STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Burlington	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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a baseline care plan that addressed the resident's immediate needs related to a diagnosis of post-traumatic stress disorder (PTSD) for 1 of 1 resident reviewed for mood and behavior (Resident #125). The findings included: A review of the discharge summary from Resident #125's previous facility revealed he was discharged on 9/12/25 with diagnoses that included PTSD. The discharge summary from the previous nursing facility did not document any information regarding residents' history of past trauma or triggers that may cause re-traumatization. Review of the FL2 (a North Carolina Medicaid form that documents a patient's medical condition and needs for long term care facilities) completed 9/12/25 revealed Resident #125 had a diagnosis of PTSD. Resident #125 was admitted to the facility on [DATE] with a diagnosis of PTSD. Review of the baseline care plan dated 9/12/25 completed by the Minimum Data Set (MDS) Nurse revealed no goal or interventions for Resident #125's diagnosis of PTSD. Review of Resident #125 physician order dated 9/12/25 indicated administer the Sertraline (antidepressant) 25 milligram (mg) along with Sertraline 50mg tablet for a total of 75mg once daily for PTSD. An interview with MDS Nurse #1 on 9/24/25 at 10:48am revealed she had 48 hours to complete a baseline care plan. MDS Nurse #1 indicated Resident #125 had care plans initiated on 9/12/25 without a care plan for PTSD or behaviors associated with PTSD. PTSD and behaviors associated with PTSD would normally be included in the baseline care plan. Interview conducted with MDS Nurse #2 on 9/24/25 at 10:55am revealed she did not know why Resident #125 did not have a baseline care plan to address his diagnosis of PTSD. She stated it may not have been added at the time the baseline care plan was completed if the facility had not received information about Resident #125 PTSD diagnosis from the discharging facility. An interview conducted with the Director of Nursing (DON) on 9/25/25 at 12:31pm revealed she was not sure if Resident #125 had a diagnosis of PTSD. The DON indicated she expected to be notified prior to or on admission of a PTSD diagnosis, trauma triggers, behaviors, or potential behaviors. She expected PTSD, trauma triggers, and behaviors to be included in the baseline care plan. The DON stated she was not sure if Resident #125's baseline care plan reflected his PTSD diagnosis. An interview with MDS Nurse #2 on 9/25/25 at 12:35pm revealed information included in the baseline care plan would depend on the information the facility received at admission. MDS Nurse #2 revealed the facility might have been waiting to get information on the trauma and triggers associated with Resident #125's PTSD diagnosis.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and resident interviews, the facility failed to follow therapy recommendations to apply a soft hand splint for 1 of 4 sampled residents (Resident #3) reviewed for positioning and mobility.The findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses that included a left-hand contracture. The Occupational Therapy (OT) Discharge summary dated [DATE] revealed Resident #3 had a left-hand contracture. The OT discharge recommendations stated Resident #3 was to be followed by Restorative Nursing with a goal that included Resident #3 would apply and wear a left-hand splint 4-6 hours daily. Review of Resident #3's annual Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact and had one upper extremity impairment. An interview and observation were conducted with Resident #3 on 9/22/25 at 3:36 PM. Resident #3's left hand was observed to have 4 fingers and thumb tight into a fist. A blue, soft resting hand splint was observed on the corner of his nightstand. Resident #3 stated the resting hand splint on the nightstand was his, but staff had not been putting in on his hand in a long time. Resident #3 was unable to identify the length of time that staff had not put the resting hand splint on his left hand.Observation on 9/24/25 at 10:00 AM revealed Resident #3's left hand to have 4 fingers and thumb held tightly into his fist. A blue soft hand splint was observed on a corner nightstand. Observation on 9/25/25 at 10:30 AM revealed Resident #3's left hand to have 4 fingers and thumb held tightly into his fist. A blue soft hand splint was observed on a corner nightstand. On 9/25/25 at 4:14 PM Resident 3's left hand was observed to have 4 fingers and thumb contracted into fist. Resident #3's left resting hand splint was observed on the corner of his nightstand. During an interview on 9/26/2025 at 9:46 AM, the Rehabilitation Director indicated when a resident transitioned from rehabilitation to restorative nursing services, a form was filled out by rehabilitation. The form would include restorative nursing services start date, interventions, frequency, precautions, and when a therapist should be alerted. The completed restorative nursing form would be placed in the Restorative Nurse's mailbox. She did not know how the previous Rehabilitation Director communicated discharge recommendations for Resident #3 to the nursing staff or the Restorative Nurse. Upon review of Resident #3's OT Discharge summary dated [DATE], the Rehabilitation Therapy Director revealed Resident #3 was discharged to Restorative Nursing Services for range of motion and splinting on 5/13/25. An interview was conducted on 9/26/2025 at 9:28 AM with the Restorative Nurse. She stated discharge instructions were given to the Restorative Nurse when a resident transitioned from therapy to restorative services. The discharge instructions were provided on the restorative nursing form which outlined program goals. To her knowledge, the Restorative Nurse had not received a Restorative Services request for Resident #3 on 5/13/25 and he was not on the restorative list. On 9/26/25 at 10:30 AM a phone interview was conducted with the Occupational Therapist who treated Resident #3 and wrote the discharge recommendations dated 5/13/25. She stated the discharge summary goals and interventions would have been documented on a restorative nursing form by the Occupational Therapy Assistant or the Rehabilitation Director. She did not know if a restorative nursing form had been filled out for Resident #3 upon his discharge from OT. She stated that to her knowledge, residents who needed restorative services were discussed during the daily morning stand-up meeting. On 9/26/2025 at 11:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated information regarding restorative nursing was relayed verbally during the morning stand up meeting. She was unaware of any form that would be given to restorative nursing regarding the need for restorative services or the application of splints. The DON stated the physician would have to sign the order for Restorative Nursing and she was unsure why Resident #3's therapy recommended splint had not been implemented. On 9/26/2025 at 1:20 PM an interview was conducted with the Administrator. He stated therapy would make recommendations for restorative services. He stated that the Restorative Nurse would use her nursing judgement on how to carry out therapy recommendations. The Administrator stated the therapy director had recently been replaced which could have been the reason Resident #3 had not received services for applying the therapy recommended left resting hand splint. It was his expectation that residents therapy recommendations be followed until a resident would be reassessed by therapy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to maintain daily nurse staffing sheets for 5 of 62 days reviewed for daily posted nurse staffing information (7/25/25, 7/29/25, 8/3/25, 8/11/25 and 8/15/25). The findings included:Review of the daily nurse staffing sheets posted for 7/1/25- 7/31/25 revealed no information was available for the days of 7/25/25 and 7/29/25.Review of the daily nurse staffing sheets posted for 8/1/25-8/31/25 revealed no information was available for the days of 8/3/25, 8/11/25, and 8/15/25. An interview was conducted with the Nursing Staff Scheduler on 9/26/25 at 3:30 PM. The Nursing Staff Scheduler stated she worked Monday through Friday, and she prepared staff postings for weekends which were given to the weekend supervisor each Friday. The Nursing Staff Scheduler stated she did not know where the weekend supervisor put weekend staffing sheets as they were not returned to her. She stated no weekend posted daily staffing sheets were returned to her since she had worked as the Nursing Staff Scheduler. She did not provide an explanation for the missing nurse staffing information sheets for weekdays. During an interview with the Director of Nursing (DON) on 9/26/25 at 4:00 PM, the DON stated the Nursing Staff Scheduler was responsible for completing and maintaining the daily posted staffing sheets. The weekend supervisor completed daily posted staffing sheets on the weekend and shared changes with the Nursing Staff Scheduler. She did not know why there were missing nurse staffing information sheets. The weekend supervisor was unavailable for interview during the time of the survey.During an interview on 9/26/25 at 4:30 PM, the Administrator stated the Nursing Staff Scheduler was responsible for the daily posted staffing sheets. His expectation was for daily staffing sheets to be accurate and posted daily.