STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345238	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Charlotte	**4009 Craig Avenue , Charlotte, North Carolina, 28211**

(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
F0000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 10/22/25 through 10/23/25. The credible allegation was validated on 10/27/25, therefore, the exit date was changed to 10/27/25. Event ID # 1D9F8D-H1. The following intake was investigated: 2646276. 1 of 1 complaint allegation did not result in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity J. Tag F684 constituted substandard quality of care. Immediate Jeopardy began on 7/7/25 and was removed on 10/26/25. A partial extended survey was conducted.	F0000		10/27/2025
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the Family Member, facility staff, Nurse Practitioner, and Medical Director, the facility failed to resume Eliquis, an anticoagulant commonly known as blood thinner, for Resident #1. Upon admission in March 2025, Resident #1 was prescribed Eliquis due to a history of deep vein thrombosis and pulmonary embolus. The medication was temporarily discontinued on 7/2/2025, in preparation for a scheduled medical procedure performed on 7/7/2025. However, the facility did not restart Eliquis	F0684	White Oak Manor – Charlotte will ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive resident-centered care plan, and the residents' choices. Resident #1 continues to reside in the facility, and their anticoagulant continues to be ordered and administered at 5mg, 1 tablet, every 12 hours for chronic atrial fibrillation. An audit of residents on anticoagulant therapy was completed by running current orders for anticoagulants and reviewing the orders for accuracy to determine whether any changes or adjustments with the anticoagulant were made, and verifying the appropriate administering or discontinuing of the medication as ordered. The audit was completed by the DON on 10/13/25. The DON ensured residents had their anticoagulant ordered and administered as required and verified that the medication was available in the medication cart. No further concerns were identified. Another audit of residents on anticoagulant therapy and residents that had discontinued anticoagulant orders for the month of October 2025 was completed on 10/23/25	11/22/2025

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 reverse for further 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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F0684 SS = SQC-J	Continued from page 1 until 10/1/2025, nearly three months later, after the resident began exhibiting symptoms including shortness of breath, bilateral lower extremity (BLE) edema, and a need for supplemental oxygen. On 10/7/2025, Resident #1 was transferred to the Emergency Department, where he was diagnosed with bilateral pulmonary emboli (blood clot in the lungs), including a complete occlusion (blockage) in the right lower lobe suggestive of pulmonary infarction (death of lung tissue due to occlusion of blood flow). The resident required a heparin (a blood thinner) drip and underwent thrombectomy (a surgical procedure) to remove the clots. Resident #1 was readmitted to the nursing home on 10/16/25 after a nine day stay at the hospital. This deficient practice affected 1 of 3 sampled residents reviewed for quality of care (Resident #1). Immediate jeopardy began on 7/7/25 when the facility failed to restart Eliquis for Resident #1. Immediate jeopardy was removed on 10/26/25 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 (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 3/19/25 with diagnoses which included atrial fibrillation (irregular heart rhythm) and benign prostatic hyperplasia (a condition where the prostate gland enlarges, causing symptoms such as difficulty urinating and a frequent need to urinate), type 2 diabetes, urinary retention, a history of deep vein thrombosis (DVT), and a history of pulmonary embolus. On 3/19/25, the physician ordered Eliquis 5 milligrams (mg) by mouth every 12 hours. Resident #1's care plan included an anticoagulant therapy problem with the start date of 3/24/25. The goal read the resident will have no complications related to anticoagulant therapy through next review. Approaches included monitoring for signs and symptoms of bleeding and provide lab work and medications as ordered.	F0684	Continued from page 1 by the DON and the Assistant Director of Nursing (ADON). There were no other concerns identified. A further audit was completed by reviewing the Healthcare Practitioner's progress notes and provider's consultations for the month of October 2025 to identify any other medication that have been discontinued specifically focused on anticoagulant medications and have not been restarted. The audit was completed on 10/24/25 by the DON, ADON and the Pharmacy Consultant. There were no other concerns identified. An additional audit of current residents on anticoagulant therapy and residents that had discontinued anticoagulant orders for 11/01/25 to 11/13/25 was completed by the Nurse Consultant on 11/13/25 revealing no concerns. Current and newly admitted residents on anticoagulants, residents with newly ordered anticoagulants, and anticoagulants that have been discontinued have the potential to be affected. The facility will ensure the residents' medications will be administered, discontinued and restarted appropriately. The Licensed Nurses were originally re-educated on the importance of ensuring a resident's medication, such as an anticoagulant, that is temporarily discontinued due to a procedure, treatment or hospitalization This re-education has been restarted. The Licensed Nurse must verify that the medication that the resident was taking prior to being discontinued has been reentered, verified and activated, if still deemed medical necessary. If the medication is held for a certain number of days, the Licensed Nurse is to ensure the medication is restarted after the last day of being held. This re-education was completed on 10/14/25 by the Staff Development Coordinator (SDC). On 10/23/25, during the survey, it was revealed that the Licensed Nurses could not articulate the re-education that they received and completed on 10/14/25. Another education with Licensed Nurses, Medication Aides and the facility's Healthcare Practitioners (attending physicians and extenders) was started on 10/23/25 and was completed on 10/24/25 by the DON, ADON and SDC. This education was conducted in-person, and the staff had to verbalize what they were educated on to ensure comprehension. The education included the following: When a physician's order for a medication, such as an anticoagulant is discontinued for a resident's procedure, they will verify that the	

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F0684 SS = SQC-J	Continued from page 2 On 6/2/25, Resident #1 was seen for a urology consultation. The progress note indicated that due to the resident's medical history and ongoing use of chronic anticoagulation therapy, medical clearance would be required to minimize bleeding risks prior to the planned procedure. The note also stated that a follow-up visit was pending based on the availability of the outpatient surgery schedule for a suprapubic catheter replacement. However, the urologist's documentation did not include a confirmed date for the procedure or any preoperative orders. Resident #1's quarterly Minimum Data Set (MDS) dated 6/25/25 revealed he was cognitively intact. He was coded for supervision, moderate assistance, and substantial assistance for activities of daily living. He was coded to have an indwelling urinary catheter and for anticoagulant medication use. Medication Administration Records (MAR) from 4/21/25 through 7/2/25 revealed Eliquis was administered as ordered. Eliquis was not administered to Resident #1 after 7/2/25. A Nurse Practitioner's (NP) progress note dated 7/2/25 indicated Resident #1 was seen, had no complaints of shortness of breath (SOB), was awake and alert and appeared comfortable in his wheelchair. Resident #1 had an indwelling catheter and would be seen on Monday (7/7/25) at the urologist for a suprapubic catheter placement procedure. Resident #1 was to be nothing by mouth on Sunday night (7/6/25) and Resident #1's Eliquis would be held per the urologist pre-operation instructions. Additionally, the progress note wrote the NP had discussed the information with nursing. A review of Resident #1's physician's orders dated 7/2/25 found Eliquis 5 mg by mouth every 12 hours was discontinued. Nurse Practitioner notes were reviewed for 7/8/25, 7/9/25, 7/15/25, 7/16/25, 7/24/25 and 7/28/25. Each note included this statement, "I have reviewed the resident's medications in the facility chart (MAR). Refer to the facility's Medication Administration Record (MAR) for a complete and up to date list of active medications". The only visits with findings that were not at baseline were 7/16/25 that included a notation for catheter site intact with mild tenderness and on 7/28/25 that included a notation for redness and mucous at catheter site. Every plan in the six notes included a mention of medication, such as active medication includes a blood thinner, medications	F0684	Continued from page 2 medication is going to be restarted after being discontinued for the procedure. The Licensed Nurse is to enter the order to discontinue the medication with a stop date, then enter another order with the restart date of when the medication should be restarted after the procedure. In the facility's electronic medical record, medication orders cannot be held. They will need to discontinue the one order and add another order to restart the medication. Remember to always verify and clarify the medications that residents should be taking, and why a medication is being discontinued with the Healthcare Practitioner. If a resident is on an anticoagulant, such as Eliquis or Coumadin, the Licensed Nurse will make sure the physician's order is appropriate for any discontinued medication and get clarification from the Healthcare Practitioner to ensure whether or not the anticoagulant should be restarted, and that there is an order to restart the anticoagulant. The education also included the review of a new Anticoagulant Monitoring Form initiated on 10/16/25 by the DON for each resident prescribed an anticoagulant medication. The form will contain resident information that will include name of the anticoagulant and dose of the medication. Whenever there is a change to their anticoagulant medication regimen, it will be documented on the form to include, dose changes or hold parameters. Each Medication cart binder will have blank copies of the monitoring form for the Licensed Nurses to complete when necessary. The forms are turned into the Unit Managers on each unit for review when there are changes to the resident's medication (dose changes or held parameters), and then the Unit Managers will forward the forms for review when the changes occur to the DON or ADON. Newly hired licensed nurses and medication aides will receive this education in person during their job specific orientation by the Staff Development Coordinator (SDC). The facility does not utilize any agency staff. SDC was notified by the Director of Nursing on 10/10/25 to begin including this in-person training for all newly hired nurses and medication aides. Newly hired healthcare practitioners will receive this education during their job specific orientation by their provider team. Curana Clinical Director was notified on 10/24/25 to begin this education by the NHC/White Regional Director. Current Nurse Aides were re-educated by the DON, ADON and SDC on the importance of reporting any changes in condition with residents to the Licensed Nurses. Changes in condition could include shortness of breath,	

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F0684 SS = SQC-J	Continued from page 3 reviewed, continue Eliquis, continue current medication including blood thinner. The Medical Director's notes were reviewed for 8/18/25, 9/5/25, 9/11/25 and 9/12/25. Each note indicated the resident's medications were reviewed in the MAR and to refer to the MAR for a complete and updated list of active medications. Each note indicated the resident was on Eliquis 5 mg twice daily. The 8/18/25 findings noted mild tenderness to the catheter site. On 9/30/25 the NP wrote a progress note that read Resident #1 was seen for a follow-up visit for BLE swelling. The resident showed slight improvement in BLE swelling. The NP discussed with the resident and Family Member the need for Resident #1 to wear compression stockings and would order a venous doppler for bilateral lower extremity to rule out a deep vein thrombosis (DVT). A review of Resident #1's medical record did not find a written order for the venous doppler. Nurse #3 wrote on 10/01/25 at 2:56 PM Resident #1 was having difficulty breathing and placed on 2 liters of oxygen via nasal cannula. His oxygen saturation was at 95%. (The normal range for oxygen saturation is 95% - 100%.) The results of the venous doppler dated 10/1/25 indicated non-occluding DVT (a blood clot that partially blocks a blood vessel) identified at the right common femoral vein (major deep vein in the thigh). The results read the DVT could have been chronic (recurring). An NP progress note dated 10/1/25 was reviewed. The note included the resident had been advised to elevate his legs and use compression stockings. Resident #1 reported dyspnea (shortness of breath), which was exacerbated on 9/30/25. He was requiring supplemental oxygen. On 10/1/2025, he did not require the use of oxygen. The NP noted that later, nursing reported that the resident's venous doppler showed non-occluding DVT (blood clot with some blood flow around the clot) of right common femoral vein (large blood vessel in the thigh) that could be chronic. The NP's plan was to reinitiate prescription medication management with Eliquis 10 mg twice daily x 7 days, then continue Eliquis 5 mg twice daily. The NP note included that the resident's chronic anticoagulation was stopped in July 2025 prior to procedure to have suprapubic catheter placed and the anticoagulation was not restarted. Will reinitiate Eliquis with loading dose 10 mg twice daily	F0684	Continued from page 3 extremity swelling, lethargy, and excessive bruising or bleeding that may be symptoms from a medication that was added or discontinued. This re-education was started on 10/24/25 and will be completed on 10/25/25. Newly hired Nurse Aides will receive this education during their job specific orientation by the Staff Development Coordinator (SDC). SDC was notified on 10/24/25 by the Director of Nursing to begin in-person training for all nurse aides. The DON and ADON started monitoring on 10/26/25 will monitor by all new orders daily, including anticoagulant medications, for 6 weeks, then 3 times a week for 6 weeks, and as needed thereafter to ensure the medications are ordered, administered, held, reduced, increased, discontinued, restarted, and verified appropriately, and proper notifications are completed as well. The DON and ADON will also monitor weekly starting on 11/14/25 for 12 weeks by conducting 2 interviews with CNAs to ensure they are reporting changes in condition with residents experiencing shortness of breath, extremity swelling, lethargy and/or excessive bruising or bleeding that may be symptoms from a medication that was added or discontinued, and 2 interviews with Licensed Nurses to ensure CNAs are reporting to them any changes in conditions with residents. Identified trends or issues from the monitoring tools will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks, and then discussions with the Quality Assurance (QA) Committee meetings for further recommendations as needed. The DON is responsible for the ongoing compliance of F684.	

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F0684 SS = SQC-J	Continued from page 4 and then continue Eliquis 5 mg daily, with no stop date. The NP wrote she will order a 2-view chest x-ray for shortness of breath requiring supplemental oxygen use. On 10/1/25 a physician's order was written for two (2) Eliquis 5 mg tablets and to administer every 12 hours for total 10 mg for 7 days then continue Eliquis 5 mg one (1) tablet every 12 hours. Additionally, on 10/1/25 a physician's order was written for a 2-way chest x-ray for dyspnea. A review of physician's orders revealed on 10/1/25 furosemide (diuretic) 20 mg; administer 0.5 tablet (10 mg) once a day was ordered at 2:00 PM. Also, on 10/1/25 furosemide 20mg 1 tablet 2 times daily was ordered for 9:00 AM and 5:00 PM. Review of the October MAR revealed Resident #1 received the furosemide as ordered from 10/1/25 through 10/7/25. An interview on 10/22/25 at 4:07 PM with the NP revealed she had followed the urology consult order recommendations to hold Resident #1's Eliquis. The NP explained that the electronic health record system the facility uses does not permit medication to be held, it had to be discontinued, and a new order entered to restart the medication. The NP did not remember if there was a specific restart date for the medication after the procedure. She stated it was an oversight and there was so much going on, she forgot to enter an order to restart the Eliquis after the procedure. She stated she was notified on 10/01/25 of the resident's increased leg swelling, ordered a venous doppler which showed a DVT, and restarted him on Eliquis. A chest x-ray was ordered 10/1/25 and completed on 10/02/25 which showed no acute cardiopulmonary process. An interview on 10/22/25 at 11:16 AM with Resident #1's Family Member revealed that Resident #1 had been on Eliquis for several years due to a history of blood clots and a stroke. The Eliquis was held on 7/02/25 for an outpatient urology procedure to insert a suprapubic urinary catheter scheduled on 7/07/25. The Family Member stated she did not recall the nurse she asked about the Eliquis being restarted after the procedure and was told it would be restarted. The Family Member stated she talked to the Assistant Director of Nursing (ADON) but was unable to recall the specific date concerning the resident's increased swelling in his legs. She stated a venous doppler study was ordered and completed which showed a blood clot in his right leg.	F0684		

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F0684 SS = SQC-J	Continued from page 5 The ADON notified her of the blood clot and told her they were going to start him on Eliquis. She questioned the ADON about starting him on Eliquis and stated he should have already been on Eliquis. The ADON wrote a progress note on 10/01/25 at 5:13 PM. The note revealed the Family Member was informed the treatment in related to the bilateral lower extremity doppler result and that Eliquis 10 mg twice a day (BID) x 7 days then Eliquis 5 mg BID (no stop date) was ordered. Resident #1 was told a chest x-ray would be done this afternoon and the Family Member would be notified. The ADON explained to the Family Member that last July, prior to suprapubic catheter surgery, the Eliquis was stopped. An interview on 10/23/25 at 8:11 AM with the Assistant Director of Nursing (ADON) revealed that on 10/01/25, she had a conversation with Resident #1's Family Member to provide an update. During this conversation, the Family Member stated that the resident was already on Eliquis and had been on the medication for 10 years due to a history of blood clots. The ADON reviewed the resident's discontinued medications and discovered his Eliquis had been discontinued on 7/02/25. The ADON indicated she notified the NP. An interview on 10/22/25 at 1:45 PM with the Director of Nursing (DON), in the presence of the Administrator, revealed Resident #1 was seen and assessed by the Nurse Practitioner (NP) on 10/01/25. The NP had ordered a venous doppler which was completed on 10/01/25. The venous doppler revealed a non-occluding deep vein thrombus (DVT) identified at the right common femoral vein. The DON stated that Resident #1 was restarted on Eliquis 10 mg every 12 hours for 7 days as ordered by the NP on 10/2/25. The DON stated that the ADON had figured out that the NP had discontinued the Eliquis on 7/02/25 and had not restarted it after his urology procedure. An interview on 10/22/25 at 3:52 PM with the Medical Director revealed she had been notified of the failure to restart Resident #1's Eliquis and his venous doppler results on 10/01/25. She stated his Eliquis should have been restarted and believed someone forgot to restart it after his urology procedure. The Medical Director stated this was a combination of human and computer error. The electronic health record system the facility uses does not have a medication hold function and the	F0684		

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F0684 SS = SQC-J	Continued from page 6 medication order must be discontinued and a new order entered. Resident #1's October 2025 MAR revealed Resident #1 received Eliquis 10 mg 2 times daily at 9:00 AM and 9:00 PM on 10/2/25 through 10/6/25 and at 9:00 AM on 10/7/25. On 10/2/25 Resident #1's vital signs were recorded. The oxygen saturation was 93% at 12:24 PM on room air. The normal range for oxygen saturation is 95% - 100%. The chest x-ray was ordered by the NP on 10/1/25 and was completed in the facility on 10/2/25. The reviewed results of the chest x-ray indicated no focal consolidation (dense tissue), no pleural effusion (excess fluid), no prominent lung markings (increased blood flow due to infection), no pneumothorax (collapsed lung). An NP progress note dated 10/2/25 Resident #1 was seen for a follow-up of a chest x-ray. The NP wrote Resident #1 had previously reported having shortness of breath requiring supplemental oxygen. The resident was not using supplemental oxygen when evaluated at this time and appeared comfortable. Resident #1 noted he felt he needed it at bedtime. The chest x-ray results were negative for any acute cardiopulmonary disease. The resident's labs were unremarkable. Resident # 1 had recently restarted Eliquis for DVT. The note included the resident had bilateral leg extremity swelling present with no evidence of infection. The NP wrote Resident #1's medications and vitals were reviewed and unremarkable, his blood pressure was stable, and to continue to monitor for any acute changes. The NP's exam of Resident #1 found he had shortness of breath, and his lungs had equal breath sounds with no wheezing, rales, or rhonchi. Additionally, the plan for the resident included treating the right leg DVT with Eliquis 10 mg 2 times daily for 7 days and then continuing Eliquis 5 mg 2 times daily with no stop date. A progress note written by Nurse #3 on 10/3/25 at 5:22 AM read Resident #1 started screaming and said he was having an anxiety attack. His blood pressure was 106/60 (normal range <120 and <80), his pulse was 109 (normal range 60-100), his oxygen saturation was 82% on room air (normal range 95%-100%), and his temperature was 98.9 (average normal temperature is 98.6 degrees Fahrenheit). The resident started oxygen via nasal cannula, and his oxygen saturation went to 88%. The	F0684		

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F0684 SS = SQC-J	Continued from page 7 resident asked the nurse to find his phone to call his wife. The resident was told by his wife she was coming to sit with him, and he immediately stopped screaming. A call was placed to the on-call doctor with a new order to give hydroxyzine 10 mg, an antihistamine that can be used for anxiety, and to increase oxygen to 3-4 liters per minute via nasal cannula. There was no physician order entered on 10/3/25 to increase the resident's oxygen to 3-4 liters per minute via nasal cannula. Review of Resident #1's October 2025 MAR revealed he was administered hydroxyzine HCl 10 mg one (1) tablet on 10/3/25 at 4:30 AM. On 10/3/25 at 2:48 PM Nurse #1 wrote Resident #1's Family Member and nurse suggested he go back to bed because he was falling asleep, he was very lethargic, and his legs were swollen. The resident refused to lie down and stated he would go back to bed at bedtime. A Medical Director progress note dated 10/3/25 indicated Resident #1 was seen at the request of nursing staff. Resident #1 was reported to have lethargy (sleepiness) this AM. Nursing staff reported Resident #1 was agitated overnight, yelling out for his family. Resident #1 did receive hydroxyzine overnight due to his agitation. The family at bedside reported concern that Resident #1 had a UTI and requested he be checked. Additionally, the note revealed the nursing staff had no further reported issues or concerns. The Medical Director wrote the resident was examined in his room and appeared awake, tired, and was responsive. He did not have a cough, shortness of breath, chest pain or palpitations, fever or chills. The Medical Director added given Resident #1's change in status and history of recurrent UTIs she will obtain STAT (immediate) labs that included a CBC (complete blood count), CMP (comprehensive metabolic panel), and a urinalysis with a culture and sensitivity (UA with C&S). The progress note included vital signs dated 10/2/25 with heart rate 72 bpm (beats per minute) at 11:00 PM, blood pressure 128/72 at 12:23 PM, oxygen saturation 93% on room air at 12:24 PM, temperature 98.2 at 12:23 PM, and respiratory rate 17 per minute at 12:23 PM. The Medical Director's plan included starting empiric antibiotic ceftriaxone (broad-spectrum antibiotic) one (1) mg IM (intramuscular) 5 days and to closely monitor and follow as clinically warranted. The Medical Director wrote an order dated 10/3/25 for	F0684		

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F0684 SS = SQC-J	Continued from page 8 STAT UA with C&S, CBC, and CMP. A review of Resident #1's October MAR revealed ceftriaxone 1 gram injection intramuscular once daily was ordered on 10/3/25. The medication was administered once daily from 10/3/25 through 10/7/25. On 10/3/25 at 5:37 PM the DON wrote a progress note that read Resident #1 had new orders from the Medical Director for Ceftriaxone, daily x 5 days, and STAT CMP, UA C&S for Dysuria (pain or burning when urinating). Unfortunately, the medical lab system was down today, and all stat services were unavailable. The labs ordered will be done in the AM and the urine specimen was collected and currently in the lab specimen refrigerator for pick up. The resident had increased lethargy on 7-3 pm shift from not resting well the previous shift. Staff attempted to lay him down, but he refused. The DON stated during interview on 10/23/25 at 9:35 the physician ordered labs on 10/3/25 were not drawn until 10/6/25. On 10/4/25 the lab was called for the ordered labs, but the lab did not arrive. The DON said she had communicated to the Medical Director verbally that the laboratory was having problems and the first availability to draw the CMP and CBC labs, and send the UA was on 10/6/25. The results were not completed prior to Resident #1 being sent out to the hospital on 10/7/25. On 10/04/25 at 1:03 PM a progress note written by Nurse #2 read she was called to Resident #1's room by his family to observe swollen left leg and draining clear fluid. Nurse #2 was not interviewed about the progress note on 10/4/25. A progress note dated 10/6/25 revealed the Medical Director Resident #1 was examined and appeared improved overall and he stated overall he was feeling better. The resident was seated upright in his wheelchair and denied any urinary discomfort, abdominal pain, chest congestion, cough, or current shortness of breath. He remained on supplemental oxygen intermittently and continued to have bilateral lower extremity edema with weeping of clear fluid. The resident did respond to some increase in diuretic. A chest x-ray was done and without any acute findings. Resident #1 remains on treatment for right lower extremity DVT with blood thinner, based on venous doppler done on 10/1/25. The Eliquis was recently restarted after having been stopped for a surgical procedure when his suprapubic	F0684		

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F0684 SS = SQC-J	Continued from page 9 catheter was placed. Resident #1's vitals remained stable overall and nursing reported no other concerns or issues. Resident #1's vital signs recorded on 10/6/25 at 8:35 AM were heart rate 86 bpm, blood pressure 126/90, oxygen saturation 97% on room air, temperature 98, and respiratory rate was 18 breaths per minute. The Medical Director ordered a CT scan (computed tomography scan, an imaging procedure) of the chest to rule out any pulmonary embolism, given the resident's ongoing intermittent shortness of breath and supplemental oxygen requirement. The note read, "Should a CT scan not be able to be scheduled within the next 1-2 days, I would recommend sending patient out to hospital to have scan completed". The Medical Director wrote to send Resident #1 to the emergency department should he have any acute changes or decompensation (the failure of an organ, especially the liver or heart), but the resident was currently medically stable. On 10/6/25 a physician's order was written for a chest CT scan with contrast. Please refer to the VA (Veteran's Administration hospital). An interview on 10/23/25 at 10:29 AM with Nurse #1 revealed she had been assigned to Resident #1's hall on 10/07/25 on the 3:00 PM to 11:00 PM shift. She stated she did not remember if he was on oxygen at that time but had started on oxygen a few days before when he stated he could not breathe even with an oxygen saturation reading of 95% on room air. She also noted he had increased anxiety and had stated he did not feel good, his skin was crawling, and he had a bad feeling. The ADON wrote a progress note dated 10/07/25 at 5:09 PM. The note read the Medical Director was notified the Veteran's Administration hospital would not do the chest CT urgently, and if in need of urgent CT to consider sending to a local hospital. The Medical Director gave a telephone order to send Resident #1 to the hospital for evaluation due to hypoxia and dyspnea. The Family Member was notified, and 911 was called at approximately 5:00 PM. The hospital admission notes included the Emergency Department progress notes dated 10/7/25 and revealed Resident #1's blood pressure was 213/96 (hypertensive), his respirations were 33 breaths per minute (normal range 12-20 per minute, and his oxygen saturation was 93% (normal range 93%-100%). Resident #1 reported tightness in his chest and shortness of breath. The	F0684		

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F0684 SS = SQC-J	Continued from page 10 emergency department lab results dated 10/7/25 revealed he was positive for a UTI. A chest x-ray result found mild pulmonary congestion, an ultrasound of his legs found a DVT in his right femoral vein of his lower leg and a CT scan of his chest found bilateral pulmonary embolism within the distal aspect of the main pulmonary arteries. Resident #1 was started on a heparin drip (an intravenous infusion of heparin, an anticoagulant used to prevent and treat blood clots) and was admitted to the hospital. Resident #1's hospital discharge summary dated 10/16/25 indicated Resident #1 was taken to the emergency room on 10/7/25 and underwent a CT scan of the chest. The CT results found bilateral pulmonary embolism of the main pulmonary arteries extending into the upper and lower lobes (lung section). Additionally, the results read the findings were worrisome for the presence of complete occlusion within the right lower lobe and for the presence of an infarction. Furthermore, the discharge summary read that a venous ultrasound of Resident #1's lower legs was completed on 10/7/25 and found a partially blocked thrombus (blood clot) of the right femoral vein. The resident received IV (intravenous) heparin in the emergency department. The discharge summary included Resident #1's admitting MD note. The MD note read Resident #1 was admitted with a medical history that included atrial fibrillation and CVA (stroke) with left sided weakness, and chronic suprapubic catheter. Resident #1 was presented to the emergency department due to exertional shortness of breath of the last several days and had oxygen started at his facility 2 days ago. The admitting physician's note included Resident #1's family stated the resident was on a blood thinner for several years that was held 2.5 months ago for suprapubic catheter placement. Resident #1 started back on the blood thinner 4 days ago (10/2/25). While admitted to the hospital Resident #1 underwent a pulmonary angiography and catheter directed thrombectomy (procedure to remove lung blood clot). Resident #1 was diagnosed with a UTI and received IV Rocephin (antibiotic). Resident #1 was discharged to the facility with the order for Eliquis 5 mg tablet every 12 hours. An additional interview on 10/23/25 at 12:10 PM with the Medical Director revealed the NP had seen Resident #1 on 10/01/25. The doppler was ordered due to increased swelling in both his legs. The chest x-ray was ordered due to shortness of breath. After the doppler results, the Eliquis was ordered. The Medical Director saw Resident #1 on 10/03/25 and she ordered	F0684		

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F0684 SS = SQC-J	Continued from page 11 labs, urinalysis, and started him on antibiotics for a suspected urinary tract infection. The labs and the urinalysis were ordered to be done 'stat' (immediately). The urinalysis was collected on 10/03/25.. The Medical Director stated when interviewed she was made aware by the DON; the lab orders could not be completed on 10/3/25 and the first availability for a lab draw was on 10/6/25. The Medical Director said the resident was receiving antibiotic for suspected UTI and the delayed UA would not have delayed the resident's treatment. The Medical Director stated the CMP and CBC were not completed before the resident went to the hospital on 10/7/25 and that she had reviewed them for the first time today (10/23/25). After reviewing the lab results, the Medical Director explained there was nothing in the lab results that would have changed how the resident was treated. The Medical Director stated the reason she sent him to the hospital on 10/07/25 was due to the inability to the CT scan of the chest which was ordered on 10/06/25 completed in a timely manner. The Medical Director acknowledged the significant medication error when the Eliquis had not been restarted following the urology procedure which placed the resident at increased risk for blood clot. The Medical Director stated ideally the pharmacy medication regimen review should have caught the medication error and brought it to her attention. She also stated there was no way to know for sure if the blood clots were chronic or acute unless he had previous ultrasound. The Medical Director stated on 10/23/25 at 12:25 PM she was made aware the lab orders (CBC, CMP, UA) could not be completed on 10/3/25 and the first availability of a lab draw was on 10/6/25. The Medical Director said the resident was receiving an antibiotic for a suspected UTI and the delayed UA would not have delayed the resident's treatment. An additional interview on 10/23/25 at 4:18 PM with the Administrator and DON revealed the medications should have been reviewed by the NP and Medical Director and the failure to restart the Eliquis should have been caught. The Administrator was notified of immediate jeopardy on 10/23/25 at 4:30 PM. The facility provided the following credible allegation of immediate jeopardy removal.	F0684		

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F0684 SS = SQC-J	Continued from page 12 Identify those residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: · Resident #1 was admitted to the facility on 03/19/25 with a diagnosis that included, but not limited to, chronic atrial fibrillation and had an admitting order for Eliquis (anticoagulant) 5mg, 1 tablet, every 12 hours. Resident #1's spouse reported a history of anticoagulant use and deep vein thrombosis (DVTs) upon admission. · On 6/2/25, Resident # 1 had an urology appointment due to feeling a burning sensation with the indwelling catheter. It was determined the resident needed to have a suprapubic catheter placed. The urology consult indicated that the patient would need medical clearance regarding past medical history and use of chronic anticoagulation to reduce his bleeding risk in preparation of his upcoming procedure. On 07/02/25, the Nurse Practitioner (NP) made the determination to discontinue the anticoagulant (Eliquis 5mg 1 tablet daily) for a suprapubic catheter placement on Monday, 07/07/25. The NP did not enter another order to restart the Eliquis after the catheter placement. The NP thought she entered an order to restart the medication but failed to do so. · On 07/08/25, NP conducted a post-op follow-up with documentation stating that the medication was reviewed and the Eliquis was listed as being ordered. On 7/11/25, Resident #1 had post-op appointment at the VA, and no Eliquis was added to Resident #1's medication list on the consultation. · On 10/01/25, the Licensed Nurse requested an order from the Healthcare Practitioner for a venous doppler to the bilateral lower extremities due to swelling to lower extremities. The doppler concluded there was non-occluding thrombus (DVT) identified at the right common femoral vein and that the finding could be chronic. The Licensed Nurse notified the NP, and the NP inquired if Resident #1 was on a blood thinner. The Licensed Nurse reviewed the chart and noted the resident was not on a blood thinner but had been on Eliquis in July 2025 and it was discontinued prior to the suprapubic catheter placement, and it was not restarted after the procedure. The anticoagulant was then restarted (Eliquis 10mg, every 12 hours x 7 days and then Eliquis 5mg, 1 tablet, every 12 hours). · On 10/03/25, Resident #1 was noted to be anxious and vital signs indicated blood pressure 106/60, oxygen saturation 82 % on room air. New order received from	F0684		

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F0684 SS = SQC-J	Continued from page 13 Healthcare Practitioner to administer hydroxyzine (helps to reduce anxiety) 10mg now and to increase oxygen to 3-4 liters per minute via nasal canula. On 10/04/25, the Resident's spouse reported swelling to · Resident's left leg which was draining clear liquid, but Resident had no pain or discomfort. The concern was provided to Healthcare Practitioners to follow up. · On 10/07/25, Resident #1 was transferred to the hospital due to being hypoxic with supplemental oxygen and having to wait for a Veteran Affairs (VA) follow-up appointment. Resident #1 was transferred and admitted to acute care hospital. Hospital records revealed pulmonary embolism, pulmonary artery of the upper and lower lobes necessitating a thrombectomy. · On 10/14/25, the Director of Nursing (DON) and the Interim Administrator had an in-person meeting with the Resident's spouse and discussed the concerns regarding the Resident's anticoagulant being held for 85 days. Formal apology provided on behalf of the facility. Official grievance was completed and resolved with spouse. Spouse agreed to allow the Resident to return to the facility. · On 10/16/25, Resident readmitted to the facility with an order for anticoagulant (Eliquis 5mg, 1 tablet, every 12 hours). An audit of current residents in the month of October on anticoagulant therapy was completed by running current orders for anticoagulants and reviewing the orders for accuracy to determine whether any changes or adjustments with the anticoagulant were made, and verifying the appropriate administering or discontinuing of the medication as ordered. The audit was completed by the DON on 10/13/25. The DON ensured residents had their anticoagulant ordered and administered as required, and verified that the medication was available in the medication cart. No further concerns were identified. · Another audit of current residents on anticoagulant therapy and residents that had discontinued anticoagulant orders for the month of October 2025 was completed on 10/23/25 by the DON and the Assistant Director of Nursing (ADON). There were no other concerns identified. · A further audit will be completed by reviewing the Healthcare Practitioner's progress notes and provider's consultations for the month of October 2025 to identify any other medication that have been discontinued	F0684		

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F0684 SS = SQC-J	Continued from page 14 specifically focused on anticoagulant medications and have not been restarted. The audit will be completed on 10/24/25 by the DON, ADON and the Pharmacy Consultant. If any further concerns are identified from the audit, the Healthcare Practitioner will be notified, and the resident will be evaluated. · Current and newly admitted residents on anticoagulants, residents with newly ordered for anticoagulants and anticoagulant that have been discontinued have the potential to be affected. The facility will ensure the residents' medications will be administered, discontinued and restarted appropriately. 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: · The Licensed Nurses were originally re-educated on the importance of ensuring a resident's medication, such as an anticoagulant, that is temporarily discontinued due to a procedure, treatment or hospitalization, has been restarted. The Licensed Nurse must verify that the medication that the resident was taking prior to being discontinued has been reentered, verified and activated, if still deemed medical necessary. If the medication is held for a certain number of days, the Licensed Nurse is to ensure the medication is restarted after the last day of being held. This re-education was completed on 10/14/25 by the Staff Development Coordinator (SDC). · On 10/23/25, during the survey, it was revealed that the Licensed Nurses could not articulate the re-education that they received and completed on 10/14/25. · Another education with Licensed Nurses, Medication Aides and the facility's Healthcare Practitioners (attending physicians and extenders) was started on 10/23/25 and will be completed on 10/24/25 by the DON, ADON and SDC. This education is being conducted in-person, and the staff is having to verbalize what they were educated on to ensure comprehension. The education is including the following: When a physician's order for a medication, such as an anticoagulant is discontinued for a resident's procedure, they will verify that the medication is going to be restarted after being discontinued for the procedure. The Licensed Nurse is to enter the order to discontinue the medication with a stop date, then enter another order with the restart date of when the medication should be restarted after the procedure.	F0684		

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F0684 SS = SQC-J	Continued from page 15 · The education provided on 10/23/25 by the DON, ADON and SDC included the following information: In the facility's electronic medical record, medication orders cannot be held. They will need to discontinue the one order and add another order to restart the medication. Remember to always verify and clarify the medications that resident should be taking, and why a medication is being discontinued with the Healthcare Practitioner. If a resident is on an anticoagulant, such as Eliquis or Coumadin, the Licensed Nurse will make sure the physician's order is appropriate for any discontinued medication and get clarification from the Healthcare Practitioner to ensure whether or not the anticoagulant should be restarted, and that there is an order to restart the anticoagulant. · The education also included the review of a new Anticoagulant Monitoring Form initiated on 10/16/25 by the DON for each resident prescribed an anticoagulant medication. The form will contain resident information that will include name of the anticoagulant and dose of the medication. Whenever there is a change to their anticoagulant medication regimen, it will be documented on the form to include, dose changes or hold parameters. Each Medication cart binder will have blank copies of the monitoring form for the Licensed Nurses to complete when necessary. The forms are turned into the Unit Managers on each unit for review when there are changes to the resident's medication (dose changes or held parameters), and then the Unit Managers will forward the forms for review when the changes occur to the DON or ADON. · Newly hired licensed nurses and medication aides will receive this education in person during their job specific orientation by the Staff Development Coordinator (SDC). The facility does not utilize any agency staff. SDC was notified by the Director of Nursing on 10/10/25 to begin including this in-person training for all newly hired nurses and medication aides. · Newly hired healthcare practitioners will receive this education during their job specific orientation by their provider team. Clinical Director was notified on 10/24/25 to begin this education by the NHC/White Regional Director. · Current Nurse Aides will be re-educated by the DON, ADON and SDC on the importance of reporting any changes in condition with residents to the Licensed Nurses. Changes in condition could include shortness of breath, extremity swelling, lethargy, and excessive bruising or	F0684		

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F0684 SS = SQC-J	Continued from page 16 bleeding that may be symptoms from a medication that was added or discontinued. This re-education was started on 10/24/25 and will be completed on 10/25/25. · Newly hired Nurse Aides will receive this education during their job specific orientation by the Staff Development Coordinator (SDC). SDC was notified on 10/24/25 by the Director of Nursing to begin in-person training for all nurse aides. Alleged date of IJ removal: 10/26/25. The facility's credible allegation of immediate jeopardy removal was validated on 10/27/25. A review of the facility's education records revealed completed staff sign in sheets dated 10/23/25 for trainings titled "discontinuing medication and restarting medication due to procedure, treatment, surgery or hospitalization" and "reporting changes in condition". Interviews conducted with licensed nurses revealed they received education related to the procedure to follow when orders were received to change or hold a resident's anticoagulation medication including completion of a monitoring form, clarifying with the provider if or when the medication was to be restarted and entering the orders accordingly in the electronic medical record (EMR). The nurses interviewed further revealed they were educated on the importance of monitoring residents for changes in condition and immediately notifying the provider when a change was observed or reported by staff. Interviews conducted with Nurse Aides (NAs) revealed they were educated on the importance of monitoring residents for any changes in condition and immediately reporting the observed changes to the nurse. During an interview with the Staff Development Coordinator (SDC) he stated education was provided on 10/23/25 and 10/24/25 to all licensed nurses and NAs related to the process to follow when orders for an anticoagulant medication were changed or held and the importance of monitoring residents for any changes in condition and notifying the provider of these changes and the education will also be provided to all new hires during orientation. An interview conducted with the Director of Nursing (DON) revealed she completed audits on 10/23/25 and 10/24/25 of current residents receiving anticoagulant medication by reviewing any orders from October 2025 to discontinue the medication and the corresponding provider notes to ensure anticoagulant medications were restarted per the providers orders and no concerns were identified. The DON indicated anticoagulant medication monitoring forms were implemented and will be completed by the nurse when there were orders to change or discontinue a	F0684		

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F0684 SS = SQC-J	Continued from page 17 resident's anticoagulant medication and she reviews the forms and the EMR to ensure the orders were entered correctly including the orders to restart the anticoagulant if indicated by the provider. A phone interview was conducted with the Clinical Director of the facility's provider service which indicated she was notified of the facility's procedure related to orders to change or hold anticoagulant medications and how the orders should be entered in the EMR. She stated the education was provided to the current NP and Medical Director and any new providers assigned to the facility will receive the education prior to seeing residents. An interview with the NP revealed she was provided education related to the procedure to follow when she gave an order to change or hold a resident's anticoagulant medication and ensuring the orders were entered correctly in the EMR. The NP indicated that when a resident's anticoagulant medication was being held temporarily, she discontinued the current order in the EMR, entered a new order with the date the medication was to resume and documented the reason the medication was being held. The facility's immediate jeopardy removal date of 10/26/25 was validated on 10/27/25.	F0684		
F0711 SS = D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Nurse Practitioner, and Physician interviews, the medical providers failed to review the total plan of care and ensure the medication list on the Nurse Practitioner and Physician	F0711	White Oak Manor – Charlotte will ensure physicians are reviewing the resident's total program of care, including medications and treatments, at each visit. Resident #1's physician/extender progress note was updated on 10/01/25 when noted and continued thereafter to reflect the resident's current and accurate medication list. An audit will be completed by 11/20/25 on comparing the most recent physician and extender progress notes with the resident's current medication list along with the resident plan of care. This audit will be completed by the Corporate Consultants. All physician/extender progress notes will be updated by 11/21/25 for current residents. The facility and the physician/extenders will ensure current and newly admitted residents are reviewed for their total plan of care and will accurately reflect the medication list. The physician/extenders were educated by their Office Manager for their practice regarding a new procedure on their electronic documentation. The physician/extenders are not to click on the icon that will automatically pull the medications listed from the previous completed progress note. The physician/extenders are to review and manually type in the medications that are being	11/22/2025

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F0711 SS = D	Continued from page 18 progress notes were accurate for 1 of 3 residents reviewed to ensure the facility is free of medication errors (Resident #1). Findings included: Resident #1 was admitted to the facility on 3/19/25 with diagnoses which included atrial fibrillation and benign prostatic hyperplasia. Resident #1's Nurse Practitioner (NP) progress note dated 7/02/25 untimed, read that the resident's Eliquis (blood thinner medication) would be held prior to a suprapubic catheter placement procedure. The medication list included Eliquis 5 milligrams (mg) oral (by mouth) every 12 hours. An order dated 7/02/25 at 1:37 PM was created by the NP to discontinue the Eliquis. Resident #1's NP progress note dated 7/31/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's NP progress note dated 8/07/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's NP progress note dated 8/11/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.'	F0711	Continued from page 18 reviewed and addressed during their visit. This education was completed on 10/30/25. The Office Manager from the practice will educate newly hired physicians and extenders during job specific orientation in their practice. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) will monitor by reviewing 5 residents' current physician/extender progress notes with the medication list to ensure the medication list is accurate and the facility is free of medication errors. The monitoring will be completed weekly for 12 weeks. Identified trends or issues from the monitoring tools will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks, and then discussions with the Quality Assurance (QA) Committee meetings for further recommendations as needed. The Medical Director and the DON are responsible for the ongoing compliance of F711.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345238	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/27/2025

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F0711 SS = D	Continued from page 19 Resident #1's Physician (MD) progress note dated 8/18/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' There was an addendum clinical clarification electronically signed by the MD on 10/22/25 which read that the patient was not taking Eliquis on the date of the progress note. Resident #1's MD progress note dated 9/05/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' There was an addendum clinical clarification electronically signed by the MD on 10/22/25 which read that the patient was not taking Eliquis on the date of the progress note. Resident #1's MD progress note dated 9/11/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' There was an addendum clinical clarification electronically signed by the MD on 10/22/25 which read that the patient was not taking Eliquis on the date of the progress note. Resident #1's MD progress note dated 9/12/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' There was an addendum clinical clarification electronically signed by the MD on 10/22/25 which read that the patient was not taking Eliquis on the date of the progress note. Resident #1's NP progress note dated 9/17/25 included	F0711		

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F0711 SS = D	Continued from page 20 Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's NP progress note dated 9/24/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's NP progress note dated 9/30/25 included Eliquis 5 mg oral every 12 hours on the medication list. The medication list had a statement which read 'I have reviewed the resident's medications in the facility chart (MAR) (Medication Administration Record). Refer to the facility's Mediation Administration Record (MAR) for a complete and up to date list of active medications.' Resident #1's NP progress note dated 10/01/25 read that the patient's chronic anticoagulation stopped in July 2025 prior to procedure to have suprapubic catheter place. Anticoagulation was not restarted. Will reinitiate Eliquis with loading dose. An order to restart the Eliquis was given by telephone from the NP on 10/01/25 at 2:46 PM. The order was for Eliquis 5 mg 2 tabs (total 10 mg) oral every 12 hours for 7 days, then 5 mg oral every 12 hours with no stop date. An interview on 10/22/25 at 3:51 PM with the NP revealed the progress notes medication list indicated that Eliquis was an active medication for Resident #1. She stated that the medications carried over from the previous note may not always be accurate or reflect medication changes. She stated the failure to restart the Eliquis was an oversight. An interview on 10/22/25 at 3:52 PM with the MD revealed Resident #1's Eliquis should have been	F0711		

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F0711 SS = D	Continued from page 21 restarted after the suprapubic catheter insertion procedure. The medication list on the progress notes were active medications and were carried over from previous progress notes. The MD stated she reviewed the facility Medication Administration Record for an accurate resident medication list. The MD was unable to explain how the Eliquis medication was missed and had not been restarted after the urology procedure. An interview on 10/23/25 at 4:18 PM with the Administrator and the Director of Nursing (DON) revealed they were aware the MD and NP progress note medication lists were not always accurate but were unaware of the specific process of how the medication list got on the progress note. The Administrator stated that the medications should have been reviewed and the failure to restart the Eliquis should have been caught.	F0711		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no	F0756	White Oak Manor – Charlotte will ensure the Consultant Pharmacist will review the resident's medical record and report any irregularities to the Director of Nursing (DON) and the attending physician/Medical Director in order for the facility to be able to act on, clarify and correct. The facility's Consultant Pharmacist and the other Consultant Pharmacists were re-educated on identifying a significant lapse in anticoagulant therapy or identifying residents that have an interruption in therapy due to a surgical procedure and to ensure it is addressed in the drug regimen reviews following the procedure. The Consultant Pharmacist is to assist in ensuring the continuation of chronic anticoagulant treatment for residents by reviewing anticoagulants that are discontinued and identifying whether the anticoagulant was intended to be on a temporary hold or discontinued permanently. If the resident has an indication for long-term use of anticoagulants and there is no documentation to support discontinuation or the anticoagulant was only intended to be placed on a short-term hold, the Consultant Pharmacist will notify the facility staff to contact the physician/extenders for clarification. This education was completed by the Pharmacy Consulting Coordinator on 10/29/25. Newly hired Consultant Pharmacists will receive this education during their job specific orientation by the Pharmacy Consulting Coordinator The Consultant Pharmacist will monitor weekly for 12 weeks the facility's residents on anticoagulant therapy	11/22/2025

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F0756 SS = D	Continued from page 22 change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the Consultant Pharmacist, Nurse Practitioner, Medical Director and Director of Nursing, the facility's Consultant Pharmacist failed to identify a significant lapse in anticoagulant therapy. Specifically, Eliquis (an anticoagulant, also known as a blood thinner) was discontinued on 7/2/25 for a surgical procedure and was not resumed until 10/1/25. This interruption in therapy was not addressed in the drug regimen reviews following the procedure, thereby failing to ensure the continuation of chronic anticoagulant treatment for Resident #1. This deficient practice was identified in 1 of 3 residents reviewed for unnecessary medications (Resident #1). Findings included: Resident #1 was admitted to the facility on 3/19/25 with diagnoses which included atrial fibrillation, type 2 diabetes, and a history of pulmonary embolus. On 3/19/25, the physician ordered Eliquis 5 milligrams (mg) by mouth every 12 hours. Resident #1's physician orders for July 2025 revealed Eliquis 5 mg by mouth every 12 hours was discontinued on 7/2/25. The Consultant Pharmacist review of Resident #1 dated 7/30/25, 8/25/25, and 9/24/25 revealed no recommendations for restarting the Eliquis medication. On 10/1/25 a physician's order was written for 2 Eliquis 5 mg tablet and to administer every 12 hours for total 10 mg. The Consultant Pharmacist was interviewed via phone on 10/23/25 at 9:07 AM. He stated a pharmacy review for Resident #1 was completed on 7/30/25, 8/25/25 and on	F0756	Continued from page 22 to ensure the continuation of chronic anticoagulant treatment are identified, notified, clarified and corrected if there is a lapse in anticoagulant therapy. Identified trends or issues from the monitoring tools will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks, and then discussions with the Quality Assurance (QA) Committee meetings for further recommendations as needed. The Consultant Pharmacist and the DON are responsible for the ongoing compliance of F756.	

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F0756 SS = D	Continued from page 23 9/24/25. The Consultant Pharmacist stated he did review NP and Medical Director's notes along with labs and it was an oversight that the Eliquis was not included on his July 2025 pharmacy review. The Consultant Pharmacist stated Eliquis was not on Resident #1's medication list for August 2025 and September 2025 because he knew Eliquis had been stopped by the physician. The pharmacist stated the Eliquis might have been stopped because of bleeding after the procedure or other reasons, but he did not remember specifics. The Medical Director was interviewed on 10/23/25 at 12:10 PM and stated the monthly pharmacy reviews should have caught the Eliquis was not restarted and brought it to her attention. An interview on 10/23/25 at 4:18 PM with the Administrator and DON revealed the Eliquis medication should have been reviewed and captured on the pharmacy reviews for Resident #1.	F0756		