STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345238	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced onsite recertification and complaint investigation survey was conducted from 4/6/2026 through 4/9/2026. Additional information was obtained offsite 4/10/2026 through 4/13/2026, therefore the exit date was changed to 4/13/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: 22C96E-H1.	E0000		
F0000	INITIAL COMMENTS An unannounced onsite recertification and complaint investigation survey was conducted from 4/6/2026 through 4/9/2026. Additional information was obtained offsite from 4/10/2026 through 4/13/2026, therefore the exit date was changed to 4/13/2026. Event ID# 22C96E-H1. The following intakes were investigated 2971721, 2742980, 2699021, 2747004. 2 of the 10 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J); the IJ began 6/28/2025 and was removed 4/11/2026. The tag F689 constituted Substandard Quality of Care. An extended survey was conducted.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F0689	F689 White Oak Manor – Charlotte will ensure that resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents, including residents that are at risk for elopement have the potential to elope if not adequately supervised. Resident #89 continued to have their wander alarm bracelet applied to their right wrist and continued to have one-on-one supervision until his transfer to	05/08/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0689 SS = SQC-J	Continued from page 1 supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews with the Nurse Practitioner (NP) and staff, the facility failed to prevent a resident with severe cognitive impairment, wandering and exit seeking behavior and at high risk for falls, from exiting the facility unsupervised without staff's knowledge. On two consecutive nights Resident #89 exited the facility through an unlocked emergency exit door near the back of the facility that was in working order, but the door had been manually unlocked, and the door alarm had been turned off with a key and therefore did not alarm. On 6/28/25 at an undetermined time early in the morning (it was still dark outside) Nurse #1 noticed Resident #89 was not walking in the hallway and was not in his room. Nurse #1 approached Nurse Aide #1 who was on the end of the hallway near the emergency exit door and reported she had not seen Resident #89 but had heard a door slam near the emergency exit. Nurse Aide #1 indicated another resident that resided in a room near the emergency exit door was known to slam her door and since the emergency door alarm did not go off, she assumed that was what she had heard. Nurse #1 exited through the emergency exit door and walked for 5 to 7 minutes from the back of the facility around to the front where he located Resident #89 standing at the main entrance. Nurse #1 estimated the resident was outside unsupervised for approximately 10 minutes. Nurse #1 thought the emergency exit door locked automatically and was not aware the emergency door alarm had been turned off with a key and did not check the door after the incident or before the end of his shift to ensure it was locked. On 6/29/25 at approximately 1:30 AM Resident #89 was observed in bed and at approximately 2:00 AM Nurse #1 noticed the resident was not in bed and walked immediately to the emergency exit door. He observed the resident through the glass window on the door outside walking away from the building and redirected him back inside. The emergency exit door was again unlocked and did not alarm when Nurse #1 exited through the door to retrieve the resident. When exiting the emergency door if you walked straight ahead and did not follow the sidewalk path, approximately 8 feet in front of the door was a concrete drain box (a concrete structure around a water drain underground). The concrete box opening was approximately 3 feet by 3 feet had no safety covering and was 3 to 4 feet deep into the ground. The sidewalk path outside of the emergency exit	F0689	Continued from page 1 another nursing facility with a secured unit on 4/23/26. All current residents and newly admitted residents will be supervised adequately to prevent elopement from the facility. The Maintenance Director reported on 4/08/26 that he recalled the incident and he checked the doors when he returned to work on 6/30/25. He noted all the exit doors were functioning properly. On 4/09/26, all exit doors were checked to ensure the switch for magnet lock and red stop sign shaped alarming device were on and functioning. The Maintenance Director also checked the 2 doors with the wander alarm device, functioning properly as well. On 4/9/26, the wander alarm company came to assess the exit doors that do not have a wander alarm system. An alarming device will be installed as a further precaution from human error in leaving the switch for the magnet lock and/or red stop sign alarming device off. The main entrance and the employee entrance doors continue to have the wander alarm system and installation of the wander alarm system to the other 6 doors in the facility is projected to be completed by 6/19/26. In the meantime, the wall switches to the magnet lock with the plastic covers have an alarming device if the plastic covers are opened. The alarm is very loud and will alert the staff that it is being opened. The open drain located outside the west exit door on the facility's property was repaired and covered with a barrier by the Maintenance Director on 4/10/26. The facility staff including administration, nursing (including nurses and nurse assistant), activities, social services, dietary, housekeeping/laundry, and maintenance department were educated starting on 4/9/26 and was completed on 4/10/26 by the SDC, DON and ADON regarding the locking mechanism on the 6 exit doors that do not have the wander alarm system. The 6 exit doors have magnet locks with a wall switch that turns magnet lock on and off and the red stop sign shaped alarming devices can be turned on or off with a key. If the wall switch is off and door is opened, the red stop sign alarming device will sound as long it is turned on. If turned off, the alarm will not sound. There will be an emphasis that the magnet lock should be always locked, and the red stop sign alarming device should always be on unless staff is present and being used for work-related purposes. The main entrance door and the employee entrance door have the wander alarm device and will lock down the door when a resident with a wander alarm bracelet comes near	05/08/2026

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F0689 SS = SQC-J	Continued from page 2 door curved immediately to the left up an inclined hill and the sidewalk then turned left and ran directly parallel to a two-lane road that had a posted speed limit of 30 miles per hour. The sidewalk ran along the road for approximately 142 feet and then turned left running along the main driveway used to enter the facility's parking lot and continued in front of the building approximately 180 feet to the main entrance door. Resident #89 was not injured; however, there was a high likelihood of serious harm, injury, or death. This deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #89). Immediate jeopardy began on 6/28/25 when Resident #89 exited the facility unsupervised and without staff knowledge. Immediate jeopardy was removed on 4/11/26 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure all staff and providers are aware of the elopement, education is completed and monitoring systems put into place are effective. The findings included: Resident #89 was admitted to the facility on 6/05/23 with diagnoses including dementia with psychotic disturbance, intracranial injury without loss of consciousness (mild traumatic brain injury), abnormalities of mobility and gait, muscle weakness, insomnia, and orthostatic hypotension (sudden drop in blood pressure when standing). The care plans initiated on 1/28/25 indicated Resident #89 had problem areas including cognitive decline, wandering and exit seeking behaviors, was at risk for falls, and had a diagnosis of insomnia with sleep pattern disturbance. The interventions included administering medications as ordered, monitoring for medication side effects (mood/behavior changes, excessive daytime sleepiness, dizziness and ineffectiveness of medication), wearing a wander guard bracelet, redirecting attempts to exit the facility, encouraging adequate rest periods, discouraging long naps during the day, ensuring proper foot wear was worn, frequent checks by staff, monitoring environment for safety and making adjustments as needed, assessing possible contributing factors of falls including blood pressure (standing and sitting), and notifying the physician of any medication side effects and/or changes in behaviors.	F0689	Continued from page 2 those doors. Nursing Shift Supervisors, DON, ADON, Quality Improvement Manager, Housekeeping Director, and the Maintenance Director have a key to the red stop sign shaped alarming device. The covered wall switch for magnet lock has an alarming device applied and will sound if opened. Staff is to respond to the alarm and ensure the switch is not to turned off by a resident. The education also included an overview of the missing person/exit seeking protocol that includes responding to doors that alarm to determine if any resident eloped, follow the chain of command by reporting to the nursing supervisor and then the DON and Administrator when the resident exits from the facility unattended. If a resident elopes then to place the resident on 1-on-1 supervision. Do not wait for multiple attempts to place the resident on 1-on-1 supervision. The education was delivered in person or by webinar with the demonstration of the exit doors via power point with images of the locking mechanism and the engaged red stop sign shaped alarming device. Newly hired staff will receive this education during their job specific orientation with the SDC, direct supervisor or corporate consultant. The Maintenance Director, Administrator, Assistant Administrator, or Nursing Shift Supervisor will check the exit doors per shift (3, 8-hour shifts during the work week and 2, 12-hour shift on the weekends) to ensure the unit exit doors are locked with magnet lock engaged and the red shaped stop sign device on. The Central Supply Manager will continue checking the 2 exit doors with the wander alarm device weekly for 12 weeks. Results of the monitoring tools of the exit doors, to ensure current and newly admitted residents with wander alarm bracelets and are at risk for exit seeking are safe and do not exit from a turned off, unlocked or not engaged exit door, 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 Administrator, Maintenance Director and the DON are responsible for the ongoing compliance of F689 Compliance date is 5/8/2026.	05/08/2026

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F0689 SS = SQC-J	Continued from page 3 Resident #89 had a physician's order dated 1/29/25 for a wander alarm bracelet due to wandering/exit seeking behaviors. A nurse's note dated 4/29/25 at 6:25 AM written by Nurse #1 revealed Resident #89 was confused roaming the building looking for an exit sign to attempt to leave and was very difficult to redirect. A nurse's note dated 4/29/25 at 6:39 AM written by Nurse #1 indicated Resident #89 was confused and kept roaming the building. Resident #89 continuously attempted to exit the building aggressively telling staff, "I have to go" and was very difficult to redirect. An elopement risk assessment dated 5/04/25 revealed Resident #89 had a history of wandering and exit seeking behaviors and exhibited these behaviors within the last 90 days. Resident #89 had risk factors related to elopement which included walking independently, cognitive impairment, poor decision-making skills and verbalizing a desire to leave the facility and/or go home. The assessment score was 3 (lowest risk 0 - highest risk 5) indicating Resident #89 was at a moderately high risk for elopement and to continue current safety interventions that were in place. The quarterly Minimum Data Set (MDS) assessment dated 5/04/25 indicated Resident #89 was severely cognitively impaired, exhibited wandering behaviors one to three days during the assessment period and wore a wander/elopement alarm daily. The MDS assessment further revealed Resident #89 required supervision to touching assistance walking 10 feet, partial to moderate assistance walking 50 feet with two turns, and supervision to touching assistance walking 150 feet and was not coded for any falls in the past 30 days. Resident #89's active physician orders as of 6/28/25 included the following: Trazodone (anti-depressant medication used for insomnia) 50 milligrams (mg) once a day at bedtime. Melatonin (a supplement used for insomnia and to regulate the sleep-wake cycle) 3 mg once a day at bedtime. Midodrine (medication for low blood pressure) 5 mg three times a day. A nurse's note dated 6/28/25 at 7:06 AM written by Nurse #1 revealed Resident #89 was wandering	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 4 throughout the night and redirected back to his room several times. Resident #89 was successful in exiting the facility through the emergency exit door on the west hallway and was located by staff standing outside at the main entrance. Resident #89 was escorted back to his room and assessed with no injuries noted. A phone interview conducted with Nurse #1 on 4/08/26 at 9:24 AM revealed he worked from 7:00 PM to 7:00 AM on Fridays and Saturdays and was assigned to Resident #89 on 6/27/25 and 6/28/25. He stated Resident #89 was cognitively impaired, wandered the hall every night and was exit seeking at times. He stated when Resident #89 was exit seeking he continuously pushed on the emergency door to see if it would open. Nurse #1 revealed Resident #89 ambulated independently but was at risk for falls due to orthostatic blood pressure and poor balance. He stated Resident #89 did not use a walker or wheelchair but would hold on to stationary items like furniture and handrails to stabilize himself and would lean against a wall as needed to rest. Nurse #1 on revealed when his shift began on 6/27/25 at 7:00 PM Resident #89 was exhibiting his normal wandering and exit seeking behaviors which included verbalizing he had somewhere to go and needed to leave. Nurse #1 stated on 6/28/25 in the early morning, he did not recall the exact time, but it was still dark outside, he noticed Resident #89 was not walking in the hallway and was not in his room. He indicated Resident #89's assigned Nurse Aide (NA), NA #1, was on the other end of the hallway near emergency exit door and reported she had not seen Resident #89 but that she had just heard the exit door close. Nurse #1 revealed when he pushed on the emergency exit door it was still unlocked and opened immediately and did not alarm. Nurse #1 stated he assumed Resident #89 exited the building when NA #1 heard the exit door slam shut and he (Nurse #1) exited the door just a few minutes later, and walked for 5 to 7 minutes from the back of the building around to the front where he located Resident #89 standing at the main entrance, so he estimated Resident #89 was outside unsupervised for approximately 10 minutes before he located him at the main entrance, but where Resident #89 walked during that time was unknown. He stated Resident #89 was wearing light colored sweatpants, a red sweatshirt and shoes. Nurse #1 stated he walked Resident #89 back into the facility through the door at the main entrance and Resident #89's wander alarm bracelet triggered the alarm on the door; he entered a code in the keypad to turn off the alarm and then escorted Resident #89 back to his room. Nurse #1 indicated he assessed Resident #89 and he	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 5 was not injured and his vital signs were within normal limits. Nurse #1 stated if the push bar on the emergency exit door was held for 15 seconds the door unlocked and opened without alarming and he thought that was how Resident #89 was able to open the door. Nurse #1 indicated he thought the emergency exit door locked automatically and the alarm re-engaged after the door was closed for an extended period of time, so he did not check the door after the incident or before the end of his shift to ensure it was locked. Nurse #1 further stated he was unaware the alarm was turned on and off with a key and could not say what staff had a key to the alarm. Nurse #1 revealed he documented in a nurse's note that Resident #89 exited the facility and reported it to Nursing Supervisor #1 and the oncoming nurse (Nurse #2) at shift change, but no additional monitoring or interventions were implemented at that time. A phone interview was conducted with NA #1 on 4/08/26 at 1:42 PM. NA #1 revealed she worked third shift (11:00 PM to 7:00 AM) on 6/27/25 and was assigned to Resident #89. NA #1 revealed Resident #89 wandered the hall all night every night, went in and out of other resident's rooms and had to be redirected back to his room several times. She indicated when she redirected Resident #89 back to his room, she encouraged Resident #89 to lay down in bed and rest, but he typically would only lay down for a few minutes. NA #1 revealed Resident #89 was exit seeking at times (not every night) and would push on the emergency exit door attempting to leave the facility. NA #1 indicated when her shift began on 6/27/25 at 11:00 PM Resident #89 was wandering as he normally did, but she had not seen him pushing on the emergency exit door or exhibit exit seeking behavior. She stated she did not recall the exact time but in the early morning on 6/28/25 she heard a door slam near the emergency exit door on the west hall. She indicated the resident that resided in the room next to the emergency door was known to slam her room door closed and since the alarm on the emergency door did not go off, she assumed that was what she heard. NA #1 revealed a few minutes later, Nurse #1 approached her looking for Resident #89 and she reported hearing a door slam near the emergency exit. NA #1 indicated when Nurse #1 pushed on the emergency exit door it was unlocked, opened and did not alarm. NA #1 stated Nurse #1 proceeded to look for Resident #89 outside while she began looking for him in the facility. NA #1 indicated Nurse #1 found Resident #89 standing at the front of the building uninjured and walked him back to his room. NA #1 indicated she thought a staff member on a previous shift had left the	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 6 emergency door unlocked and turned off the alarm but was unable to provide any further details as to who the staff member was or why they would have used that door to exit the building. NA #1 revealed she had never used the emergency door to exit the building and did not know how to unlock the door or turn off the alarm. NA #1 stated she did not recall any additional monitoring being initiated for Resident #89 after the incident on 6/28/25. A phone interview was conducted with Nurse #2 on 4/08/26 at 4:37 PM. Nurse #2 stated she was assigned to Resident #89 on 6/28/25 from 7:00 AM to 7:00 PM. She stated Nurse #1 reported to her at shift change on 6/28/25 that Resident #89 had exited the facility earlier that morning through the emergency exit door on the west hall, which was unlocked and did not alarm, and Resident #89 was found at the front of the facility without injury. She revealed Nurse #1 did not report why the exit door was unlocked and did not alarm but because both the alarm and the lock were disabled manually, she assumed a staff member had unlocked the door and disabled the alarm. Nurse #2 indicated Resident #89 did not exhibit wandering or exit seeking behaviors during the day, only at night so she did not check the exit door to ensure it was locked and the alarm was turned on. She stated when she made her first rounds Resident #89 was sleeping in bed and was at his baseline for the remainder of her shift. Nurse #2 revealed 30-minute checks were initiated for Resident #89 at the end of her shift (7:00 PM) on 6/28/25 which she reported to Nurse #1 during shift change. A nurse's note dated 6/29/25 at 4:21 AM written by Nurse #1 revealed at 1:30 AM Resident #89 was observed lying in bed but at 2:00 AM was no longer in his room. Nurse #1 walked down the west hallway to the emergency exit door which was not locked or alarming and observed Resident #89 outside the door walking away from the building. Nurse #1 redirected Resident #89 back into the facility through the emergency exit door and walked with him to his room. Resident #89 was assessed with no injuries, and his vital signs were within normal limits. During the phone interview with Nurse #1 on 4/08/26 at 9:24 AM he stated when his shift began on 6/28/25 at 7:00 PM Resident #89 was wandering normally in and out of his room and up and down the hallway. Nurse #1 indicated at 1:30 AM on 6/29/25 he observed Resident #89 lying in bed but at 2:00 AM he observed Resident #89 was no longer in his room. Nurse #1 revealed he immediately walked down the hall to the emergency exit since	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 7 that was the door Resident #89 exited out of on 6/28/25 and observed him outside the door walking away from the building through the glass window on the door. Nurse #1 stated when he pushed the emergency exit door open it was unlocked and did not alarm. Nurse #1 revealed Resident #89 had only walked a few steps away from the door before he stopped him and redirected him back inside. Nurse #1 stated Resident #89 was unable to tell him where he was going and just said “I have to go”. Nurse #1 revealed he assessed Resident #89 with no injuries, and his vital signs were within normal limits. Nurse #1 indicated he immediately notified Nursing Supervisor #1 of the incident and received instructions to initiate one to one supervision for Resident #89 as well as 30-minute checks to be completed by the nurse. A phone interview was conducted with NA #1 on 4/08/26 at 1:42 PM. NA #1 revealed she worked third shift (11:00 PM to 7:00 AM) on 6/28/25 and was assigned to Resident #89. NA #1 stated Resident #89 was wandering the hall throughout the night as normal, and she redirected him back to his room a few times and encouraged him to rest but did not recall the exact times. NA #1 revealed she did not observe Resident #89 pushing on the exit door or exhibit exit seeking behavior and did not recall any incidents occurring with Resident #89 exiting the facility during her shift. NA #1 indicated she was not aware of 30-minute checks being initiated for Resident #89 but that one on one supervision was put in place at some point however she did not recall when. A phone interview was conducted with Nurse #2 on 4/08/26 at 4:37 PM. Nurse #2 stated when she returned for her shift on 6/29/25 from 7:00 AM to 7:00 PM she was assigned to Resident #89 and Nurse #1 reported to her that Resident #89 had exited the building a second time earlier that morning through the emergency door which was unlocked and did not alarm. She stated 30-minute checks were to continue and 1 on 1 supervision was initiated for Resident #89 on 6/29/25. Nurse #2 stated the emergency exit door was unlocked by a wall switch and the alarm was turned on and off with a key. Nurse #2 stated she did not recall having a key to the alarm and was unsure what staff had a key. She indicated the emergency door exited at the back of the facility and she was unsure what purpose staff would have to exit through that door or who the staff were that left the door unlocked with the alarm disabled. Nurse #2 further stated she was not aware of any staff working during her shift that used the west hall emergency door to exit the	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 8 building. A nurse's note dated 6/29/25 at 6:29 AM written by Nursing Supervisor #1 indicated he notified the Former Administrator that Resident #89 attempted to exit the facility, and she gave instructions for 1 to 1 supervision to start immediately and to continue until further notice. During a phone interview with Nursing Supervisor #1 on 4/08/26 at 9:00 AM he stated he was the weekend (Fridays and Saturdays) nursing supervisor from 7:00 PM to 7:00 AM and was working on 6/27/25 and 6/28/25. He stated Resident #89 was cognitively impaired and exhibited wandering behaviors at night, but he did not recall being notified by Nurse #1 on 6/28/25 or 6/29/25 that Resident #89 exited the facility or that there were any concerns related to the emergency exit door on the west hallway not working properly. Nursing Supervisor #1 indicated although he did not recall the incidents involving Resident #89 if he wrote a nurse's note then the information he documented was accurate. A nurse's note dated 6/29/25 at 12:17 PM documented as a late entry for 6/28/2025 at 7:09 PM by Nurse #2 revealed Resident #89 was placed on 30-minute checks via paper report due to leaving the building on previous shift. Resident #89 remained in his room this nurse's entire shift resting in bed. Reported to oncoming nurse (Nurse #1) that 30-minute checks were initiated and to document on paper. A review of Resident #89's records revealed no documentation that 30-minute checks were initiated or completed beginning on 6/28/25. A review of Resident #89's active physician orders revealed an order dated 6/29/25 to check resident's whereabouts every 30 minutes. A review of Resident #89's treatment administration record from June 2025 through April 2026 revealed 30-minute checks were documented as completed beginning on 6/29/25 and have been ongoing. A review of the facility's staffing schedules from 6/29/25 through 7/31/25 revealed one-to-one supervision for Resident #89 was added as an assignment on the daily schedule and an NA was assigned to Resident #89 on every shift. The NP note dated 6/30/25 indicated Resident #89 had diagnoses including intracranial injury, dementia	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 9 with behaviors and insomnia and was seen for a follow up visit after eloping from the facility on 6/28/25 and 6/29/25. Resident #89 was gone from the facility for no longer than 20 minutes. Resident #89 exhibited wandering behaviors at his baseline, wore a wander bracelet and following the incidents was placed on one to one supervision. Resident #89 was assessed and observed lying in bed and appeared comfortable with no concerns. Resident #89's medications and vital signs were reviewed with no new orders given but to continue monitoring for acute changes. A phone interview was conducted with the NP on 4/13/26 at 7:38 AM. She stated she was aware that Resident #89 was up most nights wandering and exhibited exit seeking behaviors. The NP revealed treating Resident #89's insomnia and dementia related behaviors was difficult due to his risk for falls and diagnosis of orthostatic blood pressure. She stated the medications typically prescribed for sleep and anxiety also increased the risk for falls and lowered blood pressure. The NP indicated she was notified on 6/30/25 that Resident #89 exited the facility unsupervised 6/28/25 and 6/29/25 and per her note was gone no more than 20 minutes and was not injured. The NP indicated Resident #89 was not oriented to time or place and had very poor safety awareness which severely impaired his ability to recognize or navigate potential safety hazards independently. The NP revealed Resident #89 exiting the facility unsupervised, even for less than 20 minutes was extremely unsafe and could have resulted in serious injury. An interview was conducted with the Maintenance Director on 4/08/26 at 4:10 PM. He stated the emergency exit door on the west hallway had a magnetic lock that was controlled by a wall switch. He stated when the wall switch was turned on the door remained lock and when the wall switch was turned off the door remained unlocked. The Maintenance Director indicated holding the metal push bar on the door for 15 seconds would not unlock the door. He revealed there was a red alarm box secured to the door that alarmed when the door was pushed open. He stated the alarm sound came directly from the red box and there was not an announcer for the alarm at the nurse's station. He stated the red alarm box could only be turned on and off with a key and was not controlled by the wall switch. He indicated nurses, medication aides, nursing supervisors and department heads all had a key to the red alarm box. The Maintenance Director revealed he was notified by the Former Administrator on 6/29/25 that Resident #89 exited the building	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 10 through the emergency door on the west hallway and the door was unlocked and did not alarm but was not aware or notified by anyone that Resident #89 exited the facility through the same door on 6/28/25. He stated when he arrived at the facility on 6/29/25 at approximately 7:15 AM he immediately inspected the emergency door on the west hall. He stated the wall switch and the red box alarm were turned on and the door was locked. He revealed he proceeded to inspect the magnet lock, the wall switch and the red box alarm and they were all working properly. The Maintenance Director indicated the emergency door did not malfunction and that a staff member must have turned off the wall switch and used a key to turn off the alarm for the door to open and not alarm. He stated he was unsure who the staff member was or what purpose they would have had to exit to the back of the building through the emergency door. The Maintenance Director stated the door at the main entrance and the employee entrance door were the only doors in the facility that had wander alarm sensors. He stated the emergency exit doors did not have wander alarm sensors and did not lock or alarm when a wander bracelet was near the door. An independent observation was conducted of the west hallway on 4/07/26 at 3:12 PM revealed Resident #89 was located in the first room on the right side of the hallway, and the emergency exit door was approximately 50 feet from Resident #89's room on the other end of the hall. A red alarm box shaped like a stop sign was secured to the door and read "STOP, alarm will sound". On the wall to the right of the door was a paper sign that read "do not turn off switch" that was hanging over a wall switch covered by a clear plastic box. The metal push bar on the exit door was pushed and held for 15 seconds but the door remained lock and would not open. The wall switch beside the door was turned off which unlocked the magnetic door lock and the emergency exit door pushed open. Once the emergency exit door was pushed open the red alarm box secured to the door began to alarm and when the emergency exit door was pulled shut the alarm continued to sound but the door remained unlocked and could be pushed back open. An observation and interview were conducted on the west hall with Nurse #3 on 4/07/26 at 3:22 PM when she responded to the emergency exit door alarm. Nurse #3 was observed using a key on the red box alarm to turn off the alarm coming from the red box alarm secured to the door and then turning the wall switch back on to engage the magnetic lock on the door. Nurse #3 stated she was sitting at the nurse's	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 11 station located on the other end of the west hall when the red alarm box on the emergency exit door started to sound and she did not initially hear the alarm. She indicated there was not an announcer for the red box alarm at the nurse's station. Nurse #3 stated the red box alarm was turned on and off with a key and the magnetic lock on the door was turned on and off by the wall switch. Nurse #3 revealed she was assigned to Resident #89 from 7:00 AM to 3:00 PM today, but he did not exhibit wandering/exit seeking behaviors during the day when she worked, he only wandered at night. A follow up phone interview conducted with Nurse #1 on 4/10/26 at 11:01 AM revealed he was unaware that the emergency exit door had a magnetic lock that was turned on and off with a wall switch or that the alarm was controlled with a key. Nurse #1 indicated he was unaware that the door would not unlock when the push bar was held for 15 seconds nor was he aware the door lock and alarm could only be disabled manually. Nurse #1 stated he was not aware of and had not observed any staff using the emergency door on the west hall to exit the building. An observation was conducted outside of the facility from the emergency exit door on the west hall to main entrance door on 4/09/26 at 9:12 AM. The emergency door exited at the back right side of the facility with a sidewalk that curved immediately to the left and then continued 190 feet up a hill with an approximate 9 percent incline. The sidewalk then turned left and ran directly parallel to a two-lane road that was heavily trafficked and had a posted speed limit of 30 miles per hour. The sidewalk along the road was curbed but when stepping off the curb you would be standing on the road in front of oncoming traffic. The sidewalk ran along the road for approximately 142 feet and then turned left running along the main driveway used to enter the facility's parking lot and continued in front of the building approximately 180 feet to the main entrance door. Additionally, when exiting the emergency door if you walked straight ahead and did not follow the sidewalk path, approximately 8 feet in front of the door was a concrete drain box (a concrete structure around a water drain underground). The concrete box opening was approximately 3 feet by 3 feet had no safety covering and was 3 to 4 feet deep into the ground. A follow-up interview conducted with the Maintenance Director on 4/13/26 at 10:42 AM revealed when he started working at the facility in April of 2025, he observed that the concrete drain	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 12 box outside of the west hall emergency door was not covered and mentioned it to administration however sometimes it took a while “to get things done”. He stated when the incident occurred with Resident #89 on 6/28/25 and 6/29/25 the concrete drain box was uncovered and a safety hazard. The Maintenance Director indicated on 4/10/26 he installed a safety cover over the drain box. A review of the weather records for Charlotte, North Carolina found on the Weather Underground website revealed on 6/28/25 at 2:00 AM the temperature was 77 degrees Fahrenheit with no precipitation and south-southwest winds at a speed of 6 miles per hour (mph) and on 6/29/25 at 2:00 AM the temperature was 74 degrees Fahrenheit with no precipitation and southwest winds at a speed of 3 mph. During an interview with the Director of Nursing (DON) on 4/08/26 at 3:24 PM she revealed she was notified by the Former Administrator on 6/29/25 at approximately 7:00 AM that Resident #89 exited the building at approximately 2:00 AM and was immediately redirected back into the facility. She indicated the emergency exit door on the west hall was unlocked and did not alarm and there was a concern the door malfunctioned. She stated one to one supervision for Resident #89 was initiated immediately following the incident. She stated the emergency exit door was also inspected by the Maintenance Director and was working properly and they were unsure why the door was unlocked and did not alarm. The DON indicated she was not aware prior to today that Resident #89 exited the facility unsupervised on 6/28/25. She stated she reviewed Resident #89’s record and per a nurse’s note written by Nurse #2, 30-minute checks were initiated on 6/28/25 and documented on paper. The DON indicated she was unable to locate the 30-minute checks documented on paper however they were documented on the TAR beginning 6/29/25 and continued in addition to the one-to-one supervision which was added to the staffing schedule. She stated due to Resident #89’s cognitive impairment and risk for falls it was very unsafe for him to exit the facility unsupervised due to the potential of getting lost or falling which could result in injury. The DON revealed she should have been notified of the incident on 6/28/25 and one to one supervision for Resident #89 should have been initiated immediately. A phone interview was conducted with the Former Administrator on 4/08/26 at 2:41 PM. Nursing Supervisor #1 called her on 6/29/25 at	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 13 approximately 2:30 AM and notified her that Resident #89 exited the facility through an emergency exit door that was unlocked and did not alarm. She revealed she instructed Nursing Supervisor #1 to initiate 1 on 1 supervision for Resident #89 immediately and to have a staff member assigned to monitor the emergency exit door on the west hall until it was inspected by the Maintenance Director. The Former Administrator indicated that the Maintenance Director inspected the door and it was in good working order and they were unsure why the door was unlocked and did not alarm. The Former Administrator stated the wander alarm bracelets only activated the locks and alarms on the main entrance door and the employee entrance door. The Former Administrator revealed she was not aware of the incident involving Resident #89 on 6/28/25 prior to this interview. The Former Administrator stated she should have been notified of the incident on 6/28/25 and one to one supervision should have been implemented immediately for Resident #89. She stated that a cognitively impaired resident that was at risk for falls exiting the facility unsupervised was unsafe and could result in the resident being seriously injured. The Administrator was notified of immediate jeopardy on 4/09/26 at 12:15 PM. The facility provided the following credible allegation for immediate jeopardy removal: Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #89 had an order for a wander bracelet dated 3/3/25 which was applied to his right wrist. According to Nurse #1's progress note dated 6/28/25 at 7:06am, Resident #89 was noted walking around the facility and exited through the emergency exit door on the west hallway near room W4. Resident #89's wander alarm bracelet was in place. Nurse #1 pursued Resident #89 and they re-entered the facility through the main entrance and walked back to Resident #89's room. There was no acute distress or injury to Resident #89 noted in the progress note. Resident #89 has a diagnosis of insomnia and has scheduled melatonin 3 milligrams (mg) and trazodone 50 mg at bedtime. Resident #89's medications were documented as given but he was still awake and wandering throughout the facility at night. An order was initiated on 6/29/25 for 30-minute	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 14 checks of Resident #1's whereabouts. The Licensed Nurses indicated on the Medication Administration Record that staff were completing 30-minute checks during the shift they worked. On 6/29/25 at 4:21am, Resident #89 was not noted in his room when a check was made by Nurse #1 at 1:30 am but not at 2:00 am. At approximately 2:00am, Nurse #1 immediately inspected the exit door on the west hall near room W4 and discovered the exit door was unlocked, with no alarms sounding. Nurse #1 went through the unlocked exit door to look for Resident #89 and found him walking away from the facility and guided the resident back into the facility and to his room. A new intervention was immediately put in place for Resident #89 to have 1-on-1 supervision. The wander alarm system sensors are located on the main entrance door and the employee entrance door. The 6 emergency exit doors on the units do not have wander alarm systems. The emergency exit doors have magnet locks with a wall switch that turns the lock on and off. The emergency exit doors also have red stop sign shaped alarm boxes that turn on or off with a key. If the wall switch is off and the door is opened, the red stop sign alarming device will sound as long as it is turned on. If the alarming device is turned off, the alarm will not sound. The magnet lock should be always locked, and the red stop sign alarming device should always be on unless staff are present and exiting the door for work-related purposes. The facility believes the wall switch and the red stop sign alarming device were turned off on 6/28/25 and 6/29/25 when the door did not alarm. The reason why they were turned off is unknown at this time. The Maintenance Director reported on 4/08/26 that he recalled the incident and checked the doors when he returned to work on 6/29/25. He noted that all the exit doors were functioning properly. On 4/09/26, all exit doors were checked to ensure the switch for magnet lock and red stop sign shaped alarming device were on and functioning. The Maintenance Director also checked the 2 doors with the wander alarm sensors, and they were functioning properly as well. The facility currently has a total of 12 residents with the wander alarm bracelets applied, including Resident #89, and have the potential to exit through the exit doors when they are unlocked or the alarm is not engaged. Any newly admitted residents with exit seeking behaviors and current residents with new exit seeking behaviors can also be affected.	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 15 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring, and when the action will be complete: On 4/09/26, the wander alarm company came to assess the exit doors that do not have a wander alarm system. An alarming device will be installed as a further precaution from human error in leaving the switch for the magnet lock and/or red stop sign alarming device off. The open drain located outside the west exit door is on the facility's property. It will be repaired and covered with a barrier by the Maintenance Director on 4/10/26. All facility staff including administration, nursing (licensed nurses and nurse aides), activities, social services, dietary, housekeeping/laundry, and maintenance were educated starting on 4/07/26 and all staff education will be completed on 4/10/26. If there are any facility staff that could not complete the education by 4/10/26, they will receive this education prior to their next scheduled shift. The education to all staff will be provided by the Staff Development Coordinator (SDC), Director of Nursing (DON) and Assistant Director of Nursing (ADON) and include the following information regarding the locking mechanism on the 6 exit doors that do not have the wander alarm system. The 6 exit doors have magnet locks with a wall switch that turns the lock on and off, and the red stop sign shaped alarming devices that are turned on or off with a key. If the wall switch is off and the door is opened, the red stop sign alarming device will sound as long as it is turned on. If the red stop sign alarming device is turned off, the alarm will not sound. There will be an emphasis on the importance that the magnet lock should be always locked, and the red stop sign alarming device should always be on unless staff is present and the have the alarm off for work-related purposes. The main entrance door and the employee entrance door have the wander alarm device and will lock down the door when a resident with a wander alarm bracelet comes near those doors. Nursing Shift Supervisors, DON, ADON, Quality Improvement Manager, Housekeeping Director, and the Maintenance Director have a key to the red stop sign shaped alarming device. The education also included an overview of the missing person/exit seeking protocol that includes responding to doors that alarm to determine if any resident eloped, following the chain of command by	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 16 reporting to the nursing supervisor, the DON and then the Administrator when a resident exits from the facility unattended and when a resident elopes, immediately placing the resident on 1-on-1 supervision, and not waiting for the resident to make multiple attempts to exit before initiating 1-on-1 supervision. The education will be delivered in person or by webinar with the demonstration of the exit doors via power point with images of the locking mechanism for the emergency exit doors and the red stop sign shaped alarming device. Newly hired staff will receive this education during their job specific orientation with the SDC, direct supervisor or corporate consultant. The Administrator, the Maintenance Director, and the DON are responsible for the ongoing compliance of F689. Date of IJ removal is: 4/11/26. The facility's credible allegation of immediate jeopardy removal was validated on 4/13/26. An interview conducted with the Administrator revealed the DON and SDC provided education to all staff on the facility's policy regarding the magnet locking mechanism and red stop sign alarming devices on the 6 emergency exit doors and the wander alarm system on the main entrance and employee entrance doors. The Administrator indicated the education included how the magnet locking mechanisms turn on and off with the wall switch and the red stop sign alarming devices turn on and off with a key and the importance of both devices always being turned on to ensure the emergency exit doors were locked and that the alarm sounded if the doors were opened. Interviews conducted with staff revealed they received education on the missing person/exit seeking protocol that included responding to doors that alarm to determine if any resident eloped, follow the chain of command by reporting to the nursing supervisor, DON and then the Administrator when a resident exits from the facility unattended. The staff interviewed also reported that if a resident eloped they would place them on one to one supervision immediately and then notify the Administrator and Director of Nursing of the incident. An interview conducted with the Maintenance Director revealed on 4/10/26 the open concrete box drain located outside of the west emergency exit door was covered. An observation conducted of the concrete box drain revealed it was covered and secured and an observation of the emergency exit door on the west hallway revealed the door was locked and the alarming device was engaged. The education information provided during the staff training on	F0689		05/08/2026

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F0689 SS = SQC-J	Continued from page 17 4/07/26 through 4/10/26 including the staff sign-in sheets were reviewed and no concerns were identified. The facility's immediate jeopardy removal date of 4/11/26 was validated on 4/13/26.	F0689		05/08/2026
F0812 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 observations, record review, and staff interviews, the facility failed to label and date leftover food items stored for use, keep a food preparation area clean and orderly and store a scoop without the potential for cross-contamination. These practices occurred in 1 of 2 walk-in coolers, 1 of 1 food preparation areas, and 3 of 3 Nourishment rooms (Nourishment Room #1, Nourishment Room #2, Nourishment Room #3). These practices had the potential to affect food served to residents. The findings included: a. An initial tour of the main kitchen occurred on 4/6/26 at 10:05 AM with the Dietary Manager. The following concerns were identified: - Visible dirt and grime build up present on the three water spigots above the cooking range.	F0812	White Oak Manor – Charlotte will ensure the kitchen and preparation area are sanitary and orderly; food items are properly stored, sealed, labeled, dated, free from spoilage, and discarded after manufacturer's expiration date; and store a scoop properly without the potential for cross-contamination. The visible dirt and grime build up present on the 3 water spigots above the cooking range was cleaned by Toma Fire Protection Solutions Company on 05/08/2026. The plastic scoop that was left in the rice bin with the handle and bottom touching the rice in the food preparation area was removed and cleaned when noted during survey. The cardboard flat of 9 croissants that were cut open with no open or use by date and not re-sealed that was found in walk-in cooler #2 were discarded when noted during survey. The one half-eaten crème pie with three used plastic forks in the pan and the one small reusable container of ranch dressing in the refrigerator in Nourishment Room #1 that were open and not labeled with an open or use by dated were discarded when noted during survey. The vanilla pudding cup and one wrapped fast-food sandwich in the refrigerator in Nourishment Room #2 that was open with an open date but no use by date was discarded when noted during survey. The one fast food milkshake that was found in the refrigerator in Nourishment Room #3 with no open or use by date was discarded when noted during survey. A thorough audit of the sanitation of the food preparation areas of the kitchen and food items in the walk-in cooler, kitchen and the three Nourishment Rooms including proper storage of food scoops, labeling and dating leftovers and food items, and discarding items by the use by date was	05/08/2026

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F0812 SS = E	Continued from page 18 - A plastic scoop was left in the rice bin with the handle and bottom touching the rice in the food preparation area. - A cardboard flat of 9 croissants was cut open with no open or use by date was found in walk-in cooler #2. Seven croissants had been used from the container and not resealed. An interview with the Dietary Manager on 4/6/26 at 10:10 AM the vent hood had been cleaned by an outside vendor a few months prior. She stated she would have water spigots included in the next cleaning. The Dietary Manager also stated the open croissants were missed by kitchen staff and the rice scoop should be stored in the appropriate holder on the bin. b. Items found in the refrigerator in Nourishment Room #1 on 4/6/26 at 10:18 AM that were open and not labeled with an open or use by date included: - One half-eaten creme pie with three used plastic forks in the pan, - One small reusable container of ranch dressing. c. Items found in the refrigerator in Nourishment Room #2 on 4/6/26 at 10:20 AM that were open with an open date, but no use by date included: -One vanilla pudding cup dated 4/6, -One wrapped fast-food sandwich dated 3/9. d. One fast food milkshake was found in the refrigerator in Nourishment Room #3 on 4/6/26 at 10:22 AM with no open or use by date. A second interview with the Dietary Manager occurred on 4/6/26 at 10:20 AM and revealed all food in the nourishment rooms needed to be labeled with an open date and a use by date which should be seven days after the open date. The Dietary Manager stated the pudding cup should have been thrown away by nursing staff after it was opened. A third interview with the Dietary Manager on 4/9/26 at 3:02 PM revealed she had a few new staff members who were not labelling the opened items correctly in the coolers by forgetting to add the appropriate dates. The Dietary Manager stated the nourishment rooms were inspected by kitchen staff each morning and had not yet been completed on	F0812	Continued from page 18 completed on 4/09/2026 by the Dietary Manager (DM). The Dietary staff were re-educated on the sanitation of kitchen areas including the food scoops and the food preparation areas to ensure the areas are clean and the cleaning schedule is strictly followed. The re-education also included checking all food items to ensure the items are stored, labeled and dated appropriately and discarded by the used by date including in the walk-in cooler of the kitchen. All scoops used in the facility should be placed back in the designated holder after use and should never be left in the bins. All open food must be labeled with the date opened, and then covered or re-sealed prior to storing the unused portions. All kitchen range spigots will be cleaned during the hood cleaning every 6 months by the contracted Fire Protection Solutions Company. This re-education was completed on 4/09/2026by the Corporate Consultant. Newly hired Dietary staff will receive this education during their job specific orientation by the Dietary Manager (DM). The Nursing staff including licensed nurses and nurse assistants were re-educated on the sanitation of Nourishment Rooms and all food items, including leftovers are stored, labeled and dated appropriately and discarded by the used by date or 3 days after open date. All resident food stored in Nourishment Rooms' refrigerators must be labeled with the date the food was placed in the refrigerator or opened and the resident's name and room number. And any food and beverage not consumed within 72 hours of being opened must be discarded. Any unopened food or beverage may remain in the refrigerator until the expiration date on the package. All refrigerators in the Nourishment Rooms must be checked daily and any food item not correctly labeled/dated, expired, or past the 72-hour window from opening must be discarded to ensure food storage safety. This re-education was completed on 5/08/2026 by the SDC. Newly hired nursing staff will receive this education during their job specific orientation by the SDC. The Administrator or DM will monitor the kitchen twice a week for 12 weeks for sanitation and storage including the food scoops, the food preparation areas, and all food items are stored, labeled and dated appropriately and discarded by the used by date including in the walk-in cooler, and ensure the kitchen range spigots are clean. The results from the monitoring will be discussed weekly during the morning QI meetings for 12 weeks.	05/08/2026

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F0812 SS = E	Continued from page 19 the morning of 4/6/26. She stated nursing staff often left items in the nourishment room refrigerators and did not label them appropriately. An interview with the Administrator on 4/9/26 at 4:40 PM revealed he had the expectation for the kitchen staff to properly store food served in the facility.	F0812	Continued from page 19 The identified issues or trends will be further discussed at the monthly QA meeting with the team and recommendations made as indicated. The DM is responsible for the ongoing compliance of F812. Compliance date is 05/08/26.	05/08/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his	F0550	White Oak Manor – Charlotte will ensure each resident is treated with respect and dignity, and their rights are honored, including maintaining residents' dignity by wheeling them forward in a geriatric chair. Resident #67 will be wheeled forward in their geriatric chair when possible and be treated with respect and dignity. Other current and newly admitted residents will also be treated with respect and dignity and wheeled forward in their geriatric chair. Nursing Assistant (NA) #6 and other facility staff including nursing, social services, and activities were immediately re-educated verbally on always wheeling the residents forward unless there is a safety issue or a situation that can be explained to the residents if they have to be wheeled backwards. Future education will be included in orientation with an updated protocol for 'Points to Remember in Respecting Dignity' dated 04/13/2026 to follow: do not pull residents backwards in a wheelchair or Geri-chair recliner for your convenience and it would be considered, a dignity issue, not being respectful, making residents feel like a helpless object instead of a person, and frightening the residents. Backward motion in a wheelchair or Geri-chair recliner is appropriate when navigating obstacles or doorway issues. And always explain to the resident why staff are having to go backwards, always ask for permission before moving a person's mobility device or communicate by explaining what you are doing for residents that have severe cognitive impairment. The residents should be transported forward-facing whenever possible to protect their dignity, and engage with the resident at eye level as possible when talking with residents. This education was started on 5/1/2026 by the Staff Development Coordinator (SDC) and completed on 5/8/2026. Newly hired facility staff in nursing, activities and social services will receive this education during their job specific orientation by the SDC. Nursing Administration will monitor by observing 5 staff members wheeling residents in their wheelchair	05/08/2026

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F0550 SS = D	Continued from page 20 or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to maintain a resident's dignity when Nurse Aide (NA) #6 quickly pulled Resident #67 backward down the hall approximately 30 feet from the day room to her room while reclined in a geriatric chair for 1 of 3 sampled residents reviewed for dignity (Resident #67). A reasonable person would have expected to be treated with dignity and would have wanted to be wheeled forward in their geriatric chair. Findings included: Resident #67 was readmitted to the facility on 6/25/25. A review of the quarterly MDS dated 1/13/26 revealed Resident #67 was assessed as having clear speech and severe cognitive impairment. The assessment indicated Resident #67 required the use of a wheelchair for mobility. During a continuous observation on 4/6/26 at 2:45 PM in the South Hall, NA#6 was observed quickly pulling Resident #67 backward down the hall approximately 30 feet from the day room to her room while she was reclined in a geriatric chair. During an interview on 4/9/26 at 2:39 PM, NA #6 indicated the Resident #67 used a reclining geriatric chair. He stated when he took Resident #67 from the day room to her room, he felt it was better to pull her backward down the hall because it was harder to push her chair moving forward even when she was reclined. NA #6 stated he was not aware of any problems with the reclining geriatric chair. An interview and observation with Social Worker #1 were completed on 4/9/26 at 3:36 PM. While Resident #67 was resting in bed, SW #1 pushed Resident #67's reclining geriatric chair forwards and backwards in the South Hallway. There were no noted concerns with the chair not functioning properly. SW #1 stated Resident #67's reclining geriatric chair was working fine and needed no repairs. A telephone interview with the Staff Development Director on 4/13/26 at 12:06 PM revealed all staff were educated during orientation and received ongoing education on residents' rights and dignity. He also stated staff were frequently educated on	F0550	Continued from page 20 or geriatric reclining chair weekly for 12 weeks to ensure residents are being transported appropriately forward-facing and are treated with respect and dignity while being transported. The identified trends or issues will be discussed weekly for 12 weeks during morning Quality Improvement (QI) meetings, and then brought to the Quality Assurance (QA) Committee meetings for further recommendations from the team as indicated for 3 months. The Administrator and Director of Nursing (DON) are responsible for the compliance of F550. Compliance date is 05/08/26.	05/08/2026

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F0550 SS = D	Continued from page 21 resident wheelchair use, including caution with speed and when or if footrests should be used. The Staff Development Director stated Resident #67 should not have been pulled backwards in her geriatric chair and he would make a note to include the term geriatric chair along with wheelchairs for future staff education. An interview with the Director of Nursing on 4/9/26 at 3:58 PM revealed she expected staff to push residents in their wheelchairs forward and not at a fast pace. An interview with the Administrator on 4/9/26 at 4:34 PM revealed he expected staff to push residents in wheelchairs and geriatric chairs forward in a dignified manner and at a normal pace.	F0550		05/08/2026
F0677 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 observations, record reviews, resident and staff interviews, the facility failed to provide hair washing services for 1 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #144). The findings included: Resident #144 was admitted to the facility on 2/28/24 with diagnoses which included senile degeneration of the brain, chronic obstructive pulmonary disease, and heart failure. Resident #144's care plan, last revised 3/23/26, had a focus area for ADL deficits due to generalized weakness Interventions included set up for hair and oral hygiene daily and assist with bathing and dressing, encouraging Resident #144 to do as much as possible. Resident #144's annual Minimum Data Set (MDS) assessment dated 3/24/26 revealed she was severely cognitively impaired and extensive assistance from staff for ADL. The MDS further revealed Resident #144 had no behaviors, and there was no rejection of care noted.	F0677	White Oak Manor – Charlotte will ensure residents dependent on Activities of Daily Living (ADL) receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene including hair washing services. Resident #144 will be provided with hair washing services and hair will not look greasy, dirty or stringy. Resident #144 hair was washed and groomed on 4/9/26 by Resident's assigned CNA when noted during survey. CNA completed this task later that same evening. Resident # 144 hair is washed at least twice a week but as often as needed. All current and newly admitted residents will receive timely hair washing services during their shower days, beauty shop visits or as needed when identified having first signs of greasy, stringy or dirty hair. An audit of current residents completed by the Director of Nursing and each Unit Secretary by 5/08/2026 to ensure no other resident had dirty, greasy or stringy hair and if they did, received hair washing services. The Nursing staff including licensed nurses and nursing assistants were educated on the expectation that residents should receive showers at least twice weekly with their hair also being washed as part of the shower. Residents should not be given a bed bath in place of a shower unless the resident requests the bed bath. If the resident refuses a shower or requests a bed bath instead of the shower, the licensed nurse must be notified. The nurse will then need to enter a progress note indicating the resident's refusal or preference of a bed bath and alternative means to wash the resident's hair should be arranged. If a resident has	05/08/2026

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F0677 SS = D	Continued from page 22 A review of the facility shower schedule revealed Resident #144 was to be showered on Tuesday and Friday mornings on first shift. An observation of Resident #144 on 4/6/26 at 11:30 AM revealed Resident #144 lying in her bed watching television. Her hair was long, stringy and visibly greasy. A second observation of Resident #144 on 4/7/26 (Tuesday) at 10:00 AM revealed Resident #144 sleeping in her bed and her hair was visibly greasy and dirty and stuck flat against her head. A third observation of Resident #144 on 4/9/26 at 10:40 AM revealed Resident #144 watching television in her bed. Her hair was stringy, visibly dirty and stuck against her head. A review of Resident #144's Electronic Medical Record (EMR) indicated she received a shower on the morning of 4/7/26 by Nurse Aide (NA) #5. An interview with NA #5 on 4/9/26 at 2:33 PM revealed she was assigned to Resident #144 on 4/7/26 and gave her a bed bath. NA #5 stated she did not give Resident #144 a full shower but always gave her a bed bath on her shower days. She stated she would typically wet down Resident #144's hair during the bed bath but stated her hair was becoming "all tangled up," especially in the back. NA #5 also stated a bathing team from Hospice services came a couple of times a week for additional bath visits but was unsure what they did when they visited Resident #144. NA #5 stated Resident #144 used to go to the beauty shop to have her hair washed and trimmed, but she believed it had been over two months since Resident #144 had gone, and she was not sure why her hair was not being done in the beauty shop. A telephone interview with the Hospice Nurse occurred on 4/9/26 at 4:09 PM. She stated the Hospice team visited Resident #144 a couple of times a week for bath visits and they would provide bed baths and use a no-rinse shampoo product for her hair. She was not sure when Resident #144's last bath visit was during the week of 4/6/26. The Hospice Nurse stated Resident #144 was able to get up out of bed, but she found Resident #144 to be in her bed on most of her visits. The Hospice Nurse stated she was not sure what type of showers or baths the facility provided Resident #144 regularly. A telephone interview with the Beauty Shop Operator occurred on 4/13/26 at 12:16 PM. She indicated she	F0677	Continued from page 22 a decline in condition and is unable to sit upright for a shower then the shower bed needs to be utilized and nurse management (DON, Assistant Director or Nursing (ADON) or Supervisors) need to be made aware that the resident's abilities have changed. Nurse management will assist in finding a solution for the resident to be showered and hair to be washed on a regular basis. This education was started on 5/1/2026 by the SDC and will be completed by 05/08/2026. Newly hired nursing staff members will receive this education during their job specific orientation by the SDC. Nursing Administration will monitor by observing 5 residents due for their shower/bath and their hair washed weekly for 12 weeks to ensure residents receive hair washing services. 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 05/08/26.	05/08/2026

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F0677 SS = D	Continued from page 23 had seen Resident #144 before in her shop, but she had not seen her recently. The Beauty Shop Operator stated she was in another facility and did not have her full schedule with her to verify Resident #144's appointments but stated the Unit Secretary at the facility kept track of a monthly beauty shop list for the residents who received Medicaid. She stated if a resident missed an appointment for whatever reason, they were added to the next month's schedule. The Beauty Shop Operator stated she would add Resident #144 to her list to be seen the following week. A telephone interview with the Unit Secretary on 4/13/26 at 12:22 PM revealed it had been a while since Resident #144 was in the beauty shop. She indicated she kept a book with a beauty shop list for the Beauty Shop Operator for the last two months but had just cleaned out some of the previous lists. The Unit Secretary stated she believed it had been longer than two months since Resident #144 had visited the beauty shop and her name had been left off the list by mistake. An interview with the Director of Nursing (DON) on 4/9/25 at 4:02 PM revealed Resident #144 received additional bath visits from the Hospice team two to three times a week. She indicated that any NA assigned to Resident #144 was expected to bathe her twice a week and she knew they performed a thorough wash down of each resident. The DON stated she did not know when Resident #144's hair had been washed last and indicated the NAs assigned to her would know. An interview with the Administrator on 4/9/25 at 4:35 PM was conducted. He expected when Resident #144 was scheduled for a shower, her hair would be properly washed.	F0677		05/08/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F0880	White Oak Manor – Charlotte ensures to implement and maintain an infection prevention and control program and policies designed to provide safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections, which includes following policies and procedures for Enhanced Barrier Precautions (EBP). Resident #132 will have nursing staff wearing a gown when provided with catheter care. Resident #161 will have nursing staff wearing a gown when being transferred using a mechanical lift since they have a feeding tube. Other current and newly admitted residents that have a catheter and/or feeding tubes will be provided with same care and	05/08/2026

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F0880 SS = D	Continued from page 24 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 24 maintained infection prevention. Current licensed nurses and nursing assistants were re-educated on the following: EBP are utilized to prevent the spread of Multi Drug-Resistant Organism (MDRO) infections to residents that are at increased risk. EBP must be used with residents that have indwelling devices like feeding tubes, urinary catheters, PICC lines or midlines, central lines, dialysis catheters, tracheostomies, and chronic wounds. EBP includes the use of gowns and gloves during high contact care activities including: dressing, bathing, changing linens, transferring (including with a mechanical lift, providing hygiene, assisting with toileting, and providing device care (catheter care, providing tube medications, feeding, or care, accessing or flushing lines, or providing wound care). The re-education also included that all staff must use gowns and gloves with the high contact care activities. And if doubt about the activity being considered high contact you must air on the side of caution and wear your gown and gloves. This re-education will be by 05/08/2026 by Nursing Administration. Newly hired Licensed Nursing Staff and Nursing Assistants will receive this education during their job specific orientation by the SDC. Nursing Administration will monitor by performing 3 random observations weekly for 12 weeks of nursing staff caring for residents on EBP to ensure they using gowns and gloves for high contact care and activity. Results from the monitoring will be discussed during the QI morning meetings weekly for 12 weeks. The identified issues or trends will be further discussed at the monthly QA meetings with the care team and recommendations made as indicated. The DON is responsible for ongoing compliance of F880. Compliance date is 05/08/26.	05/08/2026

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F0880 SS = D	Continued from page 25 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions (EBP) when Nurse #5 did not wear a gown while providing catheter care for Resident #132 and Nurse Aide (NA) #3 and NA #4 failed to wear a gown while conducting a mechanical lift transfer of Resident #161 who had a feeding tube. The deficient practice occurred for 3 of 10 staff members observed for infection control practices (Nurse #5, NA #3, and NA #4). The findings included: A review of the facility's policy titled "Enhanced Barrier Precautions," revised on 7/26/2022, indicated: · Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities. · High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, Peripherally Inserted Central Catheter (PICC) lines, midline catheters, and wound care if deemed chronic by a medical provider or if MDRO was present. An observation of catheter care for Resident #132 provided by Nurse #5 was made on 4/08/2026 at 1:47 PM. Resident #132's room had an enhanced barrier precautions sign posted outside the door with personal protective equipment (PPE) stored in a plastic bin on the door including gowns. The signage on the door instructed staff to apply a gown and glove during high contact resident care activities. Nurse #5 entered the room without	F0880		05/08/2026

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F0880 SS = D	Continued from page 26 wearing a gown. She washed her hands and put gloves on. She then removed the residents brief and proceeded to provide catheter care for Resident #132. Nurse #5 then discarded any unused supplies and her gloves and proceeded to wash her hands with soap and water at the sink. An interview with Nurse #5 on 4/08/2026 at 1:55 PM revealed she was aware that Resident #132 was on enhanced barrier precautions. Nurse #5 stated that she only needed to wear a gown if she were changing the catheter, not while providing catheter care. She explained she had received the infection control training on EBP but must have just misunderstood the instructions. An interview with the Infection Preventionist was completed on 4/09/26 at 9:43AM. The Infection Preventionist stated he completed rounds daily to ensure that all residents had the appropriate infection precaution signs posted and staff had available PPE. The Infection Preventionist reported that all staff were trained during orientation on proper use of PPE and proper PPE use was reviewed in monthly staff meetings on all shifts by the Infection Preventionist and shift supervisors. The facility most recently had an Infection Control in-service covering EBP two weeks prior. The Infection Preventionist stated that the staff should wear the appropriate PPE according to the infection precaution signs posted for each resident and that included wearing PPE (gown and gloves) while providing catheter care for residents on EBP. An interview with the Director of Nursing (DON) was completed on 4/08/2026 at 2:55 PM. The DON stated she expected all staff members to use the appropriate PPE according to the infection precaution sign posted for each resident. 2. An observation was conducted with Resident #161 on 4/6/2026 at 12:36 PM. Resident #161's room had an Enhanced Barrier Precautions (EBP) sign posted on the door with a hanging plastic holder containing Personal Protective Equipment (PPE) on the door. A partially filled container of tube feeding formula was hanging by the bedside. Resident #161 was returning from an outside appointment and was seated in his wheelchair. Nurse Aide #3 (NA) and NA #4 were observed entering the room with the mechanical lift to assist Resident #161 into bed. NA #3 and NA #4 were not wearing gowns. Both were wearing gloves. NA #3 and NA #4 completed the mechanical lift transfer.	F0880		05/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345238	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 27 An interview with NA #3 was conducted on 4/6/2026 at 12:56 PM as he exited Resident #161's room. NA #3 was shown the Enhanced Barrier Precautions sign and asked what it meant. NA #3 stated he was aware Resident #161 was on Enhanced Barrier Precautions due to having a gastrostomy tube for tube feeding. NA #3 stated a gown was only required when performing some type of care not when transferring a resident. When shown the portion of the sign that indicated both a gown and gloves were required for transferring a resident, NA #3 stated again that transferring was not performing care and he did not consider a transfer to be a high-contact resident care activity. An interview with NA #4 was conducted on 4/6/2026 at 1:05 PM. NA #4 indicated she usually worked on the West unit and was unsure what was required on the East unit. NA #4 stated that 4/6/2026 was the first time she had worked with Resident #161. When asked how NA #4 knew who was on EBP on the West unit, NA #4 stated she followed the EBP signage. When asked if the EBP sign on Resident #161's door was different than the signs used on the West unit, NA #4 stated, "No." NA #4 stated she sometimes used a gown when transferring residents on EBP but not all of the time. An interview was conducted on 4/9/2026 at 11:00 AM with the Infection Preventionist. The Infection Preventionist stated that NA #3 and NA #4 should have worn a gown when entering the room to provide a mechanical lift transfer for Resident #161 as that was considered a high-contact resident care activity. The Infection Preventionist indicated that the EBP sign was posted on the door along with the hanging plastic holder containing PPE as he rounded daily to make sure the signage was accurate and PPE was available. The Infection Preventionist further stated that he had completed an all staff Infection Control in-service approximately 2 weeks ago which included training on EBP and PPE use. NA #3 and NA #4 had received this recent training as well as EBP training during orientation when hired, monthly EBP/PPE use reviews during staff meetings and yearly through online training modules. An interview was conducted on 4/9/2026 at 4:10 PM with the Director of Nursing (DON). The DON stated all staff members should utilize the appropriate PPE according to the infection control signage posted for each resident. The DON stated NA #3 and NA #4 should have worn a gown when conducting the mechanical lift transfer for Resident #161.	F0880		05/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345238	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

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F0880 SS = D	Continued from page 28 An interview was conducted on 4/9/2026 at 4:28 PM with the Administrator. The Administrator stated he expected staff to wear the required PPE when providing care to residents on EBP. The Administrator stated NA #3 and NA #4 should have worn gowns when transferring Resident #161.	F0880		05/08/2026