 1 to the facility and the case would be forwarded for review and possible charges related to identity fraud.</p> <p>HRM # 1 was interviewed on 3/21/25 at 10:45 AM and reported the following information. She left employment at the facility in the middle of October 2024. She had nothing to do with Employee # 1 being hired and knew nothing about her.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The corporate Human Resources Consultant was interviewed on 3/24/25 at 11:32 AM and reported the following information. He had signed the Employment notification form on 11/5/24 in order to help get Employee # 1 in the payroll system and her start date was considered 11/5/24. He was assisting the facility in the interim when the facility was without a human resource manager. HRM # 1 had already done all the hiring paperwork before leaving on 10/25/24. It would have been HRM #1's or the DON's responsibility to have checked to see if Employee # 1 had a nursing license. This task would have fallen to whoever did her interview. He had never personally met Employee # 1. When he was helping in November 2024, during the interim when there was no human resources manager, he had noted that Employee # 1 had initially provided a nursing license that said single state licensure for Georgia only. When he noted the single state licensure, he mentioned to the DON that Employee # 1 would need to be pulled off the floor until they could verify her nursing license. He did not know what had happened to this initial nursing license she had submitted and why it was not on file in the personnel record given to the surveyor. According to human resource records, which the Corporate Human Resources Consultant referenced during the interview with the surveyor, Employee # 1 did not work from 11/14/24 through 11/18/24 because of this. Employee # 1 sent a copy of a license on 11/19/24 and he also looked at her nursing license online. At the time, he (the Corporate Human Resources Consultant) looked up her nursing license, he did not note anything suspicious. He never suspected that she was not really the person she was presenting to be. His thought was that if she had the capability to get the nursing license changed from single state to multi state, then she must be the person on the nursing license. The corporate Human Resource Consultant was interviewed regarding the lack of education and nursing experience on Employee # 1's application and reported the following information. It was not uncommon for employees to initially apply through a third-party website to their organization and then the application fed into their corporate system. At times the application might not be complete, but the applicant would then provide some sort of resume to fill in the gaps.</p> <p>Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She knew it was a shot in the dark when she applied for a nurse job at the facility. She had been homeless, living in a car, and had a child to support. She never thought that the facility would reach out to her after she submitted the application, but they did. She went to an interview. She did not know anybody by the name of HR# 1. She was interviewed by a male person and someone else, who was not the DON. Although she had never finished any type of formal health care training, she attended a medical assistant school in another state, and she did know about health care to some degree. She also had taken care of family members who were bedridden or diabetics and reported herself to be a fast learner. She told the facility during the interview she had health care experience. They never asked her for a license. She was surprised when the facility called her and offered her a job. They called and texted her to come to training which had already started. There was supposed to be four days of training, and she attended the last two days only. Then they put her with a nurse on night shift for about two or three days and she went to work. She had been working for about two weeks before they even asked her about a nursing license. She looked up her name on a website and found someone with a similar name to hers that had a nursing license and she decided to give that to the facility. She did not think the facility would accept it and reported she was baffled myself when they did, but they never questioned it and let her come back to work. Her intent was never to hurt anyone, and it was her perception that she did as well as the other nurses who had a nursing license. She was trying to go back to school to actually get a nursing license while she was working at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with the Administrator on 3/21/25 at 5:50 PM revealed HRM # 1 had been responsible for hiring Employee # 1 and no longer worked at the facility. HRM # 1 had been terminated out of the system on 10/25/24. Applicants for positions at the facility can provide an application for employment through a third-party system on the internet. That is how Employee # 1's application came through to them. He did not know everything HRM # 1 had done in hiring Employee # 1 but did know she had sent some on boarding documents through to get her hired. The Administrator stated Employee # 1's nursing license should have been verified before hire. He could find no reference checks in the personnel file.</p> <p>The records of three residents, who were cared for by Employee # 1 while she worked as a Nurse, were reviewed. Although not all inclusive of all the nursing task performed and judgements made by Employee # 1 while she was impersonating a licensed nurse and employed at the facility, these three records revealed some of the following examples of nursing duties performed or required of Employee # 1 to be done safely.</p> <p>Employee # 1 had been the responsible assigned Nurse for Resident # 3 on the night shift which began on 12/17/24 at 11:00 PM. Review of a facility investigative report revealed during this shift, Resident # 3 was identified by Resident # 3's Nurse Aide to have unexplained bruises to his chest and arm which were accompanied by swelling and discomfort with positioning. Employee # 1 would have been responsible for the assessment and notification of the physician during the night shift, and per her statement in the facility's investigative file she was aware of the bruises during the night shift. Employee # 1 noted in her statement she had seen the bruises on the resident's shoulders. Interview with the physician on 3/21/25 at 3:13 PM revealed she or another provider had not been notified by Employee # 1, and this should have been done. During the interview with the physician, the physician reported the bruising was all on the resident's upper body which included areas on his arms and chest wall which wrapped around some on his torso. He was also having some left shoulder pain. The physician further reported that Resident # 3 was a cognitively impaired resident and could not report what had happened. Further review of Resident # 3's nursing notes and 12/20/24 hospital ED (Emergency Department) records revealed Resident # 3's bruising continued to spread, and a CT (computerized tomography) scan performed on 12/20/24 at the hospital showed the resident had a large left subpectoral hematoma underlying his pacer control box measuring 9.5 X 5.2 cm. (centimeters) and superficial soft tissue contusion (bruising) of the left flank and hip.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Per record review Employee # 1 was responsible for performing FSBS (Finger Stick Blood Sugar Checks) for Resident # 9 and making judgements about when to call the physician for blood sugar readings. There was documentation in Resident # 9's record that Employee # 1 administered Insulin to Resident # 9 according to Resident # 9's MAR (Medication Administrator Record). On 1/8/25 when Employee # 1 documented on the MAR Resident # 9's FSBS was 409, there was no documentation the physician was notified and orders received although the resident had no sliding scale insulin coverage ordered at the time. Furthermore, per a 3/25/25 interview at 10:28 AM with Medication Aide (MA) #4, MA # 4 reported the following information. She (MA # 4) had taken Resident # 9's FSBS on 1/24/25 when it was due to be checked at 6:30 AM. The result was high and did not register on the glucometer. She reported the result to Employee # 1, who at the time MA # 4 believed to be a nurse. She (MA # 4) observed Employee # 1 call someone. She did not know who Employee # 1 called and did not know what she said to them. Later Employee # 1 received a notice that someone was on the phone line for her. She (MA # 4) again saw Employee # 1 talk to someone but did not hear the conversation. After the conversation, Employee # 1 went through the insulin pens on the medication cart, removed one, and walked into Resident #9's room. MA # 4 did not know what type of insulin pen was removed or to whom it belonged. A review of the chart revealed no documentation or orders for any insulin administration to address Resident # 9's 1/24/25 6:30 AM FSBS reading of high. Resident # 4's next blood sugar check was next performed when it was scheduled to be completed at 4:30 PM, and the result was documented as 524. During an interview with Resident # 9's NP (Nurse Practitioner) on 3/25/25 at 9:00 AM, the NP validated she had not been called on the morning of 1/24/25. The NP further reported she had checked the on-call log for that date, and there was no record of a call being placed to the on-call provider on the morning of 1/24/25 regarding Resident #9. The NP did not know to whom Employee # 1 had spoken before Employee # 1 went into Resident # 9's room with an insulin pen. The interview with Resident # 9's physician revealed she only had given her personal number to the Unit Managers and therefore she did not know how the employee could have reached her. She did not usually answer her phone before 7:00 AM when she was not on call for the medical practice, and she did not know to whom Employee # 1 had spoken on 1/24/25 before going into Resident # 9's room with an insulin pen.</p> <p>According to Resident # 11's record, the resident's 12/16/24 Minimum Data Set assessment coded the resident as severely cognitively impaired, and a review of physician orders revealed he received an anticoagulant. According to nursing notes, Employee # 1 documented Resident # 1 was on the floor on the dates of 12/28/24 and 1/9/25. Within her nursing note of 1/9/25, Employee # 1 documented she did a neurological assessment to make sure the resident did not sustain any blows to the head. Employee # 1 was responsible for making a nursing judgment regarding whether to call the physician that night and there was no documentation she did so although a review of Resident # 11's orders revealed he was receiving Eliquis (an anticoagulant) when the falls were sustained.</p> <p>On 3/24/25 at 8:55 PM the Administrator was notified of Immediate Jeopardy and provided the following Credible Allegation of Immediate Jeopardy Removal Plan</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.</p> <p>The facility failed to implement their abuse and neglect policy to screen, conduct reference checks, and thoroughly evaluate Employee # 1 when she was hired in November 2024. As a result, Employee #1 was hired as a nurse, despite not being licensed as a nurse and provided care to multiple residents during her employment period at the facility which lasted from her hire date in November 2024 until her termination on 2/6/2025.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During this time, unlicensed Employee # 1 performed multiple job duties which require education and training to perform correctly to ensure residents are safe and not neglected. This includes but is not limited to blood sugar checks, neurological checks following falls, insulin administration and other medication administration, and oxygen saturation level assessments.</p> <p>Furthermore, the facility failed to implement their abuse/neglect/ and injury of unknown origin policy when Nursing aide # 5 failed to report unexplained injuries- bruises she found on Resident #3 during night shift of 12/17/25 11pm to 12/18/25 7am to the charge nurse on the shift.</p> <p>On 2/6/25 The Human Resource (HR) manager conducted a complete audit of all nursing licenses and CNA certifications to ensure no discrepancies in name spelling or state of residence. There were no discrepancies noted in the audit.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>On 2/6/25 the Human Resources (HR) manager was performing an audit of nursing licenses and noted a slight discrepancy in the spelling of Employee #1's name on her identification (ID) and the name on the presented Georgia LPN license. It was also noted that employee #1 had a [NAME] North Carolina address on her ID and was practicing with a GA LPN license. Employee #1 was questioned by the HR manager and the DON related to the discrepancies and was immediately removed from resident care duties and terminated.</p> <p>On 2/6/25 the Director of Nursing submitted a complaint to the North Carolina Board of Nursing (NCBON) related to unlicensed employee #1 and the suspicion that she had falsified her credentials as an LPN.</p> <p>On 3/18/25 the NCBON contacted the Director of Nursing and informed her that they had completed their investigation and unlicensed employee #1 had falsified her LPN credentials and advised the DON to contact law enforcement.</p> <p>On 3/18/25 The DON contacted the [NAME] NC Police and filed a report with the findings from the facility internal investigation and the NCBON investigation.</p> <p>Since 2/6/25 the HR manager has continued to evaluate licenses and certifications for any potential nurse or CNA seeking employment to ensure there are no discrepancies with the spelling of names or state of residence. The HR manager also ensures that any potential nurse seeking employment has a valid license and is in good standing with the Board of Nursing (BON). The HR manager also checks the North Carolina Nurse Aide Registry for any potential CNA seeking employment to ensure that they have an active certification and are in good standing. This will prevent any unlicensed or uncertified staff from working in the facility.</p> <p>On 2/6/2024 the HR manager received verbal and written re-education on the hiring policy and all of the above-mentioned steps from the Corporate Human Resources Manager. Any newly hired HR managers will receive this education from the Corporate Human Resources Manager as part of their orientation process.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 3/27/25 the decision was made by the Corporate HR Manager to review and revise the current hiring policy for this center to state that the HR Manager will obtain two professional references prior to employment. The HR Manager will also ensure that all employees undergo background checks prior to employment.</p> <p>On 2/20/25 the DON identified in her investigation of Resident #3's injury of unknown origin that NA #5 had noted bruising and discomfort but had failed to report it to any nurse. The DON then implemented education with all nurses and CNAs on unit 300 about reporting bruising or injuries of unknown origin. The education was face to face and was completed on 2/27/25.</p> <p>On 3/26/25 through 3/27/25 The DON, SDC, and Administrator completed education with all staff on immediately reporting any injury of unknown origin to the DON or administrator. Education was presented face to face or via telephone. There are no Agency nurses currently contracted. Newly hired agency staff will be educated during orientation by the Staff Development Coordinator to immediately report an injury of unknown origin to the DON or administrator.</p> <p>Date of Immediate Jeopardy removal will be 3/28/25.</p> <p>On 3/31/25 the facility's Credible Allegation of Immediate Jeopardy Removal Plan was validated by the following actions:</p> <p>The facility presented evidence of license verification audits per their plan.</p> <p>The facility presented evidence they had reviewed and revised their hiring process per their plan of action to ensure employees were screened to prevent abuse and neglect.</p> <p>The facility presented evidence of inservice records per their removal plan.</p> <p>Interviews were conducted and validated that staff had been trained regarding abuse, neglect, and injuries of unknown origin and were aware they were immediately report instances when identified.</p> <p>The facility's date of immediate jeopardy removal was validated to be 3/28/25.</p> <p>2. Review of the facility's Plan for the Prevention of Elder Abuse, which was undated and provided to the surveyor as the facility's current policy, included information that it was the responsibility of employees to promptly report any instances of injuries of unknown origin.</p> <p>Review of the facility's investigative file for reportable incidents of injuries for which there was no known cause revealed the following information. On 12/18/24 the facility submitted an initial report, which was completed by Unit Coordinator # 1, to the state agency noting that at 7:20 AM on 12/18/24 Resident # 3 had been identified with a baseball size bruise on the front right shoulder, large hematoma to his left side under arm, swelling and bruising on his left upper chest and below clavicle. The report also noted the resident was unable to lift his left arm without pain and there was swelling.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However I notice some bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I notice while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aid to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON.</p> <p>NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been washed up by the 2nd shift. He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was a golf sized bruise on his arm which appeared light reddish and turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise, and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift and staff were already aware and therefore she did not report it. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse. She did not immediately report the bruises to anyone. Employee # 1 further reported that after her shift had ended, she later received a phone call from the Director of Nursing and the DON (Director of Nursing) informed her that she was supposed to report bruises immediately to the nurse on duty and not to wait to report.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289</p> <p>Based on record review, resident interview, staff interview and Physician Interview the facility failed to complete a thorough investigation related to unexplained swelling, discomfort, and bruising Resident # 3 experienced although there had been no reported accident and the resident was not on an anticoagulant. Review of the facility's completed investigation revealed the facility 1) failed to identify a hospital CT (computerized tomography) showed the resident's bruising extended to his hip area which they had not identified in their investigation 2) failed to investigate discrepancies further which were noted by reviewing Employee # 1's statements with other employees' statements and the resident's record and 3) failed to further question and clarify who had obtained a weight on the resident during the shift when the injuries were first identified in order to determine if something had happened while the resident was weighed.</p> <p>The findings included:</p> <p>Resident # 3 was admitted to the facility on [DATE]. The resident's diagnoses in part included dementia, congestive heart failure, Parkinsons, atrial fibrillation, anxiety, and dysphagia.</p> <p>Resident # 3's annual Minimum Data Set (MDS) assessment, dated 10/14/24, coded the resident as severely cognitively impaired and as needing total staff assistance for bathing, dressing, and hygiene needs. Resident # 3 was coded as needing partial to moderate assistance to roll from side to side in bed and as needing substantial to maximum assistance to transfer. The resident was coded as using a manual wheelchair to roll 50 feet after set-up assistance. The resident was not coded as having falls during the assessment period.</p> <p>Review of Resident # 3's medical record revealed no falls in December 2024 were documented.</p> <p>Review of Resident # 3's medication regimen for December 2024 revealed Resident # 3 was not on an anticoagulant.</p> <p>Review of the facility's investigative file for reportable incidents of injuries for which there was no known cause revealed the following information. On 12/18/24 the facility submitted an initial report, which was completed by Unit Coordinator # 1, to the state agency noting that at 7:20 AM on 12/18/24 Resident # 3 had been identified with a baseball size bruise on the front right shoulder, large hematoma to his left side under arm, swelling and bruising on his left upper chest and below clavicle. The report also noted the resident was unable to lift his left arm without pain and there was swelling.</p> <p>Review of Employee # 1's statement, which was located in the facility's investigative file read, I was collecting [Resident # 3's] routine 02 (oxygen) when I notice he had some bruising to his right shoulder as well as some to his left. No fall or bruising was reported from the previous shift to me in report so my next thought was to bring it to our unit coordinators attn. (attention) that he had bruising on him. Before I could bring it to [Unit Coordinator's] attention it was brought to my attention once more by the next shift and when the unit coordinator got here I immediately let her know my findings so it could be documented properly.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident # 3's vital sign log revealed Employee # 1 documented Resident # 3's oxygen level was checked at 12/18/24 at 12:56 AM. (According to Employee # 1's statement this was when she noticed the bruises.) The reading was 94%. There was no notation it was taken again on Employee # 1's shift. Employee # 1 also documented Resident # 3's weight was 127 pounds at 6:38 AM on 12/18/24.</p> <p>According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However I notice some bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I notice while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aid to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON.</p> <p>NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been washed up by the 2nd shift. He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was a golf ball sized bruise on his arm which appeared light reddish and turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise, and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse. She thought Employee # 1 had been in Resident # 3's room before her (NA # 5) at some time during the night shift but she did not see Employee # 1 go into Resident # 3's room.</p> <p>During a follow up interview with NA # 5 on 3/24/25 at 1:02 PM, NA # 5 reported she had not obtained Resident # 3's weight that had been documented on 12/18/24 at 6:38 AM.</p> <p>Review of the facility's investigative file revealed a statement from NA # 6 which showed that Employee # 1 had claimed she knew nothing about the bruises when Nurse Aide # 6 approached her about the bruises at breakfast time on 12/18/24, although in Employee # 1's written statement she had written she was aware of them when she checked the resident's oxygen level during the night. NA # 6's statement read, On 12/18/24 I came to work passing the trays (breakfast trays). I got [Resident # 3's] tray. As soon I drop it off, I saw him with no shirt on. I saw bruises on his right shoulder, left upper quadrant. As soon I saw the bruises I talked to 3rd shift nurse [Employee # 1]. I saw her go to [Resident # 3's] room and showed her the bruises. She told me that this first time seeing this, that they had no falls last night.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employee # 1 was interviewed on 3/25/25 at 2:57 PM and reported she had been working as a nurse at the facility but had no license as a nurse and had not completed any formal health care program. Employee # 1 acknowledged she had falsely provided information to the facility and given them another individual's nursing license. Employee # 1 was interviewed regarding Resident #3's injury and reported she had called the DON at 12 something when she did the oxygen level and saw bruising. Employee # 1 reported she did not know who obtained Resident # 3's weight which she had recorded.</p> <p>Interview with Unit Coordinator # 1 revealed she first became aware of the bruising on the morning of 12/18/24. She had been stopped in the hallway but did not recall who told her about it. She knew that Employee # 1 had been aware of the bruising and had said she had just seen it.</p> <p>A review of nursing notes revealed the first entry documenting the resident's bruising was on 12/18/24 at 7:32 AM by Nurse # 1. The entry was entered into the record as a late entry on the date of 12/19/24 at 8:08 AM. The entry read, Resident able to make needs writer made aware during report that resident had bruising to left side of chest, armpits, and arms. VS 128/77 (blood pressure), 97 % on RA (room air), 18 (respirations), 97.9 (temperature), 63 (pulse.) No s/s (signs and symptoms) of SOB (shortness of breath), wheezing or labored breathing . Facial grimacing noted when resident move his left arm. Resident refused to be repositioned . Nurse # 1 further noted Resident # 3 had an order for Tylenol 325 mg (milligrams) 2 tabs every 6 hours. Nurse # 1 also noted the physician was notified and orders were obtained for a stat x-ray on the chest, right arm and left arm. The DON, Unit Coordinator, and social worker were also notified.</p> <p>Review of nursing notes revealed on 12/20/24 at 2:21 PM the Unit Coordinator noted that Resident # 3's bruising was spreading from his bilateral shoulders down into his abdomen, left arm, and left side rib cage and he was being transferred to the hospital for further evaluation.</p> <p>Review of 12/20/24 ED (Emergency Department) notes revealed the following information was documented. Resident # 3 had extensive chest and abdominal wall ecchymosis. A CT (computerized tomography) of the chest abdomen and pelvis with contrast was completed. The CT impression read, 1) large left subpectoral hematoma underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip 3) No other CT evidence of acute traumatic injury to the chest, abdomen, or pelvis. 4) emphysema, 5) coronary artery disease. Upon preparing for discharge, the ED physician did not note any further comments about the hip contusion. The ED physician did note CT scan obtained demonstrating hematoma around his pacemaker site but otherwise superficial contusion. There was no notation regarding how the hematoma could have formed around the pacemaker site. The resident was noted to be stable for discharge from the ED with a final diagnosis of chest wall hematoma, left and superficial bruising of back, left.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident # 3's physician was interviewed on 3/21/25 at 3:13 PM and reported the following information. When she evaluated Resident # 3 on 12/18/24 the bruising was all on his upper body which included areas on his arms and chest wall which wrapped around some on his torso. She did not recall any bruising extending to his hip when she examined him on 12/18/24. He was also having some left shoulder pain. Prior to 12/18/24 there had been no history the resident had a pacemaker. The resident was thin and on the date of 12/18/24 the pacemaker was noticeable and appeared to be turned more to a lateral position and more towards the antecubital area. The resident had poor safety awareness and was not able to explain how the bruising occurred when she talked to him. If he had told the staff he had fallen, she was not sure the staff could go totally by what the resident had said because of his confusion. He was sent to the ED to be reviewed also, but the ED physician did not make mention of problems with the pacemaker itself. The ED physician also had not put anything in his notes about the contusion to the left hip which had shown up on the CT scan. It had not been brought to her attention that the CT in the ED showed a contusion to the left hip. She was unsure if the contusion to the left hip was related to the 12/18/24 incident or a separate event. They had made a referral for a cardiologist, but the son had canceled the appointment. She (the physician) was not a cardiologist and was not aware of what type of stitches had been placed when the pacemaker had originally been placed. She would think that over time scar tissue would help hold the pacemaker in place. She could not say 100 % for sure, but would think that something would have had to happen to cause a pacemaker to move if it had done so. She did not know how far it could be moved. She would have to refer to a cardiologist's opinion.</p> <p>Resident # 3 was interviewed on 3/20/25 at 2:45 PM and was unable to report how the injury had occurred.</p> <p>Interview with the DON and Administrator on 3/21/25 at 5:30 PM revealed the following information. They had conducted their investigation following the identification of the bruising on 12/18/24. Employee # 1 had never called on her shift to report any injury. It was not reported until the dayshift on 12/18/24 and at that time they did an investigation and reported the incident to the state. None of the staff had reported they witnessed Resident # 3 to fall or have an accident for them to conclude a particular cause to the bruising. They thought something had happened to the pacemaker spontaneously, which had caused bleeding under the skin and had spread downwards. They had not been aware that the hospital CT showed there was a contusion of the hip also and had not included that in their investigation. The ED report had been sent to them and scanned into their computer without this being drawn to their attention.</p> <p>During a follow up interview with the Administrator on 3/24/25 at 4:15 PM the Administrator reported they did not look into who actually did Resident # 3's weight on the shift on which he was identified to have the injury. The Administrator reported he assumed Employee # 1 did the weight since she noted it in the record.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's five-day report to the state agency revealed the DON submitted the report on 12/20/24 without any mention of the ED's findings that there had been a contusion to Resident # 3's left hip identified. Also, there was no mention in the five-day completed report that the facility had noted that by Employee # 1 writing that she had noted the bruises when she checked the resident's oxygen level, this would have indicated discrepancies in statements and the resident's record. According to Employee # 1's statement she knew about the bruises when she checked his oxygen level. According to NA # 6's statement, Employee # 1 denied she knew anything about the bruises when they were pointed out to her at breakfast time on 12/18/24. There was no indication Employee # 1 was further questioned in the five-day report and discrepancies accounted for.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289</p> <p>Based on record review, and interviews with staff, physician, and Nurse Practitioner, the facility failed to ensure Resident # 3 was initially assessed by a nurse after Nurse Aide # 5 identified the resident to have discomfort with positioning, swelling, and bruises on his arm and chest with no known cause and while the resident was not receiving an anticoagulant. When Resident # 3's was assessed the following shift by the physician multiple bruises were found on both arms and the resident's chest which was a broader area than had been reported by Nurse Aide # 5. The bruising was irregular in shape and included both red and purple bruising. The bruises continued to spread and two days following the initial identification of the bruises, Resident # 3 was seen in the ED (Emergency Department) where a CT (Computed Tomography) of the chest abdomen and pelvis with contrast was completed. The CT impression read, 1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip. Additionally, the facility failed to ensure staff communicated amongst themselves effectively regarding Resident # 9's documented elevated finger stick blood sugar readings and also failed to ensure he was monitored for hyperglycemia in order that he receive treatment. On three consecutive days Resident # 9's documented finger stick blood sugar (FSBS) exceeded 400 or registered high on the glucometer after intermittent readings had already exceeded 400 during the month of January 2025. On the evening of 1/24/25 after Resident # 9's last documented finger stick blood sugar (FSBS) reading registered 524 the resident fell in the shower room after becoming dizzy. The resident was transferred to the hospital where he was diagnosed with a small subdural hematoma (type of bleeding near your brain that can happen after a head injury). The facility also failed to ensure Resident # 11 received an assessment by a nurse following falls while on an anticoagulant medication. This was for three of five sampled residents reviewed for professional standards of practice.</p> <p>Immediate Jeopardy began on 12/18/24 for Resident # 3 when Nurse Aide # 5 identified during her shift that Resident # 3 had unexplained bruises, swelling, and discomfort and there was no assessment by a nurse. Immediate Jeopardy began for Resident # 9 on 1/8/25 when his FSBS registered 409 and the facility failed to effectively treat his dangerously high blood sugars. Immediate Jeopardy was removed on 3/28/25 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 E to ensure education is completed and monitoring systems put in place are effective. Example # 3 was cited at a scope and severity level of D.</p> <p>The findings included:</p> <p>1. Resident # 3 was admitted to the facility on [DATE]. The resident's diagnoses in part included dementia, congestive heart failure, Parkinson's, atrial fibrillation, anxiety, and dysphagia.</p> <p>Review of physician orders revealed Resident # 3 was not ordered to receive an anticoagulant.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident # 3's annual Minimum Data Set (MDS) assessment, dated 10/14/24, coded the resident as severely cognitively impaired and as needing total staff assistance for bathing, dressing, and hygiene needs. Resident # 3 was coded as needing partial to moderate assistance to roll from side to side in bed and as needing substantial to maximum assistance to transfer. The resident was coded as using a manual wheelchair to roll 50 feet after set-up assistance. The resident was not coded as having falls during the assessment period.</p> <p>Review of Resident # 3's care plan revealed the following information. On 10/19/23 staff added the resident was at risk for falls. This remained part of the resident's active care plan. On 10/27/23 staff added the resident picked at his skin causing skin tears and bruises at times. This remained as part of the resident's active care plan. On 2/10/24 staff added that Resident # 3 could be combative with care. This remained as part of the resident's active care plan.</p> <p>Review of the facility's investigative file for reportable incidents of injuries for which there was no known cause revealed the following information. On 12/18/24 the facility submitted an initial report, which was completed by Unit Coordinator # 1, to the state agency noting that at 7:20 AM on 12/18/24 Resident # 3 had been identified with a baseball size bruise on the front right shoulder, large hematoma to his left side under arm, swelling and bruising on his left upper chest and below clavicle. The report also noted the resident was unable to lift his left arm without pain and there was swelling.</p> <p>Review of staffing sheets revealed on the night shift which began at 11:00 PM on 12/17/24 and ended at 7:00 AM on 12/18/24, Employee # 1 was assigned to care for Resident # 3 as a nurse.</p> <p>Review of Employee # 1's personnel file revealed Employee # 1 was hired as a nurse but was not licensed as a nurse and her application prior to hire indicated no nursing education.</p> <p>During an interview with the DON (Director of Nursing) on 3/21/25 at 9:00 AM, the DON confirmed that Employee # 1 had submitted someone else's nursing license number upon hire in November 2024 and was terminated in February 2025 when this had been validated. At the time she had been caring for Resident # 3 on the night shift of 12/17/24, the facility had not noted she was impersonating a nurse and was not licensed and trained to perform assessments and nursing duties.</p> <p>Review of Employee # 1's statement read, I was collecting [Resident # 3's] routine 02 (oxygen) when I notice he had some bruising to his right shoulder as well as some to his left. No fall or bruising was reported from the previous shift to me in report, so my next thought was to bring it to our unit coordinators attn. that he had bruising on him. Before I could bring it to [Unit Coordinator's] attention it was brought to my attention once more by the next shift and when the unit coordinator got here, I immediately let her know my findings so it could be documented properly.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Employee # 1 was interviewed on 3/25/25 at 2:57 PM and acknowledged she had given someone else's nursing license number who shared a similar name to the facility in order to work as a nurse. According to Employee # 1 she completed no type of Nurse Education or Nurse Aide training. She reported she had some medical assistant training from another state but had not completed that either. She was interviewed regarding Resident #3's bruises and reported she had called the DON at 12 something when she saw them on the 11:00 PM to 7:00 AM shift which began on 12/17/24 when she did the oxygen level and saw the bruises. Employee # 1 reported she did not know who obtained Resident # 3's weight which she had recorded. Employee # 1 did not know how the bruises occurred and reported she would never do anything to hurt a resident.</p> <p>A review of Resident # 3's vital sign log revealed Employee # 1 documented Resident # 3's oxygen level was checked at 12/18/24 at 12:56 AM. The reading was 94%. There was no notation it was taken again on Employee # 1's shift.</p> <p>According to staffing sheets, NA # 5 was assigned to care for Resident # 3 on the night shift which began at 11:00 PM on 12/17/24. NA # 5's written statement within the facility's investigative file read, When I was doing my 3:00 AM rounds, upon entering [Resident # 3's] room I noticed he had removed his gown and blanket which he usually does. However, I noticed some bruising on his arm and chest along with some swelling. Upon me waking him up he seemed startled (more than usual) but he eventually calmed down after I talked with him. I noticed while turning him to his left he jerked himself back and became uncomfortable so I turned him back on his back and since he had not soiled himself, I put the gown and blanket back over him. When I came back around 5 AM I did change him but made sure not to roll him on his left arm since that is where his bruise that I noticed was located. Moving forward I will make sure to have another aid to do a walk through with me and/or assist with changes. No matter how minor or major it be if I notice ANYTHING it will be reported to the NURSE and I will leave written reports to the DON.</p> <p>NA # 5 was interviewed on 3/21/25 at 11:25 AM and reported the following information about her 12/17/24 shift which began at 11:00 PM. When she arrived at work, she got report and had been told that Resident # 3 had been washed up by the 2nd shift (3:00 PM to 11:00 PM). He was asleep in bed on first rounds and again at 1:00 AM and she did not disturb him. Around 3:00 AM she noticed Resident # 3 had bruising. There was a golf ball sized bruise on his arm which appeared light reddish and turning purple. There was bruising on his chest which was larger than what was on his arm, but his gown partially covered the bruise, and she did not pull the gown down to look at the extent of the bruising. She assumed the bruising had happened earlier during another shift and therefore the nurses were already aware of it. Nothing had happened on her shift. She did not tell Employee # 1, who she thought was a nurse. She thought Employee # 1 had been in Resident # 3's room before her (NA # 5) at some time during the night shift but she did not see Employee # 1 go into Resident # 3's room and did not know what all she had done for the resident that night.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A review of nursing notes revealed the first entry documenting an assessment of Resident #3 was on 12/18/24 at 7:32 AM by Nurse # 1. The entry was entered into the record as a late entry on the date of 12/19/24 at 8:08 AM. The entry read, Resident able to make needs writer made aware during report that resident had bruising to left side of chest, armpits, and arms. VS (vital signs) 128/77 (blood pressure), 97 % on RA (room air), 18 (respirations), 97.9 (temperature), 63 (pulse.) No s/s (signs and symptoms) of SOB (shortness of breath), wheezing or labored breathing. Facial grimacing noted when resident move his left arm. Resident refused to be repositioned . Nurse # 1 further noted Resident # 3 had an order for Tylenol 325 mg (milligrams) 2 tabs every 6 hours. Nurse # 1 also noted the physician was notified and orders were obtained for a stat x-ray on the chest, right arm and left arm. The DON, Unit Coordinator, and Social Worker were also notified.</p> <p>An attempt was made to interview Nurse # 1 on 3/21/25 at 12:01 PM and she could not be reached for an interview.</p> <p>The next nursing entry was dated 12/18/24 at 7:36 PM by Nurse # 2 and read, Was informed from previous shift nurse that resident had discoloration noted to chest area. Resident has discoloration noted to chest, sides of chest, armpits and arms. Measurements obtained and put in DON office Supervisor, MD (Medical Doctor), and DON aware.</p> <p>Nurse # 2 was interviewed on 3/21/25 at 10:28 AM and reported the following information. On the date of 12/18/24 she had reported to work at 11:00 AM because Nurse # 1 had to leave early that day. She had been told about Resident # 3's bruises in report at 11:00 AM and went to assess him and found bruises on his arms and chest. When he talked, he mumbled but if she asked him yes and no questions he would answer simple questions. When asked if he had fallen, Resident # 3 had replied, yes. When asked where he had fallen, Resident # 3 had pointed to the closet area of the room. The resident was not able to convey more about the incident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of physician progress notes revealed the resident's physician, who served as the facility medical director, assessed Resident # 3 on 12/18/24. The physician noted, He (Resident # 3) was noted this morning to have bruising on his upper body. Patient has cognitive impairment and is not able to tell us what happened. Last BIMS (brief interview for mental status) 2/15. He seems to only have pain when moving the left shoulder. No documented falls. He was given Tylenol for pain. The physician further documented measurements of the bruising as follows: Note Bruises were irregular shaped and were measured at largest diameter. Right anterior chest upper near midline, about 5.5 X 3.5 cm (centimeters) reddish with some faint purplish area inferior to it. Right shoulder near AC joint (joint at the top of the shoulder) circular reddish abrasion. Right shoulder lateral clavicle about 7 x 6 cm irregular shaped reddish bruise with faint deeper purple underneath it extending further down about 5 X 8 cm at largest diameter. Right arm-3 circular bruises about 1 cm each-2 inner bicep mid to distal and 1 lateral inferior. Left chest wall- Pacemaker scar with 6 small irregular shaped purplish red bruises. Pacemaker appears more lateral and turned/sticking out. Left side -about 7 X 3 cm reddish bruise with faint edges in shoulder near clavicle. Large reddish purple about 10 X 4 cm inferior to tattoo on lateral upper arm. Left arm-irregular shaped bruise going down bicep with varying colors-reddish to darker purple inferior, 12 X 4 cm around to lateral aspect of arm. 8 X 3 cm circular bruise purplish inferior and medial to elbow. Large left chest wall bruise light purplish edges wraps around chest lateral to nipple, darker purple on posterior chest. No ecchymosis (discoloration of the skin, typically caused by bruising) neck, facial area, or body below waist. Within the progress note, the physician noted a chest x-ray and complete blood count would be obtained. The physician further noted that she was unsure when the pacemaker had been placed or last tested . She further noted the pacemaker appeared to be turned/sticking out more.</p> <p>On 12/18/24 at 7:38 PM Nurse # 2 noted Resident # 3's chest x-ray was normal.</p> <p>Review of the 12/18/24 Chest x-ray result showed that the pacemaker was present but did not note any abnormalities with the pacemaker or with the resident's heart or lungs. The radiologist noted the report was negative.</p> <p>A review of Resident # 3's 12/18/24 CBC result revealed the resident's platelet count was normal. (Low platelets can increase the chance of bleeding.)</p> <p>On 12/19/24 Resident # 3 was seen by the NP (Nurse Practitioner) who noted the following information. Resident # 3's CBC (complete blood count) did not show thrombocytopenia (low platelets), and the chest x-ray had been normal. There had been a concern that the resident's pacemaker had been dislodged, and she had asked for a reread of the chest x-ray. Resident # 3 denied pain at the time.</p> <p>Interview with Resident # 3's Nurse Practitioner on 3/24/25 at 5:15 PM revealed she was not aware of how the bruising had occurred. The NP reported she attempted to see if the radiologist, who performed the chest x-ray at the facility, could determine if something occurred to the resident's pacemaker, but they were not able to determine.</p> <p>Review of nursing notes revealed on 12/20/24 at 2:21 PM Unit Coordinator #1 noted that Resident # 3's bruising was spreading from his bilateral shoulders down into his abdomen, left arm, and left side rib cage and he was being transferred to the hospital for further evaluation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2025
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Burlington		STREET ADDRESS, CITY, STATE, ZIP CODE 323 Baldwin Road Burlington, NC 27217	
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with Unit Coordinator # 1 on 3/21/25 at 11:10 AM revealed she first became aware of the bruising on the morning of 12/18/24. She had been stopped in the hallway but did not recall who told her about it. She initially recalled the bruising to be on the resident's shoulder and over time it spread downwards.</p> <p>Review of 12/20/24 ED (Emergency Department) notes revealed the following information was documented. Resident # 3 had extensive chest and abdominal wall ecchymosis. A CT (Computed Tomography) of the chest abdomen and pelvis with contrast was completed. The CT impression read, 1) large left subpectoral hematoma (a collection of blood, usually clotted, outside of a blood vessel) underlying pacer control box measuring 9.5 X 5.2 cm. 2) Superficial soft tissue contusion of the left flank and hip 3) No other CT evidence of acute traumatic injury to the chest, abdomen, or pelvis. 4) emphysema, 5) coronary artery disease. Upon preparing for discharge, the ED physician did not note any further comments about the hip contusion. The ED physician did note CT scan obtained demonstrating hematoma around his pacemaker site but otherwise superficial contusion. There was no notation regarding how the hematoma could have formed around the pacemaker site. The resident was noted to be stable for discharge from the ED with a final diagnosis of chest wall hematoma, left and superficial bruising of back, left. There were no ED discharge orders.</p> <p>On 12/20/24 at 10:55 PM Nurse # 1 documented Resident # 3 returned from the hospital in no distress, no pain, and no new orders.</p> <p>Interview with the Director of Nursing at 5:30 PM on 3/21/25 revealed the facility had not recognized that Employee # 1 was not licensed and trained to do an assessment of Resident # 3 when she was caring for him during the time the injury was first observed on her shift.</p> <p>2. Record review revealed Resident # 9 was admitted to the facility on [DATE] and had diagnoses which in part included diabetes, Alzheimer's dementia, atrial flutter, cardiomyopathy, and congestive heart failure.</p> <p>Review of physician orders revealed Resident # 9 was ordered to receive Eliquis 5 mg (milligrams) every 12 hours for atrial flutter. This order began on 11/8/24. (Eliquis is an anticoagulant and increases the chances of bleeding).</p> <p>Review of Resident # 9's admission Minimum Data Set assessment, dated 11/13/24, coded Resident #9 as severely cognitively impaired. The resident was also coded as needing partial to moderate assistance with his bathing needs, as ambulatory with supervision, and occasionally incontinent of urine.</p> <p>Resident # 9's care plan included the information that Resident # 9 was a diabetic. This was added to the care plan on 11/8/24 and remained part of the Resident # 9's active care plan. Staff were directed on the care plan to monitor blood sugar levels as ordered and both observe and report any signs and symptoms of hyperglycemia or hypoglycemia.</p> <p>Review of physician orders and Resident # 9's January 2025 MAR (medication administration record) revealed the following information.</p> <p>Resident # 9 had an order for FSBS (fingerstick blood sugars) twice per day. This order originated on 11/8/24 and was in effect until discontinuation on 1/27/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>According to the January 2025 MAR, the FSBS's were scheduled for 6:30 AM and 4:30 PM. There were no orders for parameters to call the provider regarding results and there was no order for sliding scale insulin coverage based on FSBS results.</p> <p>Review of physician orders revealed between the dates of 1/1/25 and 1/24/25, the only type of insulin Resident # 3 was prescribed was a long- acting insulin given at night and there was one order change in Resident # 9's diabetic medication dosages. Specific medications and the dosage order change were as follows:</p> <p>Jardiance 25 mg (milligram) tablet once per day. This order was in effect from 12/7/24 until its discontinuation on 1/27/25.</p> <p>Metformin 500 mg tablet twice per day. This order was in effect from 12/13/24 until discontinuation on 1/27/25.</p> <p>Ozempic pen injector; 0.5 mg; subcutaneous once per week on Monday. This order was in effect from 11/11/24 until discontinuation on 1/27/25.</p> <p>Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); Administer 15 units subcutaneous at bedtime. This order was in effect from 12/31/2024 until the discontinuation on 01/06/2025. (Lantus is a long acting insulin which can last up to 24 hours but does not have a rapid onset of action).</p> <p>Insulin glargine-yfgn insulin pen; 100 unit/mL (3 mL); Administer 15 units subcutaneous at bedtime. This order was in effect from 1/6/25 until discontinuation on 1/18/25. (Insulin glargine-yfgn is a biosimilar interchangeable insulin product to insulin glargine which the resident was already receiving. There were no dosage changes).</p> <p>According to the record, the physician saw the resident on 1/18/25 and noted his hemoglobin HgbA1c (hemoglobin A1C) on 12/24/24 had been 9.2 and she would increase the resident's long- acting insulin from 15 to 18 units. (Hemoglobin A1c is a blood test that measures the average blood sugar result in the last two to three months. A result of 6.5% and above reflects diabetes.)</p> <p>The date of 1/18/25 was the only date where an increase in insulin dosage order was noted in the chart from 1/1/25 to 1/24/25. The order was for insulin glargine-yfgn insulin pen; 100 unit/mL (3 mL); Administer 18 units subcutaneous at bedtime. This order was in effect until discontinuation on 1/27/25.</p> <p>Review of Resident # 9's MAR revealed the following FSBS results documented.</p> <p>On 1/8/25 at 6:30 AM Employee # 1 (an unlicensed employee) documented 409 on the MAR.</p> <p>On 1/10/25 at 6:30 AM Nurse # 6 documented 433 on the MAR.</p> <p>On 1/10/25 at 4:30 PM Nurse # 7 documented 423 on the MAR.</p> <p>On 1/18/25 at 4:30 PM Nurse # 8 documented 413 on the MAR.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 1/22/25 at 6:30 AM Medication Aide (MA) # 1 documented 453 on the MAR.</p> <p>On 1/22/25 at 4:30 PM MA # 2 documented 456 on the MAR.</p> <p>On 1/23/25 at 6:30 AM Nurse # 9 documented 419 on the MAR.</p> <p>On 1/23/25 at 4:30 PM MA # 3 documented 403 on the MAR.</p> <p>On 1/24/25 at 6:30 AM MA # 4 documented high on the MAR.</p> <p>On 1/24/25 at 4:30 PM Nurse # 5 documented 524 on the MAR.</p> <p>There was no documented nursing progress note with an assessment of Resident # 9 when the resident's blood sugar registered high on 1/24/25 at 6:30 AM. There were no orders entered into the record.</p> <p>MA # 4 was interviewed on 3/25/25 at 10:28 PM and reported the following information. She recalled Resident #9's blood sugar registering high on the morning of 1/24/25. At the time she was to be reporting to Employee # 1, who she thought was a nurse at the time. She told Employee # 1 about the high blood sugar and Employee # 1 stated she would check the record for sliding scale orders and call the physician. She saw Employee # 1 make a phone call and talk to someone, but she did not know to whom she was talking to. Afterwards Employee # 1 asked to look in her (MA # 4's) medication cart, obtain an insulin pen, and go into Resident # 9's room. She did not know what insulin pen Employee # 1 had obtained or what she had done when she went into the room. When she had checked the FSBS, Resident # 9 had appeared okay.</p> <p>Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She had applied and been accepted to work at the facility as a nurse. She had provided a false license to the facility and had no nursing education nor a license to perform job duties of a nurse. She had taken care of diabetic family members and had some partial training as a medication assistant in another state. On the morning of 1/24/25 when Resident # 9's blood sugar registered high she had called the doctor and gotten an order for some insulin. She had given the insulin. When interviewed about the issue that Resident # 3 did not have any short acting insulin ordered and filled for her to access for him, Employee # 1 replied they kept some on the cart or in back up for times such as this.</p> <p>An interview with Nurse # 9, who had worked on Resident #9's unit, revealed the facility did not keep back up insulin stored on medication carts for newly ordered insulin.</p> <p>Interview with Resident # 9's NP (Nurse Practitioner) on 3/24/25 at 5:15 PM and with the Physician on 3/27/25 at 1:42 PM revealed they did not know who Employee # 1 had called on the morning of 1/24/25 because there was no history of calls to them or the on-call provider.</p> <p>According to staffing sheets, Unit Coordinator #1 worked as a floor nurse on the day shift on 1/24/25 and cared for Resident # 9. Unit Coordinator # 1 was interviewed on 3/25/25 at 12:46 PM and reported the following information. She could not recall the details of 1/24/25. In general, if she had been informed in report that Resident # 9's blood sugar was high, then she would have asked what had been done about it and ensured that this was all documented. She would have rechecked it herself and monitored the resident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER White Oak Manor - Burlington		STREET ADDRESS, CITY, STATE, ZIP CODE 323 Baldwin Road Burlington, NC 27217	
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the record revealed no nursing progress notes on dayshift showing the blood sugar was rechecked and the resident was monitored on the dayshift of 1/24/25.</p> <p>According to the Medication Administration record, the next time the resident's blood sugar was checked again following the reading on 6:30 AM was on 1/24/25 at 4:30 PM by Nurse # 5. The result was 524. There was no assessment of the resident at that time or a documented follow-up reading.</p> <p>Nurse # 5 was interviewed on 3/25/25 at 1:26 PM and reported the following information. She had never received information in report that Resident # 9's blood sugar had been too high to register on the glucometer earlier that morning. She had cared for him on the evening shift (3:00 P to 11:00 PM) on 1/24/25. She was new at the time on 1/24/25 when Resident # 9's FSBS registered 524. She was walking to the desk to call the physician when she saw MA # 1. She asked MA # 1 if Resident # 9's FSBS usually ran high, and MA # 1 told her that Resident # 9 would get sugary things on his hands and recommended to clean his finger better and recheck it. There was not much time between Nurse # 5 talking to MA # 1 before she then went back to recheck the FSBS. She then obtained a result in the 300s but did not recall what it was. Nurse #5 thought she had documented the repeat FSBS but had not done so. Nurse # 5 was interviewed regarding whether she had cleaned Resident # 9's finger well the first time and responded that she thought she had done so. Nurse #5 further stated during her shift Resident # 9 appeared to be okay.</p> <p>Further review of nursing notes revealed the only nursing progress note on 1/24/25 was dated 1/24/25 at 7:16 PM and was written by Nurse # 10. Nurse # 10 documented at this time that Resident # 9 was in the shower with staff present. The resident became dizzy and fell . Resident # 9 sustained a laceration to his head with minimal bleeding. Nurse # 10 further documented that given the resident was on an anticoagulant, the resident was transferred by EMS (Emergency Medical Services) to the hospital.</p> <p>Interview with Nurse # 10 on 3/25/25 at 10:44 AM revealed she had not been caring for Resident # 9 at the time he fell on [DATE] but was closest to the shower room when Resident #9 fell . He had a cut to his head, so he was not moved. A Nurse Aide held pressure to the cut to stop the bleeding and she called 911.</p> <p>Interview with Nurse Aide # 7 on 1/25/25 at 1:40 PM revealed the following information. She had cared for Resident # 9 on the evening shift of 1/24/25. It seemed to her that Resident #9 did not feel well. He barely ate his evening meal. He was usually continent of urine and would go to the bathroom on his own. That evening he was soaked from urine. Therefore, she offered to take him to the shower room for a shower. When Resident # 9 initially stood up, he seemed dizzy and struggled to remain steady on his feet. She was able to walk him with a rolling walker to the shower. Once in the shower she let him sit to remove his top clothing. Then she helped him to stand, and as she was pulling down his pants he suddenly went blank and just fell over. She immediately called the nurse, and they called 911.</p> <p>Review of EMS records revealed the EMS paramedics arrived at 7:23 PM on 1/24/25 and Resident # 9 was alert and did not complain of blurred vision or dizziness at the time of their arrival. The paramedics documented Resident # 9's blood pressure was 101/55, pulse 61, respirations, 20, and oxygen saturation 99%. The paramedics did not record a blood sugar check.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the hospital records for the date of 1/24/25 to 1/30/25 revealed the following information. Resident # 9 was diagnosed with a small subdural hematoma. His blood sugar was 305 at 8:40 PM on 1/24/25 when drawn by the lab. The hospital physician noted Resident # 9's last HgbA1C was 10.2. The hospital physician noted the resident should receive both long acting and short acting insulin upon discharge back to the facility. Also, the hospital discharge summary included information that the resident had been hypotensive when he arrived to the hospital and his Toprol (used for heart failure) was held. Also, while hospitalized, neurosurgery was consulted and recommended holding the resident's anticoagulant medication. Prior to discharge, a repeat CT scan was performed to ensure the resident's subdural hematoma had not worsened. Discharge orders included that the resident should be placed on sliding scale insulin coverage and in addition to the prescribed sliding scale insulin, when the FSBS was greater than 400, the primary physician should be contacted.</p> <p>On 1/30/25 Resident # 9 returned to the facility with the new insulin orders and designated parameters to call the physician.</p> <p>On 3/25/25 at 8:55 PM the Administrator was informed of Immediate Jeopardy and provided the following Credible Allegation of Immediate Jeopardy Removal Plan.</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:</p> <p>Resident #3 was noted with significant chest and upper arm bruising on 12/18/24. NA #5 failed to notify any nurse of the bruising, discomfort with positioning, and swelling of the bruised area when she first saw the bruises. Her failure to report the bruising to the nurse delayed the assessment and treatment of Resident #3 by any nurse and the provider.</p> <p>In the month of January 2025 Resident # 9 experienced multiple instances of seriously elevated blood sugars (greater than 400). During this time period resident # 9 did not have orders for sliding scale insulin or parameters for notifying physician of blood sugar elevations. During January several nurses, including employee #1 and nurse #5 failed to notify the provider or nurses on subsequent shifts of these seriously high blood sugars resulting in the delayed assessment, treatment, and monitoring. And, as a result of the failure resident # 9 experienced hyperglycemia.</p> <p>On 1/24/25 at 6:30am a blood sugar check for resident # 9 was performed and the reading of high was recorded on the medication administration record. Per her statement at 6:30 a.m. MA # 5 witnessed unlicensed Employee # 1 go into the resident #9's room with an insulin pen although there were no orders for any insulin at that time and no record of the physician giving orders. On 1/24/25 the unit manager was working as the floor nurse for resident #9 during the day shift, and in her statement the unit manager could not recall the specifics of 1/24/25 but stated that if she had been told in report that the resident's blood sugar was high she would have made sure the resident was monitored and follow up done. The unit manager also indicated that if she had been aware of the seriously elevated blood sugar, she would have requested orders from the provider and entered a nursing progress note of her actions. No new orders or progress notes were entered for dayshift on 1/24/25.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER White Oak Manor - Burlington		STREET ADDRESS, CITY, STATE, ZIP CODE 323 Baldwin Road Burlington, NC 27217	

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A statement from the evening shift nurse for 1/24/25 indicated that it was never communicated to her that the resident's blood sugar was high at the 6:30 a.m. blood sugar check. When she performed the 4:30 p.m. blood sugar check the first time she received a reading of 524. A short time later the nurse re-checked the blood sugar again and received a reading in the 300s. Later in the evening shift on 1/24/25 resident #9 reported dizziness and did sustain a fall in the shower. The hyperglycemia experienced by Resident #9 shows that the Employee #1 failed to assess the resident, notify provider, and communicate the elevated blood sugar to the oncoming shift with this resulting in the resident experiencing a fall that evening.</p> <p>On 3/26/25 body audits were completed by unit coordinators for all 3 units to identify [TRUNCATED]</p>

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>13289</p> <p>Based on record review and staff and Physician interviews the facility failed to have a system in place to ensure staff who were hired as nurses were trained and competent to perform their job duties. Employee #1, who was not licensed as a nurse and had no documented nursing education, worked at the facility in the role of a licensed nurse from 11/5/24 until her termination on 2/6/25. Her job duties included, but were not limited to: insulin administration, blood sugar monitoring, medication administration, assessments of a resident who sustained falls while on an anticoagulant (blood thinner), and utilizing nursing judgement to make decisions. These job duties required knowledge and education to perform safely. There was no documented competency evaluation completed for Employee #1's job duties or nursing skills. On the nursing shift which began at 11:00 PM on 12/17/24 Employee #1 was assigned to Resident #3, who was not on an anticoagulant, when she identified bruising to the resident's shoulders with no known cause. Employee #1 was responsible for assessing the resident and utilizing nursing judgement for decisions on when to notify the physician. On 1/24/25 Employee #1 was informed by a Medication Aide (MA) that Resident #9's finger stick blood sugar (FSBS) registered outside of the meter's highest measurable range indicating a dangerously high blood sugar reading. Employee #1 was responsible for assessing the resident, providing insulin, and utilizing nursing judgement for decisions regarding when to notify the physician for blood sugar readings. On 12/8/24 and 1/9/25 Resident #11, who had severe cognitive impairment and was on an anticoagulant, experienced falls. Employee #1 was assigned to Resident #11 on both dates and was responsible for assessing the resident and utilizing nursing judgement for decisions regarding when to call the physician. Allowing Employee #1 to work in the capacity of a licensed nurse with no verification of her competencies affected Resident #3, Resident #9, and Resident #11 in addition to placing all residents Employee #1 was assigned to care for in the capacity of licensed nurse at a high likelihood of a serious adverse outcome or harm. Additionally, the facility failed to verify the competencies of Nurse #13 and Nurse #14. This was for three of three staff (Employee #1, Nurse #13, and Nurse #14) whose personnel files were reviewed for competency.</p> <p>Immediate jeopardy began on 11/5/24 when the facility allowed Employee #1, who fraudulently presented herself to the facility as a licensed nurse, to work in the capacity of a licensed nurse without verifying she was trained and competent to perform licensed nurse skills and duties. Immediate Jeopardy was removed on 3/28/25 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 E to ensure education is completed and monitoring systems put in place are effective. Example 1b. and 1c. were cited at a scope and severity of E.</p> <p>The findings included:</p> <p>1a. Review of Employee # 1's personnel file records provided to the state surveyor revealed the following information. Employee # 1's application for employment was signed as submitted on 10/21/24 for a position as a licensed practical nurse/registered nurse on third shift from 11:00 PM to 7:00 AM. The only employment history included on the application noted Employee # 1 had attended an out-of-state high school. No further education experience was listed. Under the question, Please indicate education or skills training which you believe qualifies you for the position you are applying, Employee # 1's typed response was, CNA (certified Nurse Aide and 5 years of home health.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Administrator and DON (Director of Nursing) were interviewed together on 3/21/25 at 9:00 AM and a follow up interview was conducted with the DON again on 3/21/25 at 9:45 AM revealing the following information. Employee # 1 presented herself falsely as a licensed nurse when she applied for employment and provided the facility with another individual's nursing license. The name on the nursing license, which was provided to the facility, was similar to Employee # 1's name. She was hired on 11/5/24 and continued to work until her termination on 2/6/25.</p> <p>The records of three residents, who were cared for by Employee # 1 while she worked as a Nurse, were reviewed. Although not all inclusive of all the nursing task performed and judgements made by Employee # 1 while employed at the facility, these three records revealed some of the following examples of nursing duties performed or required of Employee # 1 to be done safely.</p> <p>Employee # 1 had been the responsible assigned Nurse for Resident # 3 on the night shift which began on 12/17/24 at 11:00 PM. Review of a facility investigative report revealed during this shift, revealed Resident # 3 was identified by Resident # 3's Nurse Aide to have unexplained bruises to his chest and arm which were accompanied by swelling and discomfort with positioning during this shift. Employee # 1 would have been responsible for the assessment and notification of the physician during the night shift, and per her statement in the investigative file she was aware of the bruises during the night shift. She noted in her statement she had seen bruises on his shoulders. The interview with the physician on 3/21/25 at 3:13 PM revealed she or another provider had not been notified by Employee # 1, and this should have been done. During the interview with the physician, the physician reported the bruising was all on the resident's upper body which included areas on his arms and chest wall which wrapped around some on his torso. He was also having some left shoulder pain. The physician further reported that Resident # 3 was a cognitively impaired resident and could not report what had happened. Further review of Resident # 3's nursing notes and 12/20/24 and hospital ED (Emergency Department) records revealed Resident # 3's bruising continued to spread, and a CT (computerized tomography) scan performed on 12/20/24 at the hospital showed the resident had a large left subpectoral hematoma underlying his pacer control box measuring 9.5 X 5.2 cm. (centimeters) and superficial soft tissue contusion (bruising) of the left flank and hip.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Per record review Employee # 1 was responsible for performing FSBS (Finger Stick Blood Sugar Checks) for Resident # 9 and making judgements about when to call the physician for blood sugar readings. There was documentation in Resident # 9's record that Employee # 1 administered Insulin to Resident # 9 according to Resident # 9's MAR (Medication Administrator Record). On 1/8/25 when Employee # 1 documented on the MAR Resident # 9's FSBS was 409, there was no documentation the physician was notified and orders received although the resident had no sliding scale insulin coverage ordered at the time. Furthermore, per a 3/25/25 interview at 10:28 AM with Medication Aide (MA) #4, MA # 4 reported the following information. She (MA # 4) had taken Resident # 9's FSBS on 1/24/25 when it was due to be checked at 6:30 AM. The result was high and did not register on the glucometer. She reported the result to Employee # 1, who at the time MA # 4 believed to be a nurse. She (MA # 4) observed Employee # 1 call someone. She did not know who Employee # 1 called and did not know what she said to them. Later Employee # 1 received a notice that someone was on the phone line for her. She (MA # 4) again saw Employee # 1 talk to someone but did not hear the conversation. After the conversation, Employee # 1 went through the insulin pens on the medication cart, removed one, and walked into Resident #9's room. MA # 4 did not know what type of insulin pen was removed or to whom it belonged. A review of the chart revealed no documentation or orders for any insulin administration to address Resident # 9's 1/24/25 6:30 AM FSBS reading of high. Resident # 9's next blood sugar check was performed next when it was scheduled to be completed at 4:30 PM, and the result was documented as 524. During an interview with Resident # 9's NP (Nurse Practitioner) on 3/25/25 at 9:00 AM, the NP validated she had not been called on the morning of 1/24/25. The NP further reported she had checked the on-call log for that date, and there was no record of a call being placed to the on-call provider on the morning of 1/24/25 regarding Resident # 9. The NP did not know to whom Employee # 1 had spoken before Employee # 1 went into Resident # 9's room with an insulin pen. The interview with Resident # 9's physician revealed she only had given her personal number to the Unit Managers and therefore she did not know how the employee could have reached her. She did not usually answer her phone before 7:00 AM when she was not on call for the medical practice, and she did not know to whom Employee # 1 had spoken.</p> <p>According to Resident # 11's record, the resident's 12/16/24 Minimum Data Set assessment coded the resident as severely cognitively impaired, and a review of physician orders revealed he received an anticoagulant. According to nursing notes, Employee # 1 documented Resident # 1 was on the floor on the dates of 12/28/24 and 1/9/25. Within her nursing note of 1/9/25, Employee # 1 documented she did a neurological assessment to make sure the resident did not sustain any blows to the head. Employee # 1 was responsible for making a nursing judgment regarding whether to call the physician that night and there was no documentation she did so although a review of Resident # 11's orders revealed he was receiving Eliquis (an anticoagulant) when the falls were sustained.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Employee # 1's personnel file and training records revealed there was a Nursing Assistant-Skills Checklist in the file. The checklist had multiple job duties typically assigned to Nurse Aides and areas where the form was to be dated and signed showing satisfactory return demonstration. According to the form, Employee # 1 had this form completed in her file with the notation that the SDC (Staff Development Coordinator) had observed return demonstration on the Nurse Aide skills listed. There was no similar skills checklist to demonstrate Nurse competency for tasks and skills Employee # 1 was responsible for while working as a nurse. The file also contained: directions on how to perform the Heimlich Maneuver; an ADL Coding Quiz; a check-off sheet for use of a mechanical lift and safe handling of residents; the facility's electronic medical system Nurse Aide Checklist; a checklist orientation of nursing assistants (which included resident rights and abuse and neglect); handwashing checklist; a hand hygiene quiz; competency on PPE (personal protective equipment; a nursing home infection prevention test; a general orientation checklist; education regarding the role of a licensed nurse as it relates to what a medication aide and Nurse Aide II can do; a checklist for the facility's electronic medical record system; a copy of instructions on how to perform a FSBS; an unsigned job description for a NC licensed Practical Nurse/Charge Nurse; and a multiple choice test entitled, Nurse Orientation Program Evaluation Questions, which included some medication questions. The last page of the evaluation form was the only page that indicated the evaluation was completed by Employee # 1 by requiring a signature and date. Employee # 1's signature with the date of 11/8/24 was on this last page. The last two medication questions were marked through and not answered. There were a total of 40 questions on the evaluation form. One example on the evaluation form was the question, Before preparing a resident's medication, the nurse should A) take a deep breath or B) check to be sure the resident is in his/her room. Employee # 1 had circled both A and B. Another question read, Correct medication administration time for a scheduled dose is A) plus or minus 1 hour of the scheduled dose B) plus or minus 30 minutes of the scheduled dose C) plus or minus 2 hours of the scheduled dose or D) all but A. Employee # 1 had answered, D indicating she incorrectly thought that she could administer scheduled medications plus or minus 2 hours.</p> <p>The SDC was interviewed on 3/21/25 at 9:20 AM and on 3/21/25 at 4:00 PM and reported the following information. When nurses were hired, they went through a four-day classroom orientation. The first two days were general education with all new employees. The third and fourth day included Nurse Aides, Medication Aides, and Nurses together. She checked the nurses off on Nurse Aide duties which nurses would be overseeing. She then included the Nurse Aide checklist in the Nurse's personnel file. The nurses were also required to watch instructional videos and complete the evaluation form with questions. There were four tasks she observed nurses to perform during the four-day orientation. They were: a glucometer check, putting on and taking off of PPE (personal protective equipment), use of mechanical lifts, and handwashing. Nurses were also required to show they could use an insulin pen but there was no sign off on that during orientation. According to the SDC she had done these tasks with Employee # 1. Following their four-day orientation, then the nurse was partnered with another experienced nurse for at least three days. The Scheduler would know with whom Employee # 1 was partnered after Employee # 1 completed the four-day orientation. The SDC was interviewed regarding competencies and training on other nursing tasks which there was no indication of evaluation and validation in Employee # 1's file. The SDC reported nurses were also required to watch a library of further videos on their own and take quizzes. The SDC indicated the last two questions on Employee # 1's form, which were blank, had not been required of the group when the test was taken.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Nurse Staffing Coordinator was interviewed on 3/21/25 at 3:05 PM and reported the following information. Employee # 1 had been partnered with Nurse # 11, Nurse # 12, and Nurse # 7 following her classroom orientation. She typically partnered a new nurse with an experienced nurse for a week and the new nurse could let her know if they needed more time with an experienced nurse. Employee # 1 did not request any further time. The interview further revealed the facility used to have a competency form used to check and validate a new nurse's skills, but that was not done for Employee #1 and was not being utilized anymore for newly hired nurses. The Nursing Staffing Coordinator provided no reason a competency form was not being used.</p> <p>Nurse # 7, who was one of the nurses partnered with Employee # 1, was interviewed on 3/24/25 at 6:50 AM and reported the following information. She had only been partnered with Employee # 1 for orientation purposes one night. Employee # 1 had acted disinterested and followed her (Nurse #7) around as she cared for residents. Employee # 1 watched Nurse # 7 do tasks and duties, but she (Nurse #7) did not observe Employee # 1 perform tasks and duties. It was more of showing Employee # 1 routines. Following that night, she (Nurse # 7) did not work directly with Employee # 1 but she (Nurse # 7) was aware that Nurse # 9 would receive a nursing report from Employee # 1 in the morning at times and Nurse # 9 had some concerns.</p> <p>Nurse # 9, who would at times receive report from Employee # 1, was interviewed on 3/24/25 at 7:18 AM and reported the following information. She thought Employee # 1 was dumb and just had not received a good education. An example was regarding checking oxygen saturation levels. Employee # 1 reported in shift change report a particular resident's oxygen level had been around 86% or 87% and Employee # 1 was not able to say in report what was done about it. She (Nurse # 7) went to that resident's room and checked it herself and the oxygen level was okay when she checked it. She took Employee # 1 to this resident's room and showed her what to do, while thinking that she just had not been educated well about checking oxygen saturation levels and measures to take if it was low. Nurse # 7 reported she was not aware of this resident, who utilized oxygen, ever being harmed or experiencing difficulty due to Employee # 1 taking care of him.</p> <p>Nurse # 11, who was one of the nurses partnered with Employee # 1, was interviewed on 3/24/25 at 9:23 AM and reported the following information. Employee # 1 struck her as a new nurse. She (Nurse # 11) had mainly helped Employee # 1 with paperwork. The first few nights Employee # 1 followed her (Nurse # 11) and she showed Employee # 1 routines. Then she told Employee # 1 she would be there for back up and Employee #1 had her own assignment. Nurse # 11 was interviewed regarding what tasks and duties she observed Employee # 1 to perform. She reported that tube feedings were difficult for Employee #1. Employee # 1 didn't seem to know how to get started, and she (Nurse # 11) thought it was just because Employee # 1 was a new graduate. She (Nurse # 11) had therefore showed Employee # 1 how to administer a tube feeding and afterwards watched her do it. After she showed Employee # 1 what to do, she did it correctly. She (Nurse # 11) watched her administer some medications but never watched Employee # 1 do a complete medication pass. She did not recall ever watching her administer insulin to anyone. She never observed Employee # 1 performing dressing changes or a physical assessment of a resident which would entail listening to their heart and lungs or a neurological assessment. She (Nurse # 11) only worked at the facility as needed and had only worked with Employee # 1 for a few nights. She (Nurse # 11) thought it might have been six or seven times she had worked with her. She was not aware of any cases where a resident was hurt while under Employee # 1's care. She (Nurse #11) never signed off on anything she had observed Employee # 1 to do. There had been no competency checklist to complete for Employee # 1.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Employee # 1 was interviewed on 3/25/25 at 3:30 PM and reported the following information. She knew it was a shot in the dark when she applied for a nurse job at the facility. She never thought that the facility would reach out to her after she submitted the application, but they did. Although she had never finished any type of formal health care training, she had gone to medical assistant school in another state, and she did know about health care to some degree. She also had taken care of family members who were bedridden or diabetics and reported herself to be a fast learner. She told the facility during the interview she had health care experience. They never asked her for a license. She was surprised when the facility did call her and offer her a job. They called and texted her to come to training and the training had already started. There was supposed to be four days of orientation, and she started on the last two days of the scheduled orientation. Then they put her with a nurse on night shift for about two or three days and she went to work. She had been working for about two weeks before they even asked her about a license. She looked up her name on a website and found someone with a similar name to her that had a nursing license, and she decided to give that to the facility. She did not think the facility would accept it and she was baffled myself when they did, but they never questioned it and let her come back to work. Her intent was never to hurt anyone, and it was her perception that she did just as well as the other nurses who had a license. She was trying to go back to school to actually get a license while she was working at the facility.</p> <p>The Administrator was notified on 3/25/25 at 8:55 PM of Immediate Jeopardy.</p> <p>The Administrator presented the following Credible Allegation of Immediate Jeopardy Removal Plan.</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance</p> <p>Employee #1 was hired as a nurse on 11/5/2024 without qualifications. A timecard report in the Paycom payroll system indicated that employee #1 attended and completed 3 out of 4 days of her scheduled orientation. The center failed to ensure that employee #1 completed a formal nursing competency form to ensure she was competent to perform job duties. During this time, unlicensed Employee # 1 performed multiple job duties which require education and training to perform correctly to ensure residents are safe and not neglected. This includes but is not limited to blood sugar checks, neurological checks following falls, insulin administration and other medication administration, and oxygen saturation level. Unlicensed employee #1 through her actions of falsifying her nursing license had the high likelihood of failing to identify changes in resident conditions, and the high likelihood of providing inadequate care to any resident in the facility.</p> <p>Resident #9 did experience an untreated elevated blood sugar of 409 on 1/8/25 at 6:30 AM and a high blood sugar on 1/24/25 at 6:30 A.M. The unlicensed employee #1 failed to notify the provider of the hyperglycemic event and Resident #9 was not treated for hyperglycemia.</p> <p>Employee #1 was responsible as a nurse for Resident #3 on the night shift when NA #5 noted Resident #3 to have bruises, swelling and discomfort with positioning. There was no documentation of an assessment by employee #1 and there was no documentation that employee #1 had been evaluated to be competent in assessment skills in the personnel file.</p> <p>An audit was conducted on 3/26/25 by the Staff Development Coordinator (SDC) to identify all newly hired nurses since 2/6/2025 to ensure that all components of the current nurse orientation process were completed. No discrepancies were identified.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>Employee #1 was terminated on 2/6/2025.</p> <p>On 3/27/25 the Director of Nursing (DON) and SDC were educated by the Assistant Regional nurse consultant on a nursing competency form.</p> <p>On 3/27/25 the Assistant Regional nurse consultant notified the Staff Development Coordinator (SDC) of the following process: The SDC will initiate the nursing competency form in orientation for all newly hired nurses. The newly hired nurse will be partnered with an experienced nurse and the experienced nurse will observe the newly hired nurse complete the tasks on the competency form. Any unsatisfactory demonstrations will be communicated to the Staff Development nurse for further training with the newly hired nurse. The newly hired nurse will have 90 days to complete the nursing competency form. The SDC will review the newly hired nursing competency form after 90 days and any areas the newly hired nurse could not complete on the competency (i.e. nasogastric tubes, tracheostomies) will be performed on the nursing training mannequin for competency.</p> <p>On 3/27/25 the SDC was educated by the Assistant Regional nurse that nurses who are partnered with the newly hired nurse will be educated on the competency form by the Staff Development coordinator prior to being scheduled with the newly hired nurse and their responsibility to check the newly hired nurse off on the competency when they are scheduled to work with the newly hired nurse.</p> <p>On 3/27/25 the Assistant Regional Nurse educated the Staffing coordinator that she will be responsible for notifying the SDC which nurses the newly hired nurse will be working with.</p> <p>Immediate jeopardy removal will be 3/28/2025</p> <p>On 3/31/25 the facility's Credible Allegation of Immediate Jeopardy Removal Plan was validated by the following actions:</p> <p>The facility presented a nursing competency form which they had devised to utilize for newly hired nursing staff. The multipage competency form covered multiple tasks that nurses were required to demonstrate as evidence of competency.</p> <p>The facility presented evidence the Staff Development Nurse had been educated about competency evaluations for nurses.</p> <p>A nurse, who had recently been hired within the past few weeks, was interviewed and reported the facility began using the new competency form with her and she had started having her skills checked off on 3/28/25 as being observed by another nurse.</p> <p>The facility's date of immediate jeopardy removal was validated to be 3/28/25.</p> <p>1b. Review of Nurse # 14's personnel records and training records provided to the state surveyor revealed Nurse # 14 was hired on 2/25/25.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Nurse # 14 was interviewed on 3/24/25 at 3:27 PM and reported she had already been an employee at an earlier time period and was familiar with the facility policies and procedures. Upon her rehire she watched videos and took test. She was then partnered with another nurse on the floor who did skills with her and showed her how to use the facility's electronic medical record system.</p> <p>A review of training records did not reveal a competency validation form for all the nursing skills for which Nurse # 14 would be responsible.</p> <p>The Nurse Staffing Coordinator was interviewed on 3/21/25 at 3:05 PM and reported the following information. She typically partnered a new nurse with an experienced nurse for a week and the new nurse could let her know if they needed more time with an experienced nurse. They used to have a competency form used to check and validate a new nurse's skills, but that was not being utilized anymore. The Nursing Staffing Coordinator did not provide a reason why the competency form was not being used anymore.</p> <p>1c. Review of Nurse # 13's personnel records and training records provided to the state surveyor revealed Nurse # 13 was hired on 2/25/25.</p> <p>An attempt was made to interview Nurse # 13 on 3/24/25 at 1:33 PM and she could not be reached.</p> <p>A review of training records did not reveal a competency validation form for all the nursing skills for which Nurse # 14 would be responsible.</p> <p>The Nurse Staffing Coordinator was interviewed on 3/21/25 at 3:05 PM and reported the following information. She typically partnered a new nurse with an experienced nurse for a week and the new nurse could let her know if they needed more time with an experienced nurse. They used to have a competency form used to check and validate a new nurse's skills, but that was not being utilized anymore. The Nursing Staffing Coordinator did not provide a reason why the competency form was not being</p>		