STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365748	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor	1926 Ridge Avenue Warren, OH 44484

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy, the facility failed to ensure medications were stored in a safe and secure manner when the medication cart was left unlocked in the facility. This had the potential to affect 20 residents (#1, #2, #3, #4, #5, #7, #8, #9, #10, #11, #13, #14, #15, #17, #19, #20, #22, #23, #24, and #25) residing in the facility, as the facility identified nine residents as immobile (Residents #6, #12, #16, #18, #21, #26, #27, #28, and #29). Also, the facility failed to ensure medications were not removed from original labeled packaging and pre-poured prior to administration to residents. This affected four residents (Resident #1, #7, #8 and #16) of four residents reviewed for medication administration. The facility census was 29. Findings include: 1. On 01/28/26 at 8:55 A.M., an observation revealed a medication storage cart labeled 100/300 Halls was unlocked. The medication cart was located in an open hallway in front of the nurses' station and was unattended at the time of the observation. An interview on 01/28/26 at 8:56 A.M. with the Assistant Director of Nursing (ADON) #144 confirmed the medication cart was unlocked and stated the cart was required to be locked when unattended. A review of the facility policy titled Storage of Medication, dated 04/2007, revealed the facility policy stated all drugs and biologicals to be stored in a safe, secure, and orderly manner. The policy further stated nursing staff were responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary condition. The policy specified that compartments including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes containing drugs and biologicals must be locked when not in use, and carts or trays used to transport medications must not be left unattended if open or otherwise accessible. 2. Review of the medical record revealed Resident #1 was admitted on [DATE] with significant diagnoses including epilepsy. Physician orders included Phenobarbital 32.4 milligram (mg), take one tablet by mouth one time daily for seizure control. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact, had a seizure disorder and received anticonvulsant medications. Review of the care plan dated 12/03/25 identified Resident #1 had a seizure disorder with interventions to administer seizure medications as ordered. 3. Review of the medical record revealed Resident #7 was admitted on [DATE] with diagnoses including localization-related idiopathic epilepsy and epileptic seizures. Physician orders included Phenobarbital 64.8 mg, give one tablet by mouth twice daily for seizure control. Review of the MDS assessment dated [DATE] revealed Resident #7 was cognitively intact, and received anticonvulsant medications. Review of the care plan dated 01/12/26 identified Resident #7 had altered neurological status secondary to seizure disorder with interventions to administer medications as ordered. 4. Review of the medical record revealed Resident #8 was admitted on [DATE] with diagnoses including chronic cholecystitis, psychoactive substance abuse, muscle weakness, and difficulty walking. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders included Tramadol 50 mg, give one tablet by mouth every six hours as needed for pain. Review of the MDS assessment dated [DATE] revealed Resident #8 was cognitively intact and used opioid pain medications. Review of the care plan for Resident #8 dated 01/06/26 addressed altered comfort related to pain, difficulty walking, and muscle weakness, with interventions to administer medications as ordered. 5. Review of the medical record revealed Resident #16 was admitted on [DATE] with a diagnosis of opioid dependence in remission. Physician orders included Buprenorphine HCl-Naloxone (Suboxone) 8-2 mg, one tablet sublingually daily for history of substance abuse. Review of the MDS assessment dated [DATE] revealed Resident #16 was cognitively intact and received opioid medications. Review of the care plan for Resident #16 dated 11/05/25 identified Suboxone therapy related to substance abuse history, with interventions to administer medications as ordered. On 01/28/26 at 8:30 A.M. an observation of the medication pass revealed a clear plastic medication cup labeled with Resident #1's name contained a single pill and was sitting on top of the medication cart. Licensed Practical Nurse (LPN) #115 identified the pill as Resident #1's phenobarbital. A second clear medication cup labeled with Resident #7's name contained a single pill and was sitting on top of the medication cart. LPN #155 identified the pill as Resident #7's phenobarbitol. A third clear medication cup labeled with Resident #8's name contained a single pill and was sitting on top of the medication cart. LPN #115 identified the pill as Resident #8's tramadol. A fourth clear medication cup labeled with Resident #16's name contained a single pill and was sitting on top of the medication cart. LPN #115 identified the pill as Resident #16's Suboxone. LPN #115 verified she had pre-poured Resident #1, #7, #8 and #16's medications at one time into the medication cups so she did not have to keep going back and forth into the narcotic drawer for each resident during the medication pass. An interview on 01/28/26 at 1:30 P.M. with the Director of Nursing confirmed medications were not to be pre-poured prior to administration to each resident. An interview on 01/28/26 at 1:34 P.M. with LPN #115 revealed she routinely prepared all narcotics before beginning her medication pass to avoid repeatedly accessing the locked narcotics drawer. LPN #115 stated she believed this practice was acceptable because the medication cups were labeled with the resident names. Review of the facility policy titled Medication Administration, dated 08/22/22, revealed medications are to be administered in accordance with professional standards of practice. The policy requires medications to be removed from their source immediately prior to administration, administered as ordered, and observed for resident consumption. This deficiency represents non-compliance investigated under Complaint Number 2667734.