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 _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 2/16/21 - 2/18/21. 12 of the 13 allegations were unsubstantiated. 1 of the 13 allegations was substantiated and resulted in deficient practice. See CMS 2567 for further information. Event ID# QYHW11.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff and pharmacy interviews, the facility failed to accurately transcribe physician ' s orders to the declining count sheet for 1 of 2 residents (Resident #2) reviewed for pain. The findings included: Resident #2 was admitted to the facility on 9/30/20 with a diagnosis of pain. Resident #2 ' s admission orders dated 9/30/20 and signed by the physician on 10/1/20 revealed an order for methadone (a narcotic pain reliever) 5 milligrams per 5 milliliters oral solution give 2.5 milliliters (2.5 milligrams) three times a daily as needed for pain. A narcotic count sheet dated 9/30/20 had the following handwritten label instructions for use: Resident #2 ' s name and read, methadone	F 658	White Oak Manor Burlington will ensure services to meet professional standards of quality. The transcription discrepancy of Resident #2's narcotic pain reliever medication was identified on 10/24/2020 by the weekend supervisor. The narcotic sheet and medication was immediately removed from the medication cart. The former Director of Nursing conducted an investigation on 10/25/20 addressing the transcription errors. The physician's order, medication administration record, labeling and declining narcotic count were updated and reflected each other with a final clarification order on 10/29/2020. An inservice was conducted on 10/30/2020 for licensed nurses.	3/18/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2021

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.

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 _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 solution take 2.5 milligrams by mouth three times a day. The information on the narcotic record did not reflect the current order. On 10/8/20, the facility received a bottle of methadone for Resident #2. A narcotic count record was initiated with a label that reflected the current order. On 10/22/20, a new order was written for methadone 5 milligrams per 5 milliliters, give 2.5 milliliters by mouth three times a day for pain/dyspnea. On 10/24/20, the methadone order was changed to 2.5 milliliters twice a day, on 10/26/20, the order was changed to 2.5 milliliters twice a day as needed and on 10/28/20, the order was changed to 2.5 milliliters twice a day. The narcotic count record was not updated to reflect the order changes. An interview was conducted on 2/16/20 at 12:30 PM with the Director of Nursing (DON). He stated he was not in the DON role during October 2020 while Resident #2 was a resident. He stated he reviewed the narcotic count record and Resident #2 ' s physician orders. He stated when a new order for a narcotic is received, it gets faxed to the pharmacy and they send the medication. The pharmacy doesn ' t send the narcotic count sheet, the facility initiated it. He stated when the pharmacy sent the medication on 10/8/20, the methadone brought in by Resident #2 ' s family should have been removed from the medication cart and the narcotic count sheet removed as well. When new orders were received, the narcotic count sheet should have been changed to reflect the current order. An interview was conducted with the pharmacist	F 658	An audit of the transcribed physician's order for the current resident narcotic medications revealed the physician's orders, medication administration record and declining narcotic count sheets noted were reviewed and reflected each other. This audit was completed on 2/24/2021 by the Nurse Unit Managers. The licensed nurses were re-educated on accurately transcribing physician's orders to the declining count sheet including the clarification of narcotic medications and using the correct declining narcotic count sheet for the narcotic medication ordered, and reflecting correctly on the declining narcotic count sheet. The re-education was completed on 2/18/2021 by the staff development coordinator and director of nurses. Newly hired licensed nurses will receive this education during their job specific orientation by the Staff Development Coordinator. The medication orders and declining count sheets will be monitored by reviewing 4 residents with narcotic medications daily for 4 weeks, then 5 residents with narcotic medications twice a week for 4 weeks and then 5 residents with narcotic medications once a week for 4 weeks. The Nurse Unit Managers will complete the audits. Results from the audits will be discussed Monday through Friday during the Quality Improvement (QI) morning meetings and any identified issues or trends will be further discussed at the Quality Assurance	

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 _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 2 on 2/16/20 at 2:18 PM. The pharmacist stated they delivered 30 milliliters of methadone for Resident #2 on 10/8/20 once they received the prescription. He added upon receipt of a new order, the facility would add a sticker to the narcotic count sheet to indicate there was a dose or frequency change.	F 658	meeting with the team and recommendations made as indicated. The Director of Nurses is responsible for ongoing compliance of Tag F658.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		3/18/21

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 _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 3 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an accurate accounting of a controlled pain medication for 1 of 2 residents (Resident #2) reviewed for pain. The finding included: Resident #2 was admitted to the facility on 9/30/20 with a diagnosis of chronic pain. Resident #2 ' s admission physicians orders dated 9/30/20 revealed an order for Methadone (a narcotic pain medication) 5 milligrams per 5 milliliters oral solution, give 2.5 milliliters (2.5 milligrams) three times a day as needed for pain. Resident #2 ' s Medication Administration Record (MAR) for October 2020 indicated the resident received Methadone 2.5 milligrams at 5:00 PM and 10:00 PM on 10/22/20, 9:00 AM, 5:00 PM and 10:00 PM on 10/23/20, 9:00 AM, 5:00 PM and 9:00 PM on 10/24/20, 9:35 on 10/26/20, 6:52 o 10/27/20 and 8:07 PM on 10/28/20. Record review revealed a declining narcotic count sheet dated 9/30/20 for Resident #2 ' s methadone that was brought in from the family on admission. Handwritten instructions on the sheet read, methadone solution take 2.5 milligrams by mouth three times a day (0.25 milliliters). On 10/8/20, a second declining count sheet was initiated for 30 milliliters of Methadone that was received from the pharmacy. The label read, methadone 5milligrams per 5 milliliters solution,	F 755	White Oak Burlington will ensure pharmaceutical services that are accurate and meets the needs of each resident. The discrepancy of the accounting of Resident #2's narcotic pain reliever medication was identified on 10/24/2020 by the weekend supervisor. The narcotic sheet and medication was immediately removed from the medication cart.The former Director of Nursing conducted an investigation on 10/25/2020 and addressed the accounting errors. The physician's order medication administration record, labeling and the declining count sheet were updated and reflected each other with a clarification order on 10/29/2020. An inservice was conduced by the Staff Development Coordinator on 10/30/2020 for licensed nurses. An audit of the accurate accounting of controlled pain medication for current resident narcotic medications revealed the physician's orders, medication administration record and declining narcotic count sheets noted were reviewed and reflected each other. The audit was completed on 2/24/2021 by the Nurse Unit Managers. The licensed nurses were re-educated on accurate accounting of controlled pain	

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 _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 4 take 2.5 milliliters (2.5 milligrams) by mouth three times daily as needed for pain. The doses documented on the MAR as administered on 10/23/20 for 5:00 PM and 10:00 PM were not reflected on the declining count sheet. The dose signed off on the MAR for 10/23/20 at 9:00 AM was documented on the incorrect declining narcotic count sheet dated 9/30/20, which indicated Resident #2 received an incorrect dosage. Doses documented as administered on the MAR on 10/26/20 at 9:35 PM, 10/27/20 at 6:52 PM and 10/28/20 at 8:07 PM were not reflected on the declining count sheet. A medication variance report dated 10/26/20 and reported the previous DON revealed a nurse signed out a dose of methadone on 10/23/20 and documented it on the incorrect declining narcotic record. An interview was conducted on 2/16/20 at 12:30 PM with the Director of Nursing (DON). He stated he was not in the DON role during October 2020 while Resident #2 was a resident. He stated he was aware that there were medication discrepancies and the previous DON handled it. The DON added when Resident #2 was admitted, the family brought in the methadone from home until the pharmacy sent if after they received the prescription. He added they initiated a declining narcotic count sheet and the instructions were handwritten. He stated a new declining count sheet was sent when the pharmacy sent the medication. He stated the previous count sheet and the medication brought from the family on admission should have been removed from the cart at that point to decrease the chance of errors.	F 755	medications including clarification of narcotic medications and using the correct declining narcotic count sheet for the narcotic medication ordered, and reflecting correctly on the declining narcotic count sheet. This re-education was completed on 2/18/2021 by the Staff Development Coordinator and Director of Nurses. Newly hired licensed nurses will receive this education during their job specific orientation by the Staff Development Coordinator. The medication orders and declining count sheets will be monitored by reviewing 4 residents with narcotic medications daily for 4 weeks, then 5 residents with narcotic medications twice a week for 4 weeks and then 5 residents with narcotic medications once a week for 4 weeks. The Nurse Unit Managers will complete the audits. Results from the audits will be discussed Monday through Friday during the Quality Improvement morning meetings and any identified issues or trends will be further discussed at the Quality Assurance meeting with the team and recommendations made as indicated. The Director of Nursing is responsible for the compliance of Tag F755.	

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 _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 5 An interview was conducted on 2/16/20 at 12:40 PM with the Administrator. She stated she did not know anything about the medication error for Resident #2. She stated the previous DON and nurse consultant handled it. She added she did expect the medication records and count sheets to be accurate. An interview was conduced on 2/16/20 at 1:50 PM with the previous DON. She stated when she was made aware of the medication error for Resident #2, she discovered there were several documentation errors surrounding the methadone. She stated the nurses were not documenting the doses given and were documenting on the wrong declining count sheet. She recalled talking to the consultant and the educator about it but she ended her employment at the facility around that time and did not know how it was handled from there.	F 755		