STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 08/01/2024

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/29/24 through 8/1/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #TGO411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/29/24 through 8/1/24. Event ID# TGO411. The following intakes were investigated NC00207099; NC00207651; NC00209081; NC00211870; NC00212149; NC00214736; NC00218812; and NC00219703. 9 of the 23 complaint allegations resulted in deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		8/26/24

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

Electronically Signed | 08/21/2024

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F 600	Continued From page 1 Based on resident interviews, staff interview and record review, the facility failed to protect a resident's right to be free from abuse for 1 of 5 residents reviewed for physical abuse. Resident #84 was sent to the emergency room for evaluation due an injury. Resident #84 was hit in the mouth resulting in treatment with Dermabond on his upper lip and a referral was sent to the dentist due to missing tooth on the resident's bridge. (Resident # 84). The findings included: Resident #82 was admitted to the facility on 10/12/19 with diagnoses of neurogenic bladder, cognitive communication deficit, gastrostomy, chronic kidney disease, diabetes, and wounds on the heels. The quarterly Minimum Data Set (MDS) dated 5/21/24 indicated Resident #82 was severely cognitively impaired. Review of Resident #82's care plan dated 10/25/23 revealed the focus area that Resident #82 was at risk for behaviors: socially inappropriate/disruptive behavior by voicing thoughts of self-harm related to neurocognitive disorder and history of alcohol abuse. Resident #82 was at risk for isolation related to history of resident-to-resident altercation and dementia. The goal included episodes of inappropriate aggressive and/or disruptive behaviors would decrease by 50% within specified time frame. The intervention included to talk in calm voice when behavior was disruptive. Remove from public area when behavior is disruptive and unacceptable. Identify causes for behavior and reduce factors that may provoke aggressive behaviors.	F 600	White Oak Manor-Burlington ensures to protect residents' right to be free from abuse, including resident to resident altercations. Resident #84 and Resident #82 were immediately separated, relocated, monitored and Resident #84 was administered care and sent to the hospital for intervention. The facility initiated the abuse protocol which included contacting state agencies. The facility will protect resident #84, resident #82 and current residents' right to be free from abuse. The facility will also protect newly admitted residents' right to be free from abuse. An audit of current residents with similar behaviors and that may have potential for resident to resident altercations was conducted by social services department on 8/26/2024 to ensure appropriate interventions and services are in place and to protect the residents' right from abuse. The facility's staff members were re-educated on abuse protocol which included the protection of residents from resident to resident altercation and the right to be free from abuse. This re-education was completed by staff Development Coordination (SDC) on 8/26/2024. Newly hired facility staff members will receive this education during the job specific orientation bye staff Development Coordinator and/or	

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F 600	Continued From page 2 An interview was conducted on 07/30/24 08:34 AM with Resident #82 who stated he did not recall an incident of hitting another resident and he would not hit anyone unless provoked. He reported he treated everyone well with respect. He was pleasantly confused. Resident #84 was admitted to the facility on 8/5/20 with the diagnoses of benign prostatic hyperplasia dementia, psychotic and mood disturbance, and cognitive communication deficit. The quarterly Minimum Data Set(MDS) 5/21/24 , indicated Resident #84 was severely cognitively impaired and no behaviors. Review of Resident #84's care plan dated 6/26/24 revealed the focus area Resident #84 had tendencies to be verbally antagonizing others and physical towards his roommate and others. The goal included episodes of aggressive behaviors would decrease by 50% within specified time frame. The interventions included approach resident of unacceptability of verbal abuse and reinforce positive behavior. Administer behavior medications as ordered by physician, monitor and document target behaviors using aggression alleviation method., provide diversional activities when resident is having problems, monitor resident in intervals as indicated, removed resident from public area when behaviors is disruptive and unacceptable, praise for demonstration desired behavior, monitor target behaviors and talk in a calm voice when behaviors is disruptive. An interview was conducted on 07/29/24 at 1:53 PM with Resident #84 who stated he and his former roommate did have an altercation based on some words they had between each other.	F 600	Department's Director. The Administrator of Nursing Administration will monitor weekly for 12 weeks by observing 3 residents identified with behaviors and their interactions with residents, and the staff members interactions and interventions with them. The Administrator or Nursing Administrator will also monitor for 12 weeks by renewing the 24-hour report during Morning Quality Improvement (QI) meetings to ensure no resident to resident altercations were noted, but if so, reported to Administration immediately and to appropriate state agencies. Identify trends or issues from the monitoring tools will be discussed during the morning QI meetings, weekly 12 weeks, and then further discussions with the Quality Assurance (QA) committee meetings for recommendations as indicated. The Administrator and Director of Nursing (DON) are responsible for the ongoing compliance of F600. Compliance date is 8/26/2024.	

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Resident #84 stated they had been roommates for a while and he did not have any issues with Resident #82 before the incident, he did not have a real reason for making the statements he did to the other resident. He was aware the roommate had some life issues, and the conversation went too far between them. Resident #84 stated he was hit in the face and had some light bleeding nothing serious resulted in a cut on his lip and a missing tooth. Resident #84 further stated they were separated, and he went to the hospital to get checked out. He reported he had no hard feelings with the other resident and there had been no further interaction. Resident #84 declined feelings of being unsafe or demonstrated any changes in behaviors. He indicated he had no issues on how the facility handled things. He was moved to a different room and things have been fine.

The initial facility investigation summary dated 10/23/23 revealed the alleged victim was Resident #84, his roommate Resident #82 was the perpetrator. The following stated agencies and responsible persons were notified on 10/23/23 at 11:30 AM. The resident -to- resident altercation assessment was done for both residents. Resident #82 was observed by staff hitting Resident #84 in the mouth. Staff immediately interceded and were able to separate Resident #82 and Resident # 84. Resident #84 was sent to the emergency room on 10/23/23 for treatment of an open wound to upper lip with Dermabond to the outer surface. Emergency room recommendations revealed the use of ice to help with swelling and pain. Resident #84 received an antibiotic to help prevent an infection and neuro- checks should be initiated at the facility. Resident #84 also lost a tooth from his

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F 600	Continued From page 4	F 600		

bridge and was sent to the dentist for repairs on 10/27/23, with follow-up visits on 11/6/23 and 11/9/23. There were no other alterations. Resident #84 was placed on 15-minute neuro checks upon return from the emergency room. Resident #82 was moved to another room on a different hall in the facility and placed on one- to-one monitoring. The responsible person and medical director were notified on behalf of both residents.

Review of the hospital summary report dated 10/23/23 revealed Resident #84 was treated for an open wound of his upper lip today. The outer surface was closed using Dermabond. Try to keep Resident #84 from playing or picking at the area. He should apply ice to help with swelling and pain. The open area inside of his mouth should heal but I have placed him on antibiotic to help prevent an infection. Initiate neuro checks at facility and call the on-call provider to have the antibiotic approved to start today. If the areas opened up he should go to ER for stitches.

The 5-day summary investigation dated 10/228/23 read in part: revealed on 10/23//23 it was reported to the Social Worker two roommates had an altercation. Staff heard yelling on A hall wing and observed Resident #82 was on the A wing hallway when he hit Resident #84. Resident #84 was verbally insulting Resident #82 when he stood from the wheelchair and hit Resident #84 in the mouth. Both residents were separated immediately for safety. Resident #82 stated that he did hit Resident #84 because he was calling him names. Resident #84 did admit to this allegation and stated, "he is brown nosing". Resident #82 was immediately placed on 1 to 1 and moved to another room on a different hall.

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Resident #84 was transferred to the emergency room for further evaluation due to cut lip and missing tooth. Resident #84 did receive Dermabond treatment at the emergency room. Resident #84 was sent to the dentist for bridge repair for the missing tooth. Care plan for both residents were updated. Both residents were referred to psych services including talk therapy. Resident #82 agreed to a room change. The abuse protocol in-service was completed. Resident interviews for alert and oriented residents were conducted on abuse. Resident #84 had several dental follow-ups to repair bridge. There were no other altercations between the two residents.

Review of the nursing note dated 10/24/2023 revealed Resident #82 was ambulating via wheelchair up hallway and was involved in altercation with another resident. Separated for safety placed on one to one. A referral for psychiatric service place in the physician notebook. The responsible person was made aware of the altercation and the provider would follow up today.

Review of the Nurse Practitioner note dated 10/24/23 revealed Resident #84 was seen for follow-up visit due to recent treatment at urgent care for an open wound on his upper lip. Following and altercation with another resident who hit him in the face. This caused his upper lip to split, and he lost a tooth. He went to fast med and the laceration on his lip was closed with Dermabond. He was started on antibiotic prophylactically. He has no acute complaints at this time and no concerns were addressed by nursing staff.

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Review of the statement written by dietary staff revealed both residents were on the hall when staff was providing coffee to another resident. Resident #84 was antagonizing Resident #82. Resident #82 attacked Resident #84. The two residents were separated immediately. Resident #84 was bleeding from the mouth. There was no further description of the actual events of the attack. The dietary staff was unavailable for interview.

An interview was conducted on 8/1/24 at 9:59 AM with Staff Development Coordinator who stated she was working in the dining room and heard the end of the resident conversations/interactions, Staff had already separated the two residents and they were taken to their rooms. She noticed Resident #84 had light bleeding around the mouth around the top of lip and missing tooth. The Staff Development Coordinator further stated Resident #84 did wear dentures. She reported she cleaned the lip and applied a steri-strip. Resident#84 was sent to the emergency room for further evaluation and sent to the dentist a few days later. The social worker met with both residents and a decision was made to move residents to different halls. She reported there had been no further incidents between the two residents prior to the altercation or after they were moved to different halls. Nurse stated she did not directly see what happen but provided the treatment following the altercation.

An interview was conducted on 8/1/24 at 10:00 AM with Nurse #6 who stated a nurse aide reported some words were passed between the two residents and Resident #82 hit Resident #84 in the mouth. Nurse #6 reported there had been no prior altercations between the two residents.

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Resident #84 was assessed and sent to the hospital and later to the dentist due to a missing tooth. Resident #84 was moved to another part of the facility.

An interview was conducted on 8/1/24 at 10:30 AM with the Social Worker who stated she was called to the dining area due to a resident- to-resident altercation between Resident #82 and Resident #84. The Social Worker stated it had been reported Resident #84 had been verbally insulting Resident #82 when Resident #82 became upset and stated he was tired of being bullied by the resident and hit the resident in the mouth. Resident #82 only hit Resident #84 once and staff separated the two individuals immediately. Social Worker stated during her investigation there was no report if Resident #84 was hit with an open hand or closed hand. The employee that initially saw the incident and separated the resident was unavailable for interview. Resident #84 had a slight cut on his lip and a tooth was missing. The nursing staff cleaned the lip and sent the resident to the hospital and later to the dentist. She reported Resident #82 was moved to another part of the building to prevent further interaction. She further stated there had been no incidents or behaviors between the two residents prior to the incident. The Social Worker reported she had spoken with Resident #84 about why he was verbally insulting Resident #82. Resident #84 indicated he felt like Resident #82 was a weak person and he did not have a real reason to be saying the things he did. Both residents were referred for psych services and provided with talk therapy to address any emotional concerns. She reported during the interview with Resident #84 he had no ill feelings toward Resident #82. Resident #82 was upset

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with Resident #84 about being insulted and he had not done anything to him, so he popped him in the mouth to shut him up. Resident #82 reported during the interview he had never had a problem before when they were roommates, and he did not understand why the other resident was saying those things to him. The Social Worker reported since the two residents were moved to another part of the building and had limited contact there had been no further incidents between the two. She reported both families were notified of the incident and were satisfied with decision to move Resident #82's room. She further stated both residents were also placed on 15-minute checks for a few days and there was no new development or behaviors.

Administrator #1 who was working at the time of incident was not available for interview.

A telephone interview was conducted on 8/1/24 at 1:20 PM with Nurse Aide #10 who stated the two residents were in the hallway, Resident #84 made verbal insults toward Resident #82. Resident #84 was known to make verbal insults toward Resident #82 and other residents, but the two never had any physical altercations before. Resident # 82 who was very quiet person got tired of Resident #84's verbal insults and he stood up from his wheelchair and hit him hard enough to knock his tooth out and Resident #82 made a statement he was tired of being bullied. Based on the position of both resident Nurse Aide #10 could not tell if the hand was open or closed but it was hard enough for the tooth to fall out. She and a nurse whom she could not recall the name immediately separated the two residents. Resident #82 was moved to another hall. The nurse assessed Resident #84 clean the mouth

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F 600	Continued From page 9 and he was sent to the emergency room and/or dentist. An interview was conducted on 8/1/24 at 2:50 PM with Administrator #3 who stated he was not employed at the facility during the incident. Upon inquiry the facility administrator was unable to identify a performance plan that was implemented at the time of the altercation.	F 600		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to protect the residents' right to be free from misappropriation of a controlled substance medication, oxycodone, which was prescribed for Resident #9 and a combination medication containing oxycodone and acetaminophen prescribed to treat pain which was prescribed for Resident #225. The facility also failed to protect a resident's right to be free from the misappropriation of a bottle of alcohol prescribed for the resident (Resident #42). This occurred for 3 of 3 residents reviewed for misappropriation of property. Findings included:	F 602	White Oak Manor Burlington ensures residents are free from misappropriation including the residents prescriptions for controlled substance medication, pain medication and prescribed alcohol. Resident #9, Resident #225 discharged on 9/26/2023 and has not returned to facility, and Resident #42 have their medications available including pain medication and prescribed alcohol. Newly admitted residents will be free from misappropriation. The facility initiated the abuse protocol which included contacting state agencies.	8/26/24

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F 602	Continued From page 10 1. Resident #9 was readmitted to the facility on 3/4/24. Review of the Quarterly Minimum Data Set (MDS) assessment dated 6/12/24 revealed Resident #9 was admitted on 4/29/22. The assessment indicated the resident was assessed as cognitively impaired. Resident #9 had an order dated 12/9/23 for oxycodone 5 milligrams (mg) every 6 hours. Review of Resident #9's Medication Administration Record (MAR) for January 2024 revealed the medication was documented as administered every 6 hours as ordered by the physician. Review of Resident #9's "Individual Resident's Narcotics Record" (used to keep track of declining inventory/ doses of oxycodone) from 12/27/23 to 1/11/24 revealed as of 1/4/24 at 6 PM the amount of oxycodone 5 mg remaining was 33 pills. Review of the initial report regarding diversion of facility drugs dated 1/12/24 revealed the facility was made aware of missing medications on 1/11/24 at 2:30 PM. The report details read in part "Narcotics were delivered to cart 2 Nurses [Nurse #11 delivered the Narcotic to Nurse #6 and Nurse #12]. Witnessed being delivered at shift change. Number was correct." After the day shift nurse (Nurse #6) left, the night shift nurse (Nurse #12) did not place medication in the medication drawer and count sheet was not placed in the book. The report documented law enforcement was notified. Review of the Pharmacy consolidation delivery	F 602	An audit completed by Nursing Administration on 8/20/2024 of current residents to ensure no other residents had misappropriation of property including prescribed medications and alcohol. Narcotics are received from White oak Pharmacy and the quantity is verified and signed in by two nurses, then placed inside the lock box of the medication carts. Prescribed alcohol is brought in by residents' family or purchased by the social services department. When alcohol is received on the unit, the amount is verified and recorded on a sign out sheet, then is placed into a locked refrigerator. At every shift change both narcotics and prescribed alcohol are counted with the off going and oncoming nurses taking responsibility for that unit. In the event that a resident discharges or is no longer in our facility, all discharged medications are given to the DON, counted with her, and then she places in a double locked cabinet until the medications can be destroyed with the state agency. Any alcohol remained in the facility after a resident discharges would be wasted with the DON and a second nurse, then documented on the sign out sheet. Current and newly admitted residents prescribed alcohol will have alcohol stored in locked refrigerator. The Administrator will keep possession of all reportables to the state for now on. The facility staff members were	

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F 602	Continued From page 11 sheet dated 1/4/24 revealed 120 tablets of oxycodone 5 mg were delivered to the facility for the resident. This was signed by Nurse #10 and dated 1/4/24. Review of the Investigation Report dated 1/18/24, revealed the incident was investigated under diversion of facility drugs. The incident occurred on 1/5/24 and the facility was made aware of the incident on 1/11/24 at 2:20 PM. The medication was delivered to A1 wing medication cart. The medication was oxycodone 5 mg x 120 (the count of pills). Resident #9 had more medication in the drawer and did not go without medication. Nurse #12 was suspended for investigation and later terminated. The allegation was substantiated. During an interview on 7/31/24 at 4:45 PM, Nurse #9 stated she was the weekend supervisor. Nurse #9 stated it was during one of the weekends in January (date unknown) the nurse (name unknown) had contacted the pharmacy for Resident #9's medication refills of oxycodone. Nurse #9 indicated the nurse was informed by the pharmacy the medications were refilled recently and delivered to the facility. Nurse #9 indicated she was notified by the nurse (name unknown). Nurse #9 stated the previous Director of Nursing (DON) was immediately notified about the medications (oxycodone) had been delivered to the facility but were unavailable on the cart. Nurse #9 indicated Resident #9 had some medication (oxycodone) and was never without any medication (oxycodone). It was only because the medications (oxycodone) were running low, the pharmacy was called for a refill. Nurse #9 stated the previous DON did an investigation regarding missing narcotic medications.	F 602	re-educated on the abuse protocol which included misappropriation of residents property. This re-education was completed on 8/26/2024 by the SDC. Newly hired facility staff members will receive this education during their job specific orientation by the SDC or Department s Director. The Administrator or Social Services Department will monitor by conducting 3 resident/resident representative interviews weekly for 12 weeks to ensure prescribed medication and alcohol are not misappropriated. The DON will perform weekly medication cart checks to ensure that prescribed narcotics and alcohol are available and stored appropriately. She will also monitor the narcotic count sheets and alcohol sign out sheets during this weekly check to ensure there are no signs of diversion. Weekly monitoring/checks will be completed for 12 weeks. Identified trends or issues from the monitoring tool will be discussed during Morning QI meetings weekly for 12 weeks, and then further discussions with the QA Committee meetings for recommendations as indicated. The Administrator and DON are responsible for the continued compliance of F602. Compliance date is 8/26/24.	

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During an interview on 7/31/24 at 2:28 PM, Nurse Practitioner #1 stated the resident had a diagnosis of stiff person syndrome. Oxycodone was administered for pain management. Nurse Practitioner #1 further stated that a nurse (name unknown) had requested a refill. The resident was on scheduled oxycodone medication at that time and 120 medication pills were ordered. Nurse Practitioner #1 indicated it was a week later, when she received another request for a refill. Nurse Practitioner #1 stated she made the facility aware that the medication prescription order was recently filled on 1/4/24. It was then the facility became aware of the missing Narcotics and started to investigate. The medications were delivered to the facility on 1/4/24 but were not placed in the medication cart. Nurse Practitioner #1 indicated the resident never went without pain medication and her pain was controlled. Resident #9 received all her medications as ordered. A new prescription refill was provided due to drug diversion.

During a telephone interview on 7/31/24 at 11:00 AM, the Pharmacist with the dispensing pharmacy stated on 1/4/24 the dispensing pharmacy sent out to the facility a "continuation of schedule medication therapy" form. This was a form from that the dispensing pharmacy computer system would print and send to the facility when their current prescription was going to expire. A new prescription was needed for a refill. This form would then be completed by the facility physician along with the re-order and faxed back to the pharmacy. The new medication would then be sent out to the facility. The Pharmacist stated they received the form back from the facility on 1/4/24 that was signed by the Nurse Practitioner #1. The Pharmacist

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indicated based on the physician orders in January 2024, Resident #9 was on oxycodone 5 mg, one table every 6 hours. 120 pills of oxycodone 5 mg medication were dispensed in the resident's name and sent to the facility on the night of 1/4/24. The Pharmacist further stated that on 1/12/24 she received an internal email related to drug diversion and a copy of the initial investigation report sent to the North Carolina Department of Health Regulations. There was also a note from the Director of Nursing to bill the facility and not the resident due to drug diversion. The medication was refilled and sent to the facility.

During a telephone interview on 7/30/24 at 3:05 PM, the previous Director of Nursing (DON) stated she was made aware of missing oxycodone medication when the nurse (name unknown) tried to reorder the medication (oxycodone) over the weekend (date unknown). The pharmacy had indicated they had delivered the medications to the facility on 1/4/24. Nurse #11 (Unit Supervisor for C- wing) had given these medications to A1 cart nurses on 1/5/24. The incoming nurse (Nurse #12) was now in-charge of the A1 medication cart, and he did not place the medications in the cart or log the medications in the Narcotic sheet. The next day Nurse #12 was off on a vacation for about a week. DON stated the medications were delivered to the medication cart on 1/5/24 and the facility became aware of the medications missing on 1/11/24. The resident did not go without medication as she had an adequate supply of medication at that time in the medication cart. The DON indicated there were 120 tablets of oxycodone 5 mg missing. The DON stated she immediately started her investigation of drug diversion (oxycodone 120

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tablets). She indicated a drug test was done on the nurses who were involved with the resident's missing medication. Nurse #12 was suspended pending investigation due to being the last person who was known for being responsible for the missing medication. State Agencies and Law enforcement were notified about facility drug diversion.

Nurse #11 and Nurse #12 were unavailable for interviews.

3 . Resident #42 was readmitted to the facility on 8/25/17

Review of Physician orders for Resident #42 dated 12/5/22 read in part, "3 ounces of bourbon [alcohol] by mouth at bedtime as needed for sleep/pleasure."

Review of the Petty Cash Receipt dated 11/28/23 revealed the facility repurchased 750 milliliter (ml) bottle of bourbon (alcohol) for Resident #42. An amount of appropriately 20 dollars was paid from the facility petty cash.

Review of the Grievance log from October 2023 to June 2024 revealed Resident #42 had no grievances filed.

Review of the Quarterly Minimum Data Set (MDS) dated 7/10/24 revealed Resident #42 was admitted on 12/5/14. The resident was assessed as cognitively intact.

During an interview on 07/31/24 03:41 PM, Resident #42 indicated he received alcohol when he requested and had no concerns. The resident

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further indicated the nursing staff was providing him with alcohol as ordered by the physician.

During an interview on 7/31/24 at 9:50 AM, the Social Worker Director stated Resident #42 had a prescription from the physician for 3 ounces of alcohol as needed. The Social Worker Director further stated she purchased the alcohol for the resident using his personal fund. The Social Worker stated based on the receipts, she had made one purchase between November 2023 to January 2024. The alcohol was stored in the medication storage room in the locked refrigerator. The nurses had access to the locked medication room and could administer the alcohol upon request.

During a telephone interview on 8/1/24 at 2:30 PM, Nurse #8 stated he worked weekends from 7 AM - 7 PM and was assigned to the C- wing. He indicated there was a resident on the C-wing who had an order for alcohol and was supposed to receive alcohol as he needed. Nurse #8 stated on a weekend (date unknown) when he was taking alcohol for the resident, he noticed there was a little amount that was remaining in a bottle and there was no new bottle in the refrigerator. Nurse #8 stated the Social Worker Director was notified as she frequently purchased alcohol for the resident. The Social worker when contacted indicated she had recently purchased a new bottle and given it to a nurse (name unknown). Nurse #8 further stated he was unable find the new bottle of alcohol and an investigation was conducted by the previous DON. He indicated he had provided a written statement regarding the incident.

The Social Worker Director was interviewed

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again on 8/1/24 at 8:14 AM. She indicated she was contacted by the previous Director of Nursing (DON) on a weekend (date unknown) requesting her to purchase a bottle of bourbon for the resident. The Social Worker Director stated based on the receipt she had purchased a new 750 ml bottle of bourbon on 10/17/23 and 11/21/23. She further stated she notified the previous DON that a bottle was purchased recently and was given to a nurse (name unknown). The Social Worker Director indicated based on the receipt a new bottle of alcohol was purchased using facility funds on 11/27/23 as the previous bottle was not found. The Social Worker Director stated no further information was provided to her by the previous DON. The Social Worker Director further stated the facility funds were used to replace the missing bottle.

During a telephone interview on 8/1/24 at 8:00 AM, the previous Director of Nursing (DON) stated she did recall a resident residing at the facility with a physician order for alcohol as needed. The previous DON indicated the alcohol bottle was placed in the locked refrigerator in the medication room. The nurses assigned to the medication carts had access to the locked medication room and the locked refrigerator. She further indicated that on one occasion (date unknown), over the weekend, she was made aware by Nurse #9 that the resident needed a new bottle of alcohol as the bottle in the refrigerator was almost empty. The DON stated she did contact the Social Worker Director to purchase a new bottle of alcohol for the resident so that it was available to the resident the next time he requested it. The DON indicated she was informed by the Social Worker Director that she had recently purchased a bottle of alcohol for the

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resident and had given the bottle to a nurse (name unknown) to be placed in the medication refrigerator. The previous DON stated she wrote a grievance in the name of resident and an investigation was conducted. During the investigation she could not identify the staff who had taken the bottle of alcohol. Staff were interviewed and written statements were taken. The facility replaced the bottle of alcohol for the resident at the cost of the facility.

2. Resident #225 was admitted to the facility on 8/15/23 from a hospital. His cumulative diagnosis included peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and lower extremity lymphedema (swelling caused by a buildup of lymph fluid in the body between the skin and muscle).

A review of the resident's electronic medical record (EMR) revealed his physician's orders included an order dated 8/16/23 for 10 milligrams (mg) / 325 mg oxycodone / acetaminophen (a combination medication containing an opioid and an over-the-counter pain medication) to be administered as one tablet by mouth every 8 hours as needed (PRN) for pain for 14 days. This combination medication containing oxycodone is a controlled substance medication.

A telephone interview conducted on 7/31/24 at 10:43 AM with a dispensing pharmacist at the facility's contracted pharmacy revealed 42 tablets of 10 mg / 325 mg oxycodone / acetaminophen were dispensed from the pharmacy for Resident #225 on 8/16/23.

Resident #225's August 2023 Medication

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Administration Record (MAR) indicated one tablet of the prescribed oxycodone / acetaminophen was given to the resident on 8/17/23 at 7:51 AM. On 8/19/23 at 1:29 PM, Nurse #13 documented she administered one dose of oxycodone / acetaminophen to Resident #225. According to the MAR, Resident #225 did not receive any doses of oxycodone / acetaminophen on 8/20/23 or 8/21/23.

A Facility Investigation Report dated 8/22/23 and signed by the facility's Director of Nursing (DON) revealed the facility became aware of an allegation of the misappropriation of Resident #225's property on 8/22/23 at 1:05 PM. The summary of the Investigation Report read in part, "Interviewed resident that stated he requested pain medicine. Nurse told resident he no longer had a prescription ..." Nurse #13 was identified as the "Accused Employee" for the diversion of the resident's medication. The allegation details reported Nurse #13 was interviewed and verbally admitted to taking 42 tablets of Resident #225's oxycodone / acetaminophen from the medication cart. The nurse came to the facility and returned 25 of the tablets. The Investigation Report indicated Nurse #13 was "immediately terminated" on 8/22/23. This report also noted the nurse was reported to the local law enforcement, State Bureau of Investigation (SBI), and the Board of Nursing.

An interview was conducted on 7/30/24 at 1:21 PM with the facility's Administrator. During the interview, the Administrator reported he came to work at the facility on 11/30/23 (after the incident involving the misappropriation of Resident #225's medication had occurred). When asked, the Administrator stated the facility could not locate

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any record(s) related to this incident.

A telephone interview could not be conducted with Nurse #13. No current contact information was available.

A telephone interview was conducted on 7/31/24 at 12:10 PM with the former Director of Nursing (DON) who submitted the Facility Investigation Report regarding the misappropriation of Resident #225's controlled substance medication. During the interview, the former DON recalled the situation and stated the nursing staff knew the resident's medication had been delivered by the pharmacy. She reported that after talking with Resident #225, she called Nurse #13. The nurse met her in the facility's parking lot and returned some of the missing tablets. When asked as to whether the resident experienced pain due to the misappropriation of his oxycodone / acetaminophen, the former DON reported he was kept comfortable until the medication was replaced. At that time, this medication was not kept in the facility's Emergency medication kit. She stated the facility's Nurse Practitioner was in the building when the oxycodone / acetaminophen was identified as missing so she wrote a new prescription for Resident #225 medication. The facility's back-up pharmacy filled this prescription, and the former DON picked it up from the pharmacy on 8/22/23 to ensure the resident had the medication available when needed. She added that she herself "kept checking on him to be sure he was comfortable" and she reiterated that he was. Upon inquiry, the former DON recalled that in addition to the local law enforcement, SBI, and the Board of Nursing, the misappropriation of Resident #225's controlled substance medication was also

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F 602	Continued From page 20 reported to the Drug Enforcement Agency (DEA). During a telephone interview conducted on 7/31/24 at 10:43 AM, a dispensing pharmacist at the facility's contracted pharmacy confirmed 15 tablets of 10 mg / 325 mg oxycodone / acetaminophen were dispensed from the back-up pharmacy for Resident #225 on 8/22/23. An interview was conducted on 8/1/24 at 4:05 PM with the facility's Assistant Business Office Manager in the presence of the Admissions Coordinator. During the interview, the staff members reported the facility paid for the replacement of Resident #225's oxycodone / acetaminophen. The facility's former Administrator was not available for an interview. A follow-up interview was conducted on 8/1/24 at 5:11 PM with the facility's current Administrator. He confirmed there was no documentation of this incident available for review, stating, "The entire file is gone." The Administrator reported that since he was not working at the facility in August of 2023, he could not address what was done (or should have been done) with regards to the misappropriation of Resident #225's medication.	F 602		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		8/26/24

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F 607	Continued From page 21 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to follow their policy on Neglect, Abuse, Mistreatment, Threatened or Alleged Abuse of Residents to maintain documented evidence of a thorough investigation of an allegation of abuse for 1 of 5 residents (Resident #175) reviewed for abuse and of an allegation related to the misappropriation (diversion) of medication for 1 of 3 residents (Resident #225) reviewed for the misappropriation of property. The facility also failed to implement measures to prevent further potential for abuse and maintain documented evidence of the corrective action taken after the misappropriation was verified	F 607	White Oak Manor Burlington will ensure to follow the Neglect, Abuse, Mistreatment, Threatened or alleged Abuse of residents policy by maintaining the documented evidence of a thorough investigation of an allegation of abuse and measures to prevent further potential of abuse and maintain documentation of evidence for corrective actions taken after the misappropriation was verified to prevent recurrence of the abuse, and implement the abuse policy in the areas of reporting by submitting the Initial and Investigation reports to the state agency	

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F 607	Continued From page 22 (including whether more systemic actions were necessary to prevent recurrence of the situation) during these investigations. In addition, the facility failed to implement their policy in the areas of reporting by not submitting the Initial and Investigation Report to the State Regulatory Agency after the facility became aware of a bottle of alcohol prescribed for the resident missing for 1 of 3 resident (Resident #42) reviewed for the misappropriation of property. The deficient practice had the potential to affect other facility residents. The findings included: 1. Review of the annual abuse neglect policy that was updated 5/7/24 read in part: revealed the facility protocol included an investigation checklist which included a review of the staff schedule, interview(s) of employees directly involved and witness(es) who observed or had knowledge of the alleged incident or injury and complete statements of the event, interview the resident, other residents, visitors, vendors, and complete witness(es) statements of the event. A telephone interview on 7/31/24 at 1:57 PM with Administrator #2 indicated the abuse policy dated 5/7/24 was the same policy that was in place in August of 2023. Resident # 175 was admitted to the facility on 6/28/22. The annual Minimum Data Set(MDS) dated 12/14/23 revealed Resident #175's cognition was moderately impaired. The facility 24- hour incident report dated 8/31/23 at 11:00 AM, revealed the facility was made	F 607	after the facility becomes aware of misappropriation of residents property. Resident #175 was discharged from the facility on 3/4/2024. Resident #225 was also discharged on 9/26/2023. Resident #42's alcohol was replaced by the facility. Current and newly admitted residents will be free from abuse and misappropriation. The facility initiated the abuse protocol which included contacting state agencies. Current and newly admitted residents prescribed alcohol will have alcohol stored in locked refrigerator. The Administrator will keep possession of all reportables to the state for now on. The facility staff members were re-educated on the abuse protocol which included the Neglect, Abuse, Mistreatment, Threatened or alleged Abuse of residents policy and protocol by maintaining the documented evidence of a thorough investigation of an allegation of abuse, measures to prevent further potential of abuse, maintain documentation of evidence for corrective actions taken after the misappropriation is verified to prevent recurrence of the abuse, and implement the abuse policy in the areas of reporting by submitting the Initial and Investigation reports to the state agency after the facility becomes aware of misappropriation of residents property. This re-education was completed by the Corporate Consultant on 8/23/2024. Newly hired facility staff members will	

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F 607	Continued From page 23 aware by Resident #175 that Nurse Aide #7 had hit him in the chest, face and legs. A telephone interview was conducted on 7/30/24 at 12:15 PM with the responding officer who stated he responded to the call at the facility on 8/31/24 for an allegation of abuse by staff. He reported the resident was interviewed and pictures were taken, no evidence of physical abuse was observed per nursing assessment or pictures. The 5-day summary of investigation completed by the previous Administrator #1, on 8/31/23 revealed no evidence a written statement was obtained from Resident #175 or Nurse Aide #7 and no evidence of interviews or written statements with witnesses (Nurse Aide #8, Nurse Aide #9 or Nurse #7) who observed or had knowledge of the alleged incident or injury or interviews with other residents who may have had contact with the Nurse Aide #7. A telephone interview was conducted on 7/30/24 at 12:15 PM with the responding officer who stated he responded to the call at the facility on 8/31/24 for an allegation of abuse by staff. He reported the resident was interviewed and pictures were taken, no evidence of physical abuse was observed per nursing assessment or pictures. An interview was conducted on 7/31/24 at 8:58 AM, with Nurse #7 who stated Administrator #1, previous Director of Nursing and Social Worker were notified at the time of incident of the allegation of abuse on 8/31/24. The Social Worker came to the facility and interviewed the resident and staff. All the staff involved reported	F 607	receive this education during their job specific orientation by the SDC and/or Department□s Director. The Administrator or Nursing Administration will also monitor for 12 weeks by reviewing the 24-hour report during Morning Quality Improvement (QI) meetings to ensure the Abuse policy is being initiated, reported immediately to Administration and to appropriate state agencies, investigated thoroughly including written statement from resident and staff interviews to prevent recurrence of the allege abuse. Identified trends or issues from the monitoring tools will be discussed during the morning QI meetings, weekly for 12 weeks, and then further discussions with the Quality Assurance (QA) Committee meetings for recommendations as indicated. The Administrator and DON are responsible for the ongoing compliance of F600. Compliance date is 8/26/24.	

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verbally and wrote they did not witness any alleged abuse by Nurse Aide #7. Nurse Aide #7 was sent home following the interview. Nurse #7 stated full body assessments were done on residents that received care by the alleged Nurse Aides and all the information was submitted to management. She was unaware of what happened to the information after submission to management.

An interview was conducted on 7/31/24 at 9:11 AM with the Social Worker who stated she spoke with Nurse Aide #7 on 8/31/23 about the allegation of abuse. The Social Worker stated Nurse Aide #7 wrote in a statement on 8/31/23 , he did not hit Resident #175 and Nurse Aide #7 was upset about assisting Nurse Aide #8 and Nurse Aide #9. Nurse Aide #7 was not specific about anything happening during the care. She further stated she was unable to find any of the information related to the investigation that had been completed in the former administration or director of nursing files.

Resident #175 was not available for interview.

A telephone interview was conducted on 7/31/24 at 7:30 AM, the Nurse Aide #7 who stated he did not recall any incident where he was alleged to hit a resident. He stated he had not worked at the facility for a long time.

A telephone interview was conducted on 7/30/24 at 1:10 PM, with Nurse Aide #8 who stated she wrote a statement on 8/31/24 when asked about Nurse Aide #7 abusing Resident #175. Nurse Aide #8 stated she did not observe Nurse Aide #7 do anything to the resident.

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A telephone interview was conducted on 7/31/24 at 8:05 AM with Nurse Aide #9 who stated on 8/31/23 she was providing care for Resident #175 with Nurse Aide #7 and #8. She stated at no time was the resident hit or abused by anyone in the room. Nurse Aide #9 stated she wrote a statement stating that she did not see Nurse #7 hit the resident.

A telephone interview was conducted on 7/31/24 at 1:46 PM with the former Director of Nursing who stated she obtained statements on 8/31/23 from all the employees involved in the allegation of abuse and the police department came and interviewed Resident #175 and took pictures, skin assessments were done on all the residents on the hall the resident resided on, and the Social Worker did interviews with the residents. She indicated the information was given to Administrator #1 who did all the reports to the state agencies. She was unaware of what happened to the investigation reports.

A telephone interview on 7/31/24 at 1:57 PM, with Administrator #2 who stated the abuse file was kept in the file cabinet in the administrator's office and there were staff statements, training records and the reportable information. Administrator #2 stated the full investigation was completed by Administrator #1.

Administrator #1 was not available for interview.

An interview was conducted on 7/31/24 at 8:36 AM with the current Administrator who stated he was unable to find any part of the investigation for this 8/31/23 abuse allegation for Resident #175. He indicated the only information available was what was submitted to the state.

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2. The facility's Policy and Procedure entitled Neglect, Abuse, Mistreatment, Threatened or Alleged Abuse of Residents (Revised 5/2017; Reviewed on 5/7/2024) specified that neglect, abuse, exploitation, mistreatment, threatened or alleged abuse of residents included "Misappropriation of resident property." Misappropriation of resident property was defined as meaning "the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." The Investigative Procedures outlined within this Policy and Procedure indicated the facility's Investigative Process for an Unknown Cause or Alleged Abuse included placing details of the investigation in an investigation file and taking corrective action.

Resident #225 was admitted to the facility on 8/15/23 from a hospital. His cumulative diagnosis included peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and lower extremity lymphedema (swelling caused by a buildup of lymph fluid in the body between the skin and muscle).

A Facility Investigation Report dated 8/22/23 revealed the facility became aware of an allegation of the misappropriation of Resident #225's property (related to drug diversion) on 8/22/23 at 1:05 PM. The summary of the Investigation Report read in part, "Interviewed resident that stated he requested pain medicine. Nurse told resident he no longer had a prescription ..." Nurse #13 was identified as the "Accused Employee" for the diversion of the resident's medication. The allegation details reported Nurse #13 was interviewed and verbally

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admitted to taking 42 tablets of Resident #225's oxycodone / acetaminophen from the medication cart. The nurse came to the facility and returned 25 of the tablets. The Investigation Report indicated Nurse #13 was "immediately terminated" on 8/22/23. The Facility Investigation Report also noted the following:
"Corrective Actions taken following the incident:
--Called Nurse [Nurse #13] back to facility, met with Admin. [Administrator and] DON [Director of Nursing]
--Terminated
--Reported to [local] Police Dept. [Department]
--Reported to NC BON [North Carolina Board of Nursing]
--Reported to NC SBI [North Carolina State Bureau of Investigation]."

An interview was conducted on 7/30/24 at 1:21 PM with the facility's Administrator. During the interview, the Administrator reported he came to the facility on 11/30/23 (after the incident involving misappropriation of Resident #225's medication). When asked, the Administrator stated the facility could not locate any record(s) related to this incident. A follow-up interview was conducted with the Administrator on 7/31/24 at 8:35 AM to inquire if any information related to the facility's investigation and corrective action for the diversion of Resident #225's medications had been located. The Administrator stated, "I have nothing for that, it's just not here."

On 8/1/24 at 12:30 PM, an interview was conducted with the Administrator. At that time, additional information on the facility's Neglect, Abuse, Mistreatment, Threatened or Alleged Abuse of Residents (Revised 5/2017; Reviewed on 5/7/2024) Policy and Procedure was provided.

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When specifically asked, the Administrator reported this Policy and Procedure also applied to the misappropriation of a resident's property.

Another follow-up interview was conducted on 8/1/24 at 5:11 PM with the Administrator. At that time, the Administrator reiterated the facility did not have information on the investigation or corrective action taken with regards to the misappropriation of Resident #225's medication. The Administrator explained that since he was not working at the facility in August of 2023 when this incident occurred, he did not know what may have been put into place following this incident.
3 . The facility's Policy and Procedure entitled Neglect, Abuse, Mistreatment, Threatened or Alleged Abuse of Residents (Revised 5/2017; Reviewed on 5/7/2024) specified that neglect, abuse, exploitation, mistreatment, threatened or alleged abuse of residents included "Misappropriation of resident property." Misappropriation of resident property was defined as meaning "the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."

The facility's Policy and Procedure entitled Plan for the prevention of Elder Abuse (reviewed on 5/7/24) specified that it was the responsibility of all employees to promptly report theft or misappropriation of the resident property to facility management. The policy read in part "The report of the initial investigation will be telephoned or faxed to the appropriate State Agency". The facility would complete the investigation following investigation procedures outlined in the abuse and neglect manual. A five (5) day report would be filed to the State Agency summarizing the

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investigation, corrective action taken and outcome of the investigation.

Review of Physician Orders for Resident #42 read in part " 3 ounces of bourbon by mouth at bedtime as needed for sleep/pleasure."

Review of the Petty Cash Receipt dated 11/28/23 revealed a replacement bottle of bourbon was purchased for Resident #42. The 750 milliliter (ml) bottle of bourbon costed approximately 20 dollars and was paid by the facility.

During a telephone interview on 8/1/24 at 8:00 AM, Previous Director of Nursing (DON) stated she did recall a resident residing at the facility with a physician order for alcohol as needed. DON indicated the alcohol bottle was placed in the locked refrigerator in the medication room. The nurses on the medication cart had access to the locked medication room and the refrigerator. She further indicated that on one occasion (date unknown), over the weekend, she was made aware by Nurse #9 that Resident #49's alcohol bottle was almost empty, and a new bottle of alcohol was needed to be purchased for future use. The DON stated she did contact the Social Worker Director to purchase a new bottle of alcohol for the resident so that it was available to the resident the next time he requested it. The DON indicated she was informed by the Social Worker Director that she had recently purchased a bottle of alcohol for the resident and was given to a nurse (name unknown) to be placed in the medication refrigerator. The DON stated she wrote a grievance in the name of resident and an investigation was conducted. During the investigation she could not identify the staff who had taken the bottle of alcohol. Staff were

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interviewed and written statements were taken. The DON stated she was unable to identify the staff responsible for missing alcohol bottle. The facility replaced the bottle of alcohol for the resident. DON indicated she did not submit any initial or investigation report to the State Agency.

During an interview on 7/31/24 at 9:50 AM, the Social Worker Director stated Resident #42 had a prescription from the physician for 3 ounces of alcohol as needed. The Social Worker Director further stated she purchased the alcohol for the resident using his personal fund. The Social Worker stated based on the receipts, she had made one purchase between November 2023 to January 2024. The alcohol was stored in the medication storage room in the locked refrigerator. The nurses had access to the locked medication room and could administer the alcohol upon request.

The Social Worker Director was interviewed again on 8/1/24 at 8:14 AM. She indicated she was contacted by the previous Director of Nursing (DON) on a weekend (date unknown) requesting her to purchase a bottle of alcohol for the resident. The Social Worker Director stated based on the receipt she had purchased a new bottle of alcohol on 10/17/23 and 11/21/23. She further stated she notified the previous DON that a bottle was purchased recently and was given to a nurse (name unknown). The Social Worker Director indicated based on the receipt a new bottle of alcohol was purchased using facility funds on 11/27/23 as the previous bottle was not found. The facility funds were used to replace the missing bottle.

During an interview with the Administrator on 8/01/24 at 10:06 AM, he was hired end of

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F 607	Continued From page 31 November 2023, but immediately after hire was out due to COVID-19. He indicated he was unaware of any bottle of alcohol that was missing. He stated that if the previous DON had done an investigation, then the facility was unable to find and/or provide the surveyor any files or written documents related to the missing bottle of alcohol.	F 607		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to provide nail care to a resident dependent on staff. This occurred for 1 of 4 residents (Resident #16) reviewed for activities of daily living (ADL) care. The findings included: Resident # 16 was admitted to the facility on 6/11/24 with diagnoses including diabetes mellitus. Review of the recent admission Minimum Data Set (MDS) assessment, dated 6/18/24, revealed him as having intact cognition. The resident required extensive assistance with activities of daily living (ADL), including personal hygiene. He had no behaviors or rejection of care. Review of the plan of care, dated 7/11/24, revealed that Resident #16 had ADL selfcare performance deficit, with goals and interventions,	F 677	White Oak Manor – Burlington ensures residents dependent on Activities of Daily Living (ADL) receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene including nail care. Residents #16 was provided with nail care with trimming and cleaning on 7/31/2024 when noted during survey, and will be provided with nail care as needed. An audit was completed by Nursing staff of current residents' nails on 8/06/2024 to identify any residents in need of nail care (trimmed and cleanliness). Current and newly admitted residents will be provided with nail care as needed. Central Supply Manager will stock all nail supplies on each unit and will continue to check the stock and refill the supply on a weekly	8/26/24

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F 677	Continued From page 32 including for staff to provide assistance with bathing and personal hygiene. On 7/29/24 at 11:05 AM, during the observation/interview, Resident #16 was in bed, dressed and groomed. His bilateral fingernails were observed to be long (approximately one inch extended over the edge of his fingertip) with a visible dark substance under his nails. This observation was for 8 of 10 fingernails. The resident indicated that he asked the staff last week (did not recall the date or staff member name) to trim his fingernails. The staff member promised to do it later and never did. On 7/30/24 at 1:25 PM, during an observation/interview, 8 of 10 of Resident #16's fingernails were observed to be long with a visible dark substance under them. The resident indicated that nobody trimmed his fingernails on the day of the interview. On 7/31/24 at 10:00 AM, during an interview, Nurse Aide #1 indicated she was assigned for Resident #16 at first shift on 7/29/24, 7/30/24 and 7/31/24. Nurse Aide #1 stated she was aware Resident #16's fingernails were long with a visible dark substance underneath the nails. Nurse Aide #1 continued that Resident 16's fingernails should be checked every shift for cleanliness and trimmed if needed. She said Resident #16's nail care was not completed and his fingernails needed to be trimmed and cleaned. On 7/31/24 at 10:15 AM, during an interview, Nurse #1 indicated she was assigned for Resident #16. She mentioned that Resident 16's nails should be checked daily, trimmed and cleaned if needed.	F 677	basis. The nursing staff members were re-educated on nail care by the SDC on 8/26/2024. Newly hired nursing staff members will receive this education during their job specific orientation by the SDC. Nursing Administration will monitor by randomly observing 5 residents nails weekly for 12 weeks to ensure compliance. Results of the monitoring will be discussed weekly during Morning QI meetings for 12 weeks, and then further discussions with the QA Committee meetings for recommendations as indicated. The DON is responsible for ongoing compliance for F677. Compliance date is 8/26/24.	

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F 677	Continued From page 33 On 7/31/24 at 10:30 AM, during an interview, Nurse #2, Unit Manager, indicated that nail care should occur as needed. Nurse #2 stated Resident 16's fingernails should be trimmed and checked for cleanliness. On 8/1/24 at 10:00 AM, during an interview, the Administrator expected the staff to monitor residents' nails and trim them on time.	F 677		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Responsible Party and facility staff the facility failed to ensure 1 of 1 resident (Resident #76) was transported to a scheduled oncology follow-up appointment. Findings included: Resident #76 was admitted to the facility on 8/4/2023 with diagnosis of dementia and cancer. Review of Resident #76's medical record revealed she had a Physician's Order for Anastrozole one milligram once daily for chemotherapy related to breast cancer. A quarterly Minimum Data Set assessment dated 5/21/2024 indicated Resident #76 was severely cognitively impaired.	F 745	White Oak Manor □ Burlington ensures residents are transported to their scheduled out-of-facility follow up appointments. Residents #76□s oncology follow up appointment is rescheduled for 9/5/24. Resident #76 will be transported by the facility□s Transport Scheduler. An audit was completed by the Transportation Scheduler of current residents□ of similar situations for out-of-facility follow up appointments on 8/23/2024 to ensure transportation is scheduled for out-of-facility follow up appointments. Current and newly admitted residents will be provided with transportation for their scheduled	8/26/24

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F 745	Continued From page 34 During an interview with the Responsible Party on 7/29/2024 at 11:29 am he stated Resident #76 was not transported to a previously scheduled oncology appointment for follow-up for breast cancer on 2/6/2024. The Responsible party stated Resident #76 was taking an oral chemotherapy drug and saw the oncologist for follow-up, but the facility failed to have her at the appointment as planned. The Responsible Party stated he called the facility and left a message after the appointment was missed but no one returned his call. The Social Services Director was interviewed on 7/31/2024 at 5:24 pm and she stated Resident #76 was scheduled for an appointment scheduled for 9/5/2024 at the cancer center but she was not aware of Resident #76 having a missed appointment for oncology follow-up. The Social Services Director stated the Transportation Scheduler would be responsible for scheduling transportation and ensuring residents were transported to their appointments. On 7/31/2024 at 5:36 pm the Transportation Scheduler was interviewed, and she stated she failed to transport Resident #76 to her oncology appointment. The Transportation Scheduler stated she was transitioning into the role of Transportation Scheduler when Resident #76 was scheduled for her oncology appointment and the previous Transportation Scheduler did not put the appointment on the calendar which caused the appointment to be missed. The Transportation Scheduler stated Resident #76 was rescheduled for her appointment on 3/4/2024 and she was transported to the appointment.	F 745	out-of-facility follow up appointments. The licensed nursing staff, Social Services Department and the Transportation Scheduler were re-educated on ensuring transportation is scheduled for residents with out-of-facility follow up appointments by the SDC on 8/26/2024. Newly hired nursing, social services and transportation schedulers will receive this education during their job specific orientation by the SDC and/or Department□s Director. Nursing Administration will monitor by randomly checking up to 5 residents□ medical record weekly for 12 weeks for scheduled out-of-facility follow up appointments to ensure the follow up appointments are on the Transportation Calander and transportation is scheduled. Results of the monitoring will be discussed weekly during Morning QI meetings for 12 weeks, and then further discussions with the QA Committee meetings for recommendations as indicated. The DON is responsible for ongoing compliance for F745. Compliance date is 8/26/24.	

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F 745	Continued From page 35 During an interview with the Administrator on 8/1/2024 at 5:04 pm he stated he was not aware Resident #76, or any other residents had missed their scheduled appointments. The Administrator further stated the facility was responsible for ensuring residents are scheduled and transported to their appointments and Resident #76 should not have missed her oncology appointment.	F 745		
F 756 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 change in the medication, the attending	F 756		8/26/24

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F 756	Continued From page 36 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 staff and consultant pharmacist interviews and record reviews, the facility failed to: 1) Maintain documentation of the pharmacist's Monthly Medication Reviews (MMRs) within the facility and readily available for review; and 2) Retain documentation of the physician's review and response to the pharmacist's findings / recommendations in the resident's medical record. This occurred for 1 of 5 residents reviewed for Unnecessary Medications (Resident #20). The findings included: Resident #20 was initially admitted to the facility on 5/2/23 with re-entry on 12/26/23 from a hospital. Her cumulative diagnoses included epilepsy, anxiety disorder, dementia, and mild neurocognitive disorder (a collection of syndromes in which the primary clinical feature is a decline in cognitive functioning) with behavior disturbances. A review of the resident's electronic medical record (EMR) revealed a medication order was received on 12/26/23 for 2.5 milligrams (mg) olanzapine (an antipsychotic medication) to be	F 756	White Oak Manor – Burlington will ensure drug regimen is reviewed, readily available and documentation is maintained of the pharmacist's Monthly Medication Reviews, and documentation is retained of the physician's review and response to the pharmacist's findings/recommendations in the residents' medical record. Residents #20's Monthly Medication Reviews and Prescriber Recommendation Forms will be maintained with the physician's review and response as indicated by the pharmacist's findings/recommendations. Current and newly admitted residents' Monthly Medication Reviews and Prescriber Recommendation Forms will be reviewed, responded as indicated and maintained in the residents' electronic medical record. Implementation of a new electronic medical record was completed on 8/1/24. An audit was completed of current residents' medical record to ensure the	

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F 756	Continued From page 37 given as 1 tablet by mouth every day (scheduled for 8:00 AM daily) for unspecified symptoms and signs with cognitive functions and awareness. On 5/13/24, a physician's order was also received for 5 mg olanzapine to be given as one tablet by mouth daily (scheduled for 2:00 PM). Resident #20's most recent Minimum Data Set (MDS) was an assessment for a significant change in status (dated 7/2/24). Resident #20 was reported to have moderately impaired cognition with verbal behavioral symptoms on 1-3 days during the 7-day look back period. The Medication section of the MDS reported Resident #20 received an antipsychotic medication during the 7-day look back period. A review of Resident #20's paper medical record was conducted and included the "Pharmacist Progress Notes" with the monthly Medication Regiment Review (MRR) completed by the facility's consultant pharmacist. This review revealed MRRs were documented as completed during the past year on each of the following dates: 7/18/23, 11/13/23, 12/19/23, 12/28/23 (upon the resident's re-admission to the facility), 1/15/24, 2/13/24, 4/15/24, 5/13/24, and 6/13/24. Resident #20's paper medical record did not include the monthly MRRs for 8/23, 9/23, 10/23, and 3/24 nor the signed provider's review and response (documented on a "Prescriber Recommendation Form") for any pharmacist's findings / recommendations generated on these dates. An interview was conducted on 7/31/24 at 4:22 PM with the facility's Administrator. Upon inquiry, the Administrator reported all of the consultant pharmacist's MRRs should be stored in the	F 756	most recent Monthly Medication Review and Prescriber Recommendations Forms are available, reviewed, responded as indicated and maintained in the residents' medical record. This audit was completed by Pharmacy on 8/23/2024. The licensed nursing staff and the Health Information Manager (HIM) were re-educated on the process and the importance of the drug regimen to be reviewed, readily available and maintained of the pharmacist's Monthly Medication Reviews and the Prescriber Recommendation Forms with the response to the pharmacist's findings/recommendations as indicated in the residents' medical record. This re-education was completed by the SDC on 8/26/2024. Newly hired licensed nursing staff HIMs will receive this education during their job specific orientation by the SDC. Nursing Administration will monitor by randomly reviewing 5 residents' medical records weekly for 12 weeks to ensure compliance that the Monthly Medication Reviews and Prescriber Recommendation Forms are readily available, reviewed, responded as indicated and maintained in the residents' medical record. Results of the monitoring will be discussed weekly during Morning QI meetings for 12 weeks, and then further discussions with the QA Committee meetings for recommendations as indicated.	

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F 756	Continued From page 38 resident's paper medical record. A telephone interview was conducted on 8/1/24 at 11:53 AM with the facility's consultant pharmacist. During the interview, the pharmacist reported a Pharmacist Progress Note with the monthly MRR was supposed to be filed in each resident's paper medical record. If a recommendation was made, then a signed provider note (a Prescriber Recommendation Form) with the physician's review and response to the pharmacist's findings / recommendations would also be put into the paper medical record by the administrative nursing staff. When the missing pharmacist MRRs from 8/23, 9/23, 10/23, and 3/24 for Resident #20 were discussed, the pharmacist stated during this period of time there "was a huge changeover with the facility's administrative staff." The pharmacist was able to pull up the pharmacy's electronic medical records and confirmed MRRs were completed for each of the 4 months in question. The pharmacist reported the following information was included on the missing MRRs for Resident #20: --The MRR dated 8/29/23 indicated no irregularities were noted; --The MRR dated 9/19/23 indicated no irregularities were noted; --The MRR dated 10/24/23 provided a cautionary note to the prescriber regarding the use of olanzapine for a resident with a history of seizures; --The MRR dated 3/14/24 recommended consideration of gradual dose reduction (GDR) for olanzapine. When asked where the pharmacist's MRRs and signed Prescriber Recommendation Forms should be kept, the pharmacist stated they should all be under the section tabbed for "Pharmacy" in	F 756	The DON is responsible for ongoing compliance for F756. Compliance date is 8/26/24.	

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F 756	Continued From page 39 the resident's paper medical record. A follow-up interview was conducted on 8/1/24 at 5:18 PM with the facility's Administrator. During the interview, the Administrator reiterated the facility was not able to locate any additional MRRs or signed Prescriber Recommendation Forms for Resident #20. Upon inquiry, the Administrator reported he would have expected these forms to have been stored in the resident's paper medical record.	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to label and date foods brought in by resident's family member and failed	F 812	White Oak Manor – Burlington ensures the food is properly stored, sealed, labeled, dated, free from spoilage, and	8/26/24

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F 812	Continued From page 40 to maintain the nourishment refrigerators clean for 3 of 3 Nourishment refrigerators (Nourishment refrigerator #1, Nourishment refrigerator #2 and Nourishment refrigerator #3). The facility failed to maintain the ice scoop clean in 1 of 3 nourishment rooms (C wing Nourishment room). These practices had the potential to affect food served to residents. Findings included: Review of the policy "Food Brought into facility for resident" revealed foods should be stored in clean, sealed air-tight containers in the refrigerator. The container should be labeled and dated. The policy indicated the food may be stored in the refrigerator for up to 3 day. Foods improperly stored or labeled or stored for more than 3 days would be discarded by the nursing staff. 1 a. Observation of the nourishment refrigerator #1 (B Wing) on 7/29/24 at 10:13 AM, revealed a plastic grocery bag with takeout food container with no label or date. A plastic bag containing a plastic container with cut fruit with no label or date. The Dietary Manager indicated the cut fruit was watermelon. The refrigerator also contained a 16-ounce (oz.) plastic container with baked beans with no label or date. There was a 16 oz. plastic container with yellow color food with just resident name indicated on the box. There was no date as to when this container was placed in the refrigerator. There was a 12 oz opened energy drink can with straw in it. The refrigerator also contained an opened 48 oz carton of orange juice with no open date on it. The refrigerator shelves were observed to be sticky. The plastic bags containing resident's food were stuck to the	F 812	equipment is clean. The food items not labeled and dated in the nourishment refrigerators that were noted during survey that were brought in by resident's family members were discarded. The 3 nourishment refrigerators were thoroughly cleaned on 7/31/2024 by Dietary Department. The noted ice scoop noted not clean during survey was properly sanitized by the Dietary Department during survey. The other ice scoops were checked and properly sanitized by the Dietary department on 7/31/2024. The nursing staff members were re-educated on food items being labeled and dated properly including food items brought in by family members, and food items discarded when necessary. The nursing staff were also re-educated on monitoring the nourishment refrigerators daily for unlabeled, undated and expired items, discard as necessary, and check for cleanliness and clean as needed. This re-education was completed on 8/26/2024 by the SDC. Newly hired nursing staff members will receive this education during their job specific orientation by the SDC. Nursing Administration will monitor the food items and cleanliness in the nourishment refrigerators and ice scoops 3 days a week for 12 weeks. Identified trends or issues from the monitoring tools will be discussed during	

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F 812	Continued From page 41 shelves. During an interview on 7/29/24 at 10:15 AM, the Dietary Manager stated it was the responsibility of the nurses to ensure all the food placed in the nourishment refrigerator was labeled and dated. The refrigerator was to be cleaned and all food more than 3 days should be discarded by the night shift nurse. The Dietary Manager indicated that employees should not be using the nourishment refrigerator to store their personal food. The Dietary Manager stated it was the responsibility of the nursing staff to ensure the nourishment refrigerator was maintained clean and all food was labeled and dated. 1b. Observation of the nourishment refrigerator #2 (A Wing) on 7/29/24 at 10:19 AM, revealed yellow stains on the floor of the refrigerator and yellow stains on the inside of the freezer door. During an interview on 7/29/24 at 10:19 AM, the Dietary Manager indicated it was the responsibility of the nursing staff to keep the refrigerator clean. 1 c. Observation of the nourishment refrigerator #3 (C Wing) on 7/29/24 at 10:21 AM, revealed a plastic grocery bag containing a plastic box with cut watermelon with a sell by date 7/26/24. There was no label on it. A 16 oz plastic container with salad and sliced boiled egg and a 12 oz store brought dip with expiration date 8/12/24 with no label or date. The refrigerator also contained two opened 48 oz. cartons labeled apple juice and one opened 48 oz. carton labeled orange juice with no open date. The floor of the refrigerator had yellow sticky stains. The bottom drawers were stuck to the floor of the refrigerator and would not slide open.	F 812	the Morning QI meetings, weekly for 12 weeks, and then further discussions with the QA Committee meetings for recommendations as indicated. The DON is responsible for the ongoing compliance of F812 in the nourishment refrigerators. Compliance date is 8/26/24.	

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F 812	Continued From page 42	F 812		

Observation of the freezer revealed a grocery bag containing two disposable plates with frozen cake. A fast food 20 oz drink that was half filled and frozen. There was no label or date on them.

2. Observation of the ice machine on 7/29/24 at 10:25 AM in the nourishment room on C Wing revealed the ice scoop was placed on few paper towels. The paper towels were wet. There was no ice scoop holder near the ice machine.

During an interview on 7/29/24 at 10:25 AM, the Dietary Manager stated the ice scoop should be placed in the ice scoop holder and not on paper towels. The Dietary Manager was unsure where the ice scoop holder was. She indicated she would place a new ice scoop holder in the room.

During an interview on 8/1/24 at 2:20 PM, the Director of Nursing (DON) indicated the Nurse aides on each Wing were assigned to clean the pantry daily. The Nurse aides who were assigned to this task were responsible to ensure they clean the refrigerator during their assigned days. The Dietary department should also be cleaning the refrigerator when snacks were placed in the refrigerator, and clean spills. The DON indicated the resident's family members who regularly brought in food for the resident were made aware to label and date the food. The DON stated food should be brought in small, airtight containers. She further stated nursing staff who were placing the food in the nourishment refrigerator should also be ensuring that the food was labeled and dated. Food that was not dated and labeled should be discarded by the nursing staff. The DON stated all juice containers that were opened should be dated by an open by date. These should be discarded within 72 hours of opening.

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F 812	Continued From page 43 During an interview on 8/1/24 at 5:09 AM, the Administrator stated the nourishment refrigerators should be maintained clean, and all food should be labeled and dated. Any food that was not labeled or dated should be discarded.	F 812		