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

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

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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/22/25 through 09/26/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D716D-H1. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance.	E0000		11/19/2025
F0000	INITIAL COMMENTS A recertification and complaint survey was conducted from 09/22/25 through 09/26/25. The following intakes were investigated 2571751, 856572, 2602429, 856571, 856577, 2610431, and 2619987. Event ID# 1D716D-H1. 11 of the 11 complaint allegations did not result in deficiency. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance.	F0000		11/19/2025
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F0655	White Oak Manor – Burlington ensures the development and implementation of a baseline care plan for each resident that includes instructions needed to provide effective and resident-centered care of the resident that meet professional standards of quality care. Resident #125's baseline care plan was not developed for Post Traumatic Stress Disorder (PTSD) in the baseline care plan. Resident #125's comprehensive care plan was updated on 09/25/25 by the NAC. Newly admitted residents will have baseline care plans developed and implemented to ensure the care to the residents' meet professional standards of quality care. An audit will be completed by the Director of Nursing (DON) and Nurse Assessment Coordinators (NACs) to ensure current residents admitted for the month of November, from 11/01/25 to 11/21/25 had baseline care	12/01/2025

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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F0655 SS = D	Continued from page 1 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan that addressed the resident's immediate needs related to a diagnosis of post-traumatic stress disorder (PTSD) for 1 of 1 resident reviewed for mood and behavior (Resident #125). The findings included:	F0655	Continued from page 1 plans completed, including residents with a diagnosis of PTSD in order to provide residents with proper care. This audit will be completed by 11/28/25. The NACs and the Interdisciplinary Care Team (IDT) will be re-educated by the Corporate Consultant by 11/28/25 regarding the importance of developing and implementing baseline care plans for each resident, including residents with a diagnosis of PTSD, to ensure effective and resident-centered care of the resident will meet professional standards of quality care. The IDT includes the NAC Nurses, the Social Services Department, the Registered Dietician, and the Activities Department. The NAC Nurse is responsible for the overall completion of the Baseline Care Plans and to ensure IDT completes their baseline care plan. The NAC is the MDS nurse that is responsible for the completion of the MDS Assessment tool along with the interdisciplinary team to ensure the residents have baseline and comprehensive care planning. Newly hired NACs and IDT will receive this education during their job specific orientation with their Corporate Consultant. The DON will monitor newly admitted residents weekly for 12 weeks to ensure their baseline care plans are developed and implemented for effective and resident-centered care that meets professional standards of quality care, including residents with a diagnosis of PTSD. The identified trends will be discussed weekly during the Morning Quality Improvement (QI) meetings for 12 weeks. The identified issues or trends will further be discussed at the monthly Quality Assurance (QA) meetings with the care team for recommendations as indicated. The DON and the NACs are responsible for the ongoing compliance of F655. Compliance date is 12/01/25.	

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F0655 SS = D	Continued from page 2 A review of the discharge summary from Resident #125's previous facility revealed he was discharged on 9/12/25 with diagnoses that included PTSD. The discharge summary from the previous nursing facility did not document any information regarding residents' history of past trauma or triggers that may cause re-traumatization. Review of the FL2 (a North Carolina Medicaid form that documents a patient's medical condition and needs for long term care facilities) completed 9/12/25 revealed Resident #125 had a diagnosis of PTSD. Resident #125 was admitted to the facility on 9/12/25 with a diagnosis of PTSD. Review of the baseline care plan dated 9/12/25 completed by the Minimum Data Set (MDS) Nurse revealed no goal or interventions for Resident #125's diagnosis of PTSD. Review of Resident #125 physician order dated 9/12/25 indicated administer the Sertraline (antidepressant) 25 milligram (mg) along with Sertraline 50mg tablet for a total of 75mg once daily for PTSD. An interview with MDS Nurse #1 on 9/24/25 at 10:48am revealed she had 48 hours to complete a baseline care plan. MDS Nurse #1 indicated Resident #125 had care plans initiated on 9/12/25 without a care plan for PTSD or behaviors associated with PTSD. PTSD and behaviors associated with PTSD would normally be included in the baseline care plan. Interview conducted with MDS Nurse #2 on 9/24/25 at 10:55am revealed she did not know why Resident #125 did not have a baseline care plan to address his diagnosis of PTSD. She stated it may not have been added at the time the baseline care plan was completed if the facility had not received information about Resident #125 PTSD diagnosis from the discharging facility. An interview conducted with the Director of Nursing (DON) on 9/25/25 at 12:31pm revealed she was not sure if Resident #125 had a diagnosis of PTSD. The DON indicated she expected to be notified prior to or on admission of a PTSD diagnosis, trauma triggers, behaviors, or potential behaviors. She expected PTSD, trauma triggers, and behaviors to be included in the baseline care plan. The DON stated she was not sure if Resident #125's baseline care plan reflected his PTSD diagnosis.	F0655		

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F0655 SS = D	Continued from page 3 An interview with MDS Nurse #2 on 9/25/25 at 12:35pm revealed information included in the baseline care plan would depend on the information the facility received at admission. MDS Nurse #2 revealed the facility might have been waiting to get information on the trauma and triggers associated with Resident #125's PTSD diagnosis.	F0655		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to follow therapy recommendations to apply a soft hand splint for 1 of 4 sampled residents (Resident #3) reviewed for positioning and mobility. The findings included: Resident #3 was admitted to the facility on 3/30/22 with diagnoses that included a left-hand contracture. The Occupational Therapy (OT) discharge summary dated 5/13/25 revealed Resident #3 had a left-hand contracture. The OT discharge recommendations stated Resident #3 was to be followed by Restorative Nursing with a goal that included Resident #3 would apply and wear a left-hand splint 4-6 hours daily.	F0688	White Oak Manor – Burlington ensures residents with limited range of motion does not experience reduction in range of motion the development and implementation of a baseline care plan for each resident that includes instructions needed to provide effective and resident-centered care of the resident that meet professional standards of quality care. Resident #3 was referred to Therapy on 8/6/2025 for an evaluation and the recommendation was to use a splint and do passive range of motion. Resident #3 currently does not use the splint and is care planned for refusals. An audit will be completed by the Director of Nursing (DON) of therapy recommendations from 11/01/25 to 11/21/25 to ensure recommendations were followed for restorative programs and splinting. The audit will be completed by 11/28/25. The Therapy Department, Restorative Nurse and DON will be re-educated by the Corporate Consultant by 11/28/25 on communicating recommendations to ensure the initiation of restorative splinting and programs. Newly hired staff in the Therapy and Restorative Nursing Departments will receive this education during their job specific orientation with their Corporate Consultant or DON. The DON will monitor all recommendations from Therapy weekly for 12 weeks to ensure the recommended restorative splinting or programs are initiated or attempted for the residents. Monitoring started on 12/02/25 and will end on 02/20/26. The identified trends will be discussed weekly during the Morning Quality Improvement (QI) meetings for 12 weeks. The identified issues or trends will further be discussed at the monthly Quality Assurance (QA) meetings with the care team for recommendations as indicated. The DON and the Restorative Nurse are responsible for the ongoing compliance of F688.	12/01/2025

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F0688 SS = D	Continued from page 4 Review of Resident #3's annual Minimum Data Set (MDS) assessment dated 8/12/25 revealed he was cognitively intact and had one upper extremity impairment. An interview and observation were conducted with Resident #3 on 9/22/25 at 3:36 PM. Resident #3's left hand was observed to have 4 fingers and thumb tight into a fist. A blue, soft resting hand splint was observed on the corner of his nightstand. Resident #3 stated the resting hand splint on the nightstand was his, but staff had not been putting in on his hand in a long time. Resident #3 was unable to identify the length of time that staff had not put the resting hand splint on his left hand. Observation on 9/24/25 at 10:00 AM revealed Resident #3's left hand to have 4 fingers and thumb held tightly into his fist. A blue soft hand splint was observed on a corner nightstand. Observation on 9/25/25 at 10:30 AM revealed Resident #3's left hand to have 4 fingers and thumb held tightly into his fist. A blue soft hand splint was observed on a corner nightstand. On 9/25/25 at 4:14 PM Resident 3's left hand was observed to have 4 fingers and thumb contracted into fist. Resident #3's left resting hand splint was observed on the corner of his nightstand. During an interview on 9/26/2025 at 9:46 AM, the Rehabilitation Director indicated when a resident transitioned from rehabilitation to restorative nursing services, a form was filled out by rehabilitation. The form would include restorative nursing services start date, interventions, frequency, precautions, and when a therapist should be alerted. The completed restorative nursing form would be placed in the Restorative Nurse's mailbox. She did not know how the previous Rehabilitation Director communicated discharge recommendations for Resident #3 to the nursing staff or the Restorative Nurse. Upon review of Resident #3's OT discharge summary dated 5/13/25, the Rehabilitation Therapy Director revealed Resident #3 was discharged to Restorative Nursing Services for range of motion and splinting on 5/13/25.	F0688	Continued from page 4 Compliance date is 12/01/25.	

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F0688 SS = D	Continued from page 5 An interview was conducted on 9/26/2025 at 9:28 AM with the Restorative Nurse. She stated discharge instructions were given to the Restorative Nurse when a resident transitioned from therapy to restorative services. The discharge instructions were provided on the restorative nursing form which outlined program goals. To her knowledge, the Restorative Nurse had not received a Restorative Services request for Resident #3 on 5/13/25 and he was not on the restorative list. On 9/26/25 at 10:30 AM a phone interview was conducted with the Occupational Therapist who treated Resident #3 and wrote the discharge recommendations dated 5/13/25. She stated the discharge summary goals and interventions would have been documented on a restorative nursing form by the Occupational Therapy Assistant or the Rehabilitation Director. She did not know if a restorative nursing form had been filled out for Resident #3 upon his discharge from OT. She stated that to her knowledge, residents who needed restorative services were discussed during the daily morning stand-up meeting. On 9/26/2025 at 11:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated information regarding restorative nursing was relayed verbally during the morning stand up meeting. She was unaware of any form that would be given to restorative nursing regarding the need for restorative services or the application of splints. The DON stated the physician would have to sign the order for Restorative Nursing and she was unsure why Resident #3's therapy recommended splint had not been implemented. On 9/26/2025 at 1:20 PM an interview was conducted with the Administrator. He stated therapy would make recommendations for restorative services. He stated that the Restorative Nurse would use her nursing judgement on how to carry out therapy recommendations. The Administrator stated the therapy director had recently been replaced which could have been the reason Resident #3 had not received services for applying the therapy recommended left resting hand splint. It was his expectation that residents therapy recommendations be followed until a resident would be reassessed by therapy.	F0688		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4)	F0732	White Oak Manor – Burlington will ensure to provide daily posted nurse staffing sheets that are filled out completely daily and accurately.	12/01/2025

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F0732 SS = C	Continued from page 6 §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to maintain daily nurse staffing sheets	F0732	Continued from page 6 Facility's daily posted nurse staffing sheets for July to August 2025 were noted with 5 missing days of nurse staffing information. An audit of nursing staff postings from 11/01/25 to 11/21/25 will be completed by the Director of Nursing (DON) to ensure the postings are being completed accurately daily. The audit will be completed by 11/28/25. The Director of Nursing (DON), Staffing Coordinator, Nursing Supervisors, and Staff Development Coordinator (SDC) were re-educated by the Corporate Consultant to ensure the daily posted staffing sheets are posted daily and accurately. The re-education will be completed by 11/28/25. Newly hired Nursing Administration, Schedulers, and Licensed Nurses will receive this education during their job specific orientation with the DON or SDC. The DON and/or Nursing Supervisor will monitor by checking the nurse staffing sheets are completed and posted daily for 12 weeks. The identified trends or issues will be discussed weekly during the Morning Quality Improvement (QI) meetings for 12 weeks and then will further be discussed at the monthly Quality Assurance (QA) meetings with the care team for recommendations as indicated. The DON is responsible for the ongoing compliance of F732. Compliance date is 12/01/25.	

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F0732 SS = C	Continued from page 7 for 5 of 62 days reviewed for daily posted nurse staffing information (7/25/25, 7/29/25, 8/3/25, 8/11/25 and 8/15/25). The findings included: Review of the daily nurse staffing sheets posted for 7/1/25- 7/31/25 revealed no information was available for the days of 7/25/25 and 7/29/25. Review of the daily nurse staffing sheets posted for 8/1/25-8/31/25 revealed no information was available for the days of 8/3/25, 8/11/25, and 8/15/25. An interview was conducted with the Nursing Staff Scheduler on 9/26/25 at 3:30 PM. The Nursing Staff Scheduler stated she worked Monday through Friday, and she prepared staff postings for weekends which were given to the weekend supervisor each Friday. The Nursing Staff Scheduler stated she did not know where the weekend supervisor put weekend staffing sheets as they were not returned to her. She stated no weekend posted daily staffing sheets were returned to her since she had worked as the Nursing Staff Scheduler. She did not provide an explanation for the missing nurse staffing information sheets for weekdays. During an interview with the Director of Nursing (DON) on 9/26/25 at 4:00 PM, the DON stated the Nursing Staff Scheduler was responsible for completing and maintaining the daily posted staffing sheets. The weekend supervisor completed daily posted staffing sheets on the weekend and shared changes with the Nursing Staff Scheduler. She did not know why there were missing nurse staffing information sheets. The weekend supervisor was unavailable for interview during the time of the survey. During an interview on 9/26/25 at 4:30 PM, the Administrator stated the Nursing Staff Scheduler was responsible for the daily posted staffing sheets. His expectation was for daily staffing sheets to be accurate and posted daily.	F0732		