STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING ______ B. WING ______	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/13/2021 through 10/14/2021. Event ID# ETQ211 4 of the 4 complaint allegations were not substantiated.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		11/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/05/2021

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WHITE OAK MANOR - CHARLOTTE	**4009 CRAIG AVENUE** **CHARLOTTE, NC 28211**

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F 842	Continued From page 1 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff and MD interviews, the facility failed to document blood glucose	F 842	White Oak Manor-Charlotte ensures the Resident's Clinical Record reflects	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842 Continued From page 2
results for 1 of 3 residents reviewed for professional standards (Resident #1).

Resident #1 was admitted to the facility 2/5/2020 with diagnoses to include diabetes, Alzheimer's Disease, and hypertension. The most recent quarterly Minimum Data Set dated 9/8/21 assessment dated Resident #1 to be severely cognitively impaired and she had received insulin 7 out of 7 days.

A physician order dated 2/5/2020 ordered fingerstick blood sugar (FSBS) to be done before meals and at bedtime. The medication administration record (MAR) for 9/12/2021 documented Resident #1's FSBS to be 133 at 4:30 PM. The 8:00 PM FSBS had "N" documented and Nurse #1's initials. ("N" indicated the medication or task had not been completed.)

Resident #1's medical record was reviewed, and Nurse #1 documented a blood pressure of 130/80 at 8:31 PM. The FSBS was not documented.

Nurse #1 was interviewed on 10/13/2021 at 3:55 PM. Nurse #1 reported he had worked night shift (7:00 PM to 7:00 AM) on 9/12/2021. Nurse #1 explained when he arrived for his shift, Resident #1 was very agitated. Nurse #1 reported he received a physician order for an antianxiety medication to help Resident #1 calm down. Nurse #1 reported after the medication took effect, he was able to get a blood pressure and FSBS on Resident #1 at about 8:30 PM. Nurse #1 reported he had forgotten to document her blood glucose. Nurse #1 stated, "I believe her FSBS was 91." Nurse #1 explained when he went to document the FSBS at about 11:00 PM, he decided to

F 842

documentation of blood glucose to meet professional standards.

Resident #1 blood glucose level is documented in the resident's clinical record when obtained.

Residents with physician orders to check their blood glucose will have the results documented in the resident's clinical record.

Nurse #1 received re-education on documenting blood glucose results when obtained in the clinical record. This education was completed on 10/15/2021 by the Staff Development Coordinator (SDC).

Licensed Nursing Staff received re-education on documenting blood glucose results in the resident clinical record. The education was given by the SDC and completed prior to 11/11/2021.

Newly hired licensed nurses received this education during their job specific orientation with the SDC with the SDC.

The Nurse Administrative Team (Director of Nursing, (DON), SDC, Quality Improvement Manager (QIM) or the Nursing Supervisors will monitor Resident #1 and other residents with physicians orders for blood glucose checks to assure results are documented in the resident's Clinical record daily for two weeks then weekly for four weeks and randomly for two months to assure compliance with

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F 842	Continued From page 3 check Resident #1's FSBS again and when he checked it, the blood glucose level was 37. When asked why he had not documented the FSBS result from 8:30 PM, Nurse #1 reported he did not know why he had documented "N" for the FSBS result on 9/12/2021 at 8:30 PM. The Director of Nursing (DON) was interviewed on 10/14/2021 at 3:53 PM. The DON reported she did not know why Nurse #1 did not document the FSBS at 8:30 PM on 9/12/2021.	F 842	F842. Identified trends will be discussed Monday-Friday in the morning QI (Quality Improvement) meeting for two weeks then weekly for four weeks and monthly for two months, with recommendations for system changes as needed. The DON is responsible for ongoing compliance to F842.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345238	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 10/14/2021
NAME OF PROVIDER OR SUPPLIER **WHITE OAK MANOR - CHARLOTTE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4009 CRAIG AVENUE CHARLOTTE, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 809	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide a resident with an HS (bedtime) snack (Resident #1) for 1 of 1 resident reviewed for HS snacks. Findings included: Resident #1 was admitted to the facility 2/5/2020 with diagnoses to include diabetes, Alzheimer ' s Disease, and hypertension. The most recent quarterly Minimum Data Set dated 9/8/21 assessment dated Resident #1 to be severely cognitively impaired and to require set-up assistance of one person for meals. A nursing note for Resident #1 dated 9/12/2021 at 9:21 PM was reviewed. The note documented the nurse arrived on the unit at 7:15 PM and Resident #1 was in bed and very agitated. The note documented that antianxiety medication was administered to Resident #1 at 8:00 PM and she was noted to be sleeping at 8:25 PM. A meal and snack intake sheet was reviewed. The meal and snack intake sheet documented Resident #1 was offered her HS snack and she accepted the snack at 7:55 PM on 9/12/2021. An interview was conducted with Nurse #1 on 10/14/2021 at 3:55 PM. Nurse #1 reported Resident #1 was extremely agitated on 9/12/2021 from 7:15 PM until 8:20 PM. Nurse #1 reported Resident #1 required medication to help calm her down. Nurse #1 reported Resident #1 was kicking, yelling, and thrashing her legs in the bed. Nurse #2 was interviewed on 10/13/2021 at 4:39 PM. Nurse #2 reported he assisted with Resident #1 on 9/12/2021 during the episode of agitation. Nurse #2 reported Resident #2 was kicking her legs, screaming, and thrashing her legs in bed and would not calm down. Nurse #2 reported once the antianxiety medication was administered to Resident #1 at 8:00 PM, she calmed down and fell asleep about 8:20 PM.

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 809	Continued From Page 1

Nursing assistant (NA) #1 was interviewed 10/14/2021 at 11:07 AM. NA #1 reported she usually passed out the HS snacks to the residents between 8:00 PM and 9:00 PM, and typically Resident #1 would accept the snack and eat all of it. NA #1 reported she did not recall if she delivered an HS snack to Resident #1 on 9/12/2021.

The Administrator was interviewed on 10/14/2021 at 3:55 PM. The Administrator reported if the HS snack was documented as given by NA #1, she believed the snack was given to Resident #1.