DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			PLETED
		345238	B. WING			C 14/2019
NAME OF PF	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	01/	14/2019
		_	400	O CRAIG AVENUE		
WHITE OA	K MANOR - CHARLOTT	E	СН	ARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	Resident #1 verbally had stuck his finger u resident's (Resident # into action an effectiv monitor his behaviors being observed atterr intercourse with Resid Immediate Jeopardy when the facility prov credible allegation of removal. The facility at the lower scope an actual harm with pote harm that is not immer monitoring systems p An extended survey w Immediate Jeopardy when the facility prov Credible Allegation of removal. The facility at the lower scope an actual harm with pote harm that is not immer monitoring systems p An extended survey w Immediate Jeopardy when the facility prov Credible Allegation of removal. The facility at the lower scope an actual harm with pote harm that is not immer monitoring systems p An amended Statemer provided to the facility Informal Dispute Res	began on 12/27/18 when told direct care staff that he p a cognitively impaired 42) vagina. Staff failed to put e plan to address and resulting in Resident #1 opting to have sexual dent #3 on 01/04/19. was removed on 01/14/19 ided and implemented a Immediate Jeopardy remains out of compliance d severity level of D (no ntial for more than minimal ediate jeopardy) to ensure ut into place are effective. was removed on 01/14/19 ided and implemented a Immediate Jeopardy remains out of compliance d severity level of D (no ntial for more than minimal ediate jeopardy) to ensure ut into place are effective. was removed on 01/14/19 ided and implemented a Immediate Jeopardy remains out of compliance d severity level of D (no ntial for more than minimal ediate jeopardy) to ensure ut into place are effective.				
		rel citation and information in ged to reflect the results of U11.				
F 600	Free from Abuse and	Neglect	F 600			2/6/19
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	 E	TITLE		(X6) DATE
	cally Signed					02/04/2019

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 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.

	MENT OF HEALTH AN					FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		345238	B. WING _				C 14/2019	
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WHITE O	AK MANOR - CHARLOTT	E			009 CRAIG AVENUE CHARLOTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600 SS=J	CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the ineglect, misappropria and exploitation as deiincludes but is not limic corporal punishment, any physical or chemit treat the resident's me §483.12(a) The facility §483.12(a) The facility §483.12(a)(1) Not use physical abuse, corporinvoluntary seclusion; This REQUIREMENT by: Based on record revip physician interview, th of 3 sampled resident from sexual abuse from Immediate Jeopardy I Resident #1 verbally thad stuck his finger u resident's (Resident # put into action an effer monitor his behaviors being observed attern intercourse with Resid Immediate Jeopardy when the facility provident credible allegation of removal. The facility at the lower scope an actual harm with pote	m Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or ' is not met as evidenced ew, staff interviews and he facility failed to protect 2 s (Residents #2 and #3) im Resident #1. began on 12/27/18 when told direct care staff that he p a cognitively impaired '2) vagina and staff failed to ctive plan to address and resulting in Resident #1 pting to have sexual dent #3 on 01/04/19. was removed on 01/14/19 ded and implemented a	F	500	F-600 The facilities corrective actions for thos residents sited in F-600 and F-607 are follows: On 12/27/2019, regarding Resident #2, the corrective action was place Resident #1 on thirty minute monitoring and to place an alarm stop sign across the door of Resident #2. C 12/28/2019, Resident #1 was relocated a different unit within the facility. On 1/4/2019, regarding Resident #3, the corrective action was to place Resident on one-to-one monitoring which continu until Resident #1 discharged to the hospital on 1/9/2019. In addition, Resident #1 was evaluated by the facilities Medical Director and visiting Psychiatrist.	as to On I to t #1		

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 04/10/201 FORM APPROVE B NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345238	B. WING				C 01/14/2019
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE			
			4009 CRAIG AVENUE		CRAIG AVENUE		
WHILE OF	K MANOR - CHARLOTT	E		CHA	ARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	Continued From page	a 2	F 60				
1 000			FO				
	monitoring systems p	out into place are effective.		.	The facility initiated measures to ide	ontify	
	The findings included	ł.			other residents who have the poten	-	
	The mange melade				be affected by abuse, neglect, or		
	1. Resident #1 was a	dmitted to the facility on			exploitation through the re-educatio	n and	
	12/13/18 with diagnos	ses of disorientation, benign		i	in-servicing of staff, monitoring tools	s, and	
		tary gland, unspecified			weekly interviews. All nursing staff,	,	
	-	order and depressive			administration, and supporting		
	disorder.				departments received an initial		
	A 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.				re-education of the facilities policy for		
		ted 12/13/18 included			neglect, abuse, mistreatment, threa or alleged abuse of residents begin		
	Quetiapine Fumarate	tion) 25 milligrams (mg)			on 1/4/2019 and completed on 1/11	-	
		for unspecified dementia			Additional in-service trainings regar		
		bance; Mirtazapine (i.e.			the facilities abuse policy, training, a	-	
		essant medication) 15mg			reporting of abuse standards were s		
	take one tablet at bec	dtime for major depressive			on 1/25/2019 completed on 1/30/20		
	disorder unspecified;	and Donepezil (i.e. Aricept			These trainings included items deer	ned	
		moderate dementia) 5 mg			as immediately reportable to the		
	•	nspecified dementia with			Administrator and Director of Nursir	-	
	behavioral disturbance	ce.			The Administrator, Director of Nursi	ng,	
		(OT) potes dated $12/19/19$			Social Services Director, and Unit	aina an	
		(OT) notes dated 12/18/18 esident #1 demonstrated the			Coordinator received additional train F-600 items considered to be report	-	
		wheelchair brakes. The OT			to DHSR on 1/9/2019 and was com		
	-	verbal cues for safety			on 1/14/2019. All Departmental		
	•	dent #1 needed stand by			Management were in-serviced on		
		bulating in room with a			1/14/2019 for procedural reviews ar		
		ent #1 was able to manage			expectations of abuse reporting. All		
		olling walker with stand by			employee hires receive Abuse Polic	-	
	assistance.				Training during orientation. All staff		
	Desident #1's admiss	sion Minimum Data Set			annually re-inserviced on the facilition Abuse Policy and as needed to ass		
		8 coded him with being			compliance with F-600 and F-607.		
		erstanding, having intact			will be an ongoing measure. Reside		
		are 1 to 3 days during the			interviews are being conducted with		
		uiring extensive assistance			residents on a weekly basis by the		
		nsfers, walking, dressing,			Services Director. These interviews		
	and toileting, and limi				started on 1/12/2019 and will contin		

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	E CONSTRUCTION	(X3)	DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED
					-	С
		345238	B. WING			01/14/2019
NAME OF PR	ROVIDER OR SUPPLIER		- i	STREET ADDRESS, CITY,	STATE, ZIP CODE	
		-	4009 CRAIG AVENUE			
	K MANOR - CHARLOTT	E		CHARLOTTE, NC 282	11	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 600	Continued From page	23	F 60	D		
	locomotion and eating			-	. The Social Services	
				-	estions regarding being	
	A care plan was initia	ted on 12/20/18 for the issue		-	n to in a sexual manner,	
		e inappropriate comments			sexually inappropriate	
		female staff. The goal was			n staff and/or residents,	
		Id have no increase in			rivacy. The Assistant	
		comments. Interventions resident in a professional		observations on r	ng is conducting five	
		es inappropriate comments,			ng on 1/11/2019 and	
		insult as needed and liaison			19. These observations	
	with family as needed			-	or signs/symptoms of	
	,			distress, disarray	• • •	
	The Care Plan Asses	sment (CAA) for cognition		belongings, and a	assessment of residents	
		d Resident #1 had dementia		baseline. The res		
		gnition. His mood state can			ations are used to	
		. Over the look back period,		-	that are to be reported	
	and confusion.	ed times of disorientation		Director of Nursir	e Administrator or	
					morning QI meetings and	
	The CAA for behavior	rs dated 12/27/18 stated the			he QI Abuse Monitoring	
		tatus problems may also		form.		
	-	ivioral symptoms. He has a				
	diagnosis for dementi	a with behavioral				
		aking medication for this.		-	emic changes and	
	Although the resident				also aid in identifying	
		npact himself or others, he			ve the potential to be	
	this time.	nreat to himself or others at			sited in F-600 and s are being conducted	
					e plan meeting with the	
	The OT notes dated	12/26/18 at 10:31 AM stated		resident and/or th		
		oved in standing tolerance			hese interviews began	
		nents with toileting and lower			include questions	
	body dressing. He w				ouched or spoken to in a	
	wheelchair through th	ie facility.			eeing or hearing sexually	
	Desidental				navior between staff	
		onger in the facility as he			and invasion of privacy.	
	-	e hospital for surgery on w with Resident #1 could be		-	ons are also being asked Council meetings every	
	conducted.				th the meeting on	

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			000 100			IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	. ,	E SURVEY IPLETED
			7	~		С
		345238	B. WING		0	1/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
	K MANOR - CHARLOTT	F		4009 CRAIG AVENUE		
				CHARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE HENCY)	(X5) COMPLETIO DATE
F 600	Continued From page	e 4	F 60	00		
				1/15/2019. On 1/12/20	-,	
	Resident #3 was adm	-		hour report was develo		
		ses included essential		verbal or physical state		
	with mixed anxiety an	ailure, adjustment disorder		Unit coordinators and/o nursing staff are require		
	ischemic attacks.			attest to that no allegati		
				occurred during their sh		
	Her most recent MDS	S, a quarterly dated 12/20/18		signature pages are co		
		ely impaired cognitive skills,		reviewed by the Directo	-	
		and requiring extensive to		QI team on a daily basi	-	
		all activities of daily living		could be reported. The	÷	
	skills.			management staff have the revised 24 hour rep		
	Review of an occurre	nce report dated 01/04/19 at		reports being reviewed		
		at Resident #1 was in		during morning QI mee		
	Resident #3's room w	ith socially inappropriate		aware to report any sus	-	
	•	sident to resident altercation.		abuse to the Administra	ator and/or Director	
		y Nurse Aide (NA) #3 with		of Nursing immediately		
		assigned to resident care.		monitoring tool was als	-	
		nmary stated Resident #1 p of Resident #3 with his		assist in trending or find		
		#3's brief was open on the		through reporting of grid occurrence reports, the		
		ents were separated and a		and resident interviews		
		nt #3 revealed no redness or		facility has in place a m		
	blood noted in the vag			suspected abuse allega	-	
				documenting any repor		
		ely began an investigation		regardless of the type of		
	-	ements and a body audit of		help with identifying tre	•	
		audit picture signed by #6 on 01/04/19 stated no		The use of this monitor 1/13/2019 and will cont		
		e noted at 12:15 AM but also		3/9/2019. All reported a	-	
	noted on the right sid			completed per regulation		
	"excoriation."			reports made to DHSR	will be discussed	
				in the morning QI meet	ings.	
		y NA #3 dated 01/03/19				
		was doing her first round,		After 3/3/2019, the QA		
	she entered Resident	f Resident #3. Resident #3		continue to monitor on the results of the plan of		
		nd pushing his head away.		questionnaire weekly, t		

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		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · /	IPLETED	
						С	
		345238	B. WING		0	1/14/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WHITE O	AK MANOR - CHARLOTT	E		4009 CRAIG AVENUE CHARLOTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 600	The statement stated hand) position 'himse After the incident he of inappropriate sexual was looking for more Interview via phone w 1:49 AM revealed that Resident #3 beginnin through 7 AM on 01/0 began her normal rou 01/04/19 with Reside entered the resident's back the curtain she s Resident #3. Reside and pushing Residen stated Resident #3's periarea was "very m was also exposed an hand positioning hims obvious to her he was with Resident #3. Sh nurse and started to st the time he did not sa afterwards Resident # was and how Resident me die this wayI do #3 stated she had no this encounter during assigned to care for F that after this incident	"He was trying to (penis in off' better in her vaginal area." continued to make remarks and indicated he sexual activity. with NA #3 on 01/10/19 at at she was assigned to g 11 PM on 01/03/19 04/19. She stated that she unds around midnight on nt #3. NA #3 stated she s room and when she pulled saw Resident #1 on top of nt #3 was asking for help t #1's head away. NA #3 dress was up and her uch exposed." Resident #1 d he had his penis in his self. NA #3 stated it was s trying to have intercourse he immediately yelled for the separate the residents. At ay what he was doing, but #1 was saying how good it	F 60		nittee will y any lop nce with to the QA		
	care than previously. A written statement b revealed she heard th help. Upon entering						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345238	B. WING		_		C 14/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WHITE OA	K MANOR - CHARLOTT	E		1009 CRAIG AVENUE CHARLOTTE, NC 28211	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #1 had his p himself. Resident #1 audit of Resident #3 r bleeding to the vagina Nurse #5 was intervie at 7:16 PM. Nurse #5 entered Resident #3's for help. Resident #1 Resident #3. She sta Resident #3's brief wa had his pants partially It appeared to Nurse # position himself to har #3. Nurse #5 stated s #1 and screamed for lying there saying 'ple don't hurt me, please After Resident #1 was continued to just lie th stated NA #3 had pull Resident #3. Nurse # #6 with the body audii open and she was ex afterward, Resident # he got himself one tor a follow up phone inter 01/11/19 at 9:33 AM, document the 30 minus She estimated she sa at approximately 11:4	as open on one side and benis out trying to position was removed and a body evealed no redness or al area. wed via phone on 01/09/19 5 stated she immediately 5 room upon the NA calling was observed on top of ted the right side of as open and Resident #1 7 down exposing his penis. #5 Resident #1 was trying to ve intercourse with Resident she screamed at Resident NA #4. Resident #3 was ase don't hurt me, please don't let me die like this.' s removed, Resident #3 here and cry. Nurse #5 ed Resident #1 off of #5 stated she assisted Nurse t and noted the brief was posed. Nurse #5 stated 1 was bragging about how hight and she liked it. Upon erview with Nurse #5 on she stated it was her duty to ute checks on Resident #1. w him at the nursing station	F 600		DEFICIENCY)		
	during initial rounds a	ed he had seen Resident #1 round 11:15 PM to 11:30 ped with a brief and pajama					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345238	B. WING		_	(01/ ⁻	_ 14/2019
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	K MANOR - CHARLOTT	F	4	1009 CRAIG AVENUE			
	AR MANOR - CHARLOTT	E	(CHARLOTTE, NC 2821 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page bottoms on. He heard found NA #3 and Nurs By this time, Resident and leaning over the r Resident #1 was sittir with his penis expose in a wheelchair and m was immediately plac supervision. Phone interview with 7:30 PM revealed he the night shift beginni Nurse #5 called him a Resident #3's room, F the edge of the bed h and Resident #3's brid When he asked Resid Resident #1 said he w immediately reported administrator and the Resident #3 appeared frightened despite her A phone interview with occurred on 01/09/19 that she saw him initia twice more, once afte sexual behaviors. She alert and oriented but of vascular dementia. included that he was asex with Resident #3.	 7 d a NA call out for help and se #5 in Resident #3's room. #1 was observed standing resident. NA #4 then stated up on the edge of the bed d. Resident #1 was placed noved to the parlor where he ed under one on one Nurse #6 on 01/09/19 at was the supervisor during ng 01/03/19. He stated und when he arrived to Resident #1 was sitting on is pants were partially down of was open on one side. dent #1 what happened, was sorry. Nurse #6 the incident to the Director of Nursing (DON). d afraid and was visibly 	F 600				
	has had 2 children by same time which the physician stated she until talking with thera	2 different women at the					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/10/2019 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345238	B. WING			-		C 14/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
		-		4	009 CRAIG AVENUE			
WHILE UF	AK MANOR - CHARLOTT	E		c	CHARLOTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	more grandiose detail occurred and she stat incompetent. An attempt to intervie 01/09/19 at 9:50 AM op present. Resident #3 answer but one quest safe here to which sh 2. Resident #1 was an 12/13/18 with diagnos neoplasm of the pituit dementia, anxiety dist disorder. Admission orders date Quetiapine Fumarate antipsychotic medicate every day at bedtime with behavioral distur Remeron an antidepre take one tablet at bed disorder unspecified; treatment for mild to r daily at bedtime for un behavioral disturbance Occupational therapy at 4:55 PM stated Residuals assistance during am rolling walker. Reside	nething but talks about it in I to make it sound like more ted Resident #1 was w Resident #3 was made on with her family member was lethargic and would not tion which was do you feel e responded yes. dmitted to the facility on ses of disorientation, benign tary gland, unspecified order and depressive ed 12/13/18 included (i.e. Seroquel an tion) 25 milligrams (mg) for unspecified dementia bance; Mirtazapine (i.e. essant medication) 15mg dtime for major depressive and Donepezil (i.e. Aricept moderate dementia with	F	600		EFICIENCY)		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345238	B. WING				C 14/2019	
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
WHITE OA	K MANOR - CHARLOTT	E			4009 CRAIG AVENUE CHARLOTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	(MDS) dated 12/20/18 understood and unde cognition, rejecting ca previous 7 days, requi with bed mobility, tran and toileting, and limit locomotion and eating A care plan was initiat that Resident #1 mad of a sexual nature to that Resident #1 woul making inappropriate included redirect the r manner when he mak refer to psychiatric co with family as needed The Care Plan Assess dated 12/21/18 stated which affected his cog also impact cognition nursing notes indicate and confusion. The CAA for behavior resident's cognitive st contribute to his beha diagnosis for dementi disturbances and is ta Although the resident symptoms that may in is not an immediate th this time. The OT notes dated 1	ion Minimum Data Set 8 coded him with being rstanding, having intact are 1 to 3 days during the iring extensive assistance higher staff. The server in appropriate comments female staff. The goal was ld have no increase in comments. Interventions resident in a professional ces in appropriate comments, nsult as needed and liaison l. sment (CAA) for cognition d Resident #1 had dementia gnition. His mood state can . Over the look back period, ed times of disorientation rs dated 12/27/18 stated the catus problems may also invioral symptoms. He has a a with behavioral aking medication for this. displays behavioral mpact himself or others at 12/26/18 at 10:31 AM stated	F	600				
	-	oved in standing tolerance nents with toileting and lower						

Facility ID: 923554

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	
		345238	B. WING				U /14/2019
	ROVIDER OR SUPPLIER	E	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4009 CRAIG AVENUE CHARLOTTE, NC 28211	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	body dressing. He w wheelchair through the Review of the nursing revealed on 12/27/18 Nursing wrote that Re- staff to be saying he la another resident in the liked it. Resident #11 inappropriate with star residents. Family wa that prior to admission diagnosed with deme became more vocal w matters. The note co- limitations of the resid he would not be able resident. However, he minute monitoring by delusions that the fem wife." The next nursing note identified the female of Resident #2. Resident #2 was administration	as able to propel his he facility. If notes for Resident #1 at 1:11 PM the Director of esident #1 was reported by had used his fingers on eir private area and that she had been verbally ff but not with other s contacted who reported in when Resident #1 was ntia and a pituitary tumor, he with his wife regarding sexual ntinued stating "Due to the dent's physical body habitus, to do anything to another e is placed on q (every) 30 staff. The resident also has hale resident is his new	F	600			
	08/28/18 stated Resid exhibited impaired ab was nonverbal during occasional smiles. H impaired as related to information. She reco phases of care with h	ility to communicate. She					

Facility ID: 923554

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345238	B. WING				C 14/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE OA	AK MANOR - CHARLOTT	E			4009 CRAIG AVENUE CHARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	stand and ambulate v walked on and off the as needed for redirect Her most recent MDS coded her with unclear understanding, some being able to assess ambulatory, and requi most activities of daily coded for behavior or In Resident #2's nurs Director of Nursing (E 12/27/18 at 2:01 PM for stated he put his finge A body audit was con resident and no signs bruising or discharge clamped her thighs to appeared that the mat the female resident. placed on 30 minute of note written by the So 12/28/18 at 12:15 PM as Resident #1. Review of the facility's incident between Res included the following follow up interviews n *A hand written stater AM signed by Nurse / AM he went to check last night he went into "he tried to stick the h he just used his finge	vithout assistance. She unit with assistance given tion and safety. 5, a quarterly dated 10/30/18 ar speech, sometimes times being understood, not her cognition, being iring limited assistance with y living skills. She was not mood issues. ing notes, written by the OON), was an entry dated that stated a male resident ers in the resident's vagina. ducted on the female or symptoms of redness, were noted. The resident gether when assessed. It le resident had fixated on The male resident was checks. The next nursing boal Service Director dated identified the male resident is investigation of the alleged ident #1 and Resident #2 written statements and hade by the surveyor: ment dated 12/27/18 at 7:06 Aide (NA) #1 stated that at 7 on Resident #1 who stated o Resident #2's room and uead in and it wouldn't fit so	F	600			

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						FORM	MAPPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED	
	345238 B. WING					C 01/14/2019		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BULDING 345238 9. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WHITE OAK MANOR - CHARLOTTE STREET ADDRESS, CITY, STATE, ZIP CODE (M) ID PRETIX (SOU DECICIENCIANT OF DEFICIENCIES (CEOF) DEFICIENCIANT OF DEFICIENCIES (CEOF) DEFICIENCIANT OF DEFICIENCIANT PROVIDER OF ADDRESS, CITY, STATE, ZIP CODE (M) ID PRETIX (SOU DECICIENCIANT OF DEFICIENCIES (CEOF) DEFICIENCIANT OF DEFICIENCIANT PROVIDER OF ADDRESS, CITY, STATE, ZIP CODE (M) ID PRETIX (SOU DEFICIENCIANT OF DEFICIENCIANT PROVIDER OF ADDRESS, CITY, STATE, ZIP CODE (M) ID PRETIX (SOU DEFICIENCIANT OF DEFICIENCIANT PROVIDER OF ADDRESS, CITY, STATE, ZIP CODE (M) ID PRETIX (SOU DEFICIENCIANT PRETIX PROVIDER OF ADDRESS, CITY, STATE, ZIP CODE (M) ID PRETIX (SOU DEFICIENCIANT THE STATE OF THE ADDRESS, CITY, STATE, ZIP CODE PRETIX (M) ID PRETIX (SOU DEFICIENCIANT THE STATE OF THE ADDRESS, CITY, STATE, ZIP CODE PRETIX (M) ID PRETIX (SOU DEFICIENCIANT THE STATE OF THE ADDRESS, CITY, STATE, ZIP CODE PRETIX (M) ID PRESIDE (SOU DEFICIENCIANT ID PRETIX PRESIDE (M) ID PRESIDE (SOU DEFICIENCIANT ID PRESIDE PRESIDE (M) ID PRESIDE (SOU DEFICIENCIANT ID PRESIDE								
WHITE O	AK MANOR - CHARLOTT	E						
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	He stated he worked when Resident #1 tole Resident #2, Residen name. NA #1 stated to his penis (referring to #2 but ended up usin stated that he had not inappropriate between #2 previous to the alle reported this to his su *A hand written stater AM signed by NA #2 a noticed Resident #1 w Resident #1 was imm he said he was feedin that's not all I did." H presence of Nurse #2 inside her vagina yes him to do it again. Bo reported this to their se NA #2 was interviewe via phone. NA #2 sta Resident #1 referred and then stated he str NA #2 stated that he couple of days followit the first few days he of walked by himself. Si to female residents be stated she, NA #1 and statements and Resid minute checks. *A hand written note of signed by Nurse #2 st NA called her to be a	first shift. He stated that d NA #1 that he had fingered t #1 actually used her that Resident #1 tried to put his head) inside Resident ug his finger. He further t seen anything n Resident #1 and Resident egation. He immediately pervisor. ment dated 12/27/18 at 8:30 stated during breakfast, she was in Resident #2's room. ediately asked to leave and ng Resident #2 "and he said e then stated to NA #2 in the t that he stuck his finger terday and that she wanted oth the NA and Nurse supervisor. d on 01/09/19 at 3:39 PM ted she saw Resident #1 by e morning of 12/27/18. to Resident #2 as his wife uck his finger inside of her. was bedridden the first ng his admission but after could transfer himself and he stated he had called out efore to "come here." NA #2 d Nurse #2 all had to write lent #1 was placed on 30	F	600				

Facility ID: 923554

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/10/2019 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION			LETED
	345238		B. WING		_		C 14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WHITE O	AK MANOR - CHARLOTT	E		4009 CRAIG AVENUE CHARLOTTE, NC 2821 ⁷	1		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	PM. Nurse #2 stated verbalize anytime. Sh wandered independent they tried to watch he Resident #1 became residents in a flirtation the facility. Nurse #2 nurse aide called to h #1 was saying, which and motioned to indic stated she immediate She did not recall Res differently following th *A hand written stater PM signed by Nurse # Resident #1 trying to and shut the door. No Resident #1 and repo #3. At first Resident # nurse's question as to door and later stated sleep. Nurse #1 was intervie at 1:50 PM. Nurse #1 Resident #1 going int he was trying to shut him. This occurred in When she asked him Resident #1 said he w then asked Nurse #1 to jail and immediate! stated she had heard Resident #1 had said knew he was being w	d she liked it. wed on 01/09/19 at 1:31 Resident #2 did not e stated Resident #2 ntly around the halls and r for elopement risk. more vocal to staff, not is manner during his stay at stated that on 12/27/18 a er to witness what Resident was that he stuck his finger ate inside the resident. She ly informed her supervisor. sident #2 acting any is accusation. nent dated 12/27/18 at 9:00 #1 stated she caught go into Resident #2's room urse #1 noted she removed rted the incident to Nurse #1 did not answer the o why he tried to shut the he wanted to put her to wed via phone on 01/10/19 I stated that she caught to Resident #2's room and the door when she caught the evening on 12/27/18. what he was doing, vas trying to put her to sleep if he was going to be going y said never mind. She bits and pieces of what about Resident #2 and atched. She stated she on her own and left it for the	F 600				

Facility ID: 923554

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345238 B. WING 01/14/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/14/2019 WHITE OAK MANOR - CHARLOTTE STREET ADDRESS, CITY, STATE, ZIP CODE 4009 CRAIG AVENUE CHARLOTTE, NC 28211 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 MAPPROVED). 0938-0391
346238 IN WING 01/14/2019 INME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JP CODE 0000 CRAIG AVENUE STREET ADDRESS, CITY, STATE, JP CODE 0000 CRAIG AVENUE CHARLOTTE, NC 28211 C	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,			(X3) DATE COMP	SURVEY LETED
INMAE OF ROWDER OR SUPPLIER STREET ADDRESS, CITY, STREE, ZP CODE WHTE OAK MANOR - CHARLOTTE age CRAID AVENUE (MID) PREFIX ISLAMMARY STATEMENT OF DEFICIENCIES In (MID) TAG ISLAMMARY STATEMENT OF DEFICIENCIES In (MID) TAG ISLAMMARY STATEMENT OF DEFICIENCIES In (MID) TAG ISLAMMARY STATEMENT OF DEFICIENCIES In (PALL) EFFICIENCIES In PREFIX (PALL) EFFICIENCIES In In (PALL) EFFICIENCIES In <td></td> <td></td> <td>345238</td> <td>B. WING</td> <td></td> <td>-</td> <td></td> <td></td>			345238	B. WING		-		
WHITE OAK MANOR - CHARLOTTE CHARLOTTE, NC 28211 (M) ID TRO ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENT WAIST SETENCEDED BY FULL RECOLLATIONY OF LSC DEATHYTING INFORMATION) ID TAG PROVIDERS IN NOT CONRECTIVE ACTION BROUD BE CROSS-REFERENCED TO THE AMPROPRIATE DEFICIENT OF LSC DEATHYTING INFORMATION) ID TAG PROVIDERS IN NOT CONRECTIVE ACTION BROUD (CAUSS-REFERENCED TO THE AMPROPRIATE DEFICIENCY) OWNER THAN DEFICIENCY) OWNER DEFICIENCY) F 600 Continued From page 14 Interview on 01/09/19 at 2:59 PM via phone with Nurse #3, the supervisor the evening of 12/27/18, revealed she had been aware of the allegations Resident #1 was saying about what he did to Resident #2 and that he had been placed on 30 minute checks. F 600 *A hand written note dated 12/27/18 at 12:45 PM signed by the DON stated Resident #1's family member stated Resident #1's family member called and stated Resident #1's talked he was guilty of the offense of puting his fingers inside of the resident #1's talked he was guilty of the offense of puting his fingers inside of the resident #1's talked he was placed on 30 minute monitoring for location; he was noved to another unit, and he was placed on Paxil (an antidepressant). The DON was interviewed on 01/09/19 at 2:00 PM. The DON stated Resident #1 di verbalize to her that he had his fingers inside Resident #2 and pay and the depression of statef on the night shift and was unable to obtain proof off the body audit of Resident #2 having no signs or symptoms of bruiking, blood or discharge and staff reports that he was not seen near her prior to his allegations. Once she determined this allegation din or tho papen she pleaced him no 30	NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
Whitp Presext Two Summary stratement of Deprocences (#Ach DEProcency Austrate Performance) Unit Presext Presext Two PROVIDENTS IN AN OF COMPRECTION (#Ach DEPROCENT ACTION SHOULD BE CROSS-REFERENCED To The LAPPROPRIATE DEPROCENCY) Org. Configuration (CROSS-REFERENCED TO THE LAPPROPRIATE DEPROCENCY) F 600 Continued From page 14 Interview on 01/00/19 at 2:59 PM via phone with Nurse #3, the supervisor the evening of 12/27/18, revealed she had been aware of the allegations Resident #1 was saying about what he did to Resident #2 and that he had been placed on 30 minute checks. F 600 *A hand written note dated 12/27/18 at 12/45 PM signed by the DON stated Resident #1 s family member stated Resident #1 s family member stated Resident #1 s family member called and stated Resident #1 stated he was guily of the offense of putting his fingers inside of the resident #1 stated he social worker discussed concerns with Resident #1 stated to speak. The plans noted included that the social worker discussed concerns with Resident #1 store PM. The DON stated Resident #1 do verbailing he was moved to another unit, and he was placed on Paxil (an antidepressant). The was noved to another unit, and he was placed on Paxil (an antidepressant). The DON stated Resident #2 aton PM. The DON stated Resident fact having no signs or symptome of bruingeblood or discharge a			E		1009 CRAIG AVENUE			
Precipy TXG LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREX TXG LEACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE COMPETION DEFICIENCY F 600 Continued From page 14 Interview on 01/09/19 at 2:50 PM via phone with Nurse #3, the supervisor the evening of 12/27/18, revealed she had been aware of the allegations Resident #1 was saying about what he did to Resident #2 and that he had been placed on 30 minute checks. F 600 *A hand written note dated 12/27/18 at 12:45 PM signed by the DON stated Resident #1's family member stated Resident #1's rom his second Sunday at the facility. She reported this on 12/27/18. Resident #3 and ba beif on and was unable to speak. The plans noted included that the social worker discussed concerns with Resident #2 was fully clothed, had be and was unable to speak. The plans noted included the the social worker discussed concerns with Resident #1's representative, his wife and the physician; he was placed on 30 minute monitoring for location; he was moved to another unit; and he was placed on Paxil (an antidepressant). The DON was interviewed on 01/09/19 at 2:00 PM. The DON stated Resident #1 away for of the body audit of Resident #2 having no signs or symptoms of bruising, blood or discharge and staff reports that he was not seen mear her prior to his allegations. The DON based this proof off the body audit of Resident #2 having no signs or symptoms of bruising. Blood or discharge and staff reports that he was not seen mear her prior to his allegations. Once she determined this allegation din on the papen she placed him on 30			-		CHARLOTTE, NC 28211			
Interview on 01/09/19 at 2:59 PM via phone with Nurse #3, the supervisor the evening of 12/27/18, revealed she had been aware of the allegations Resident #1 was saying about what he did to Resident #2 and that he had been placed on 30 minute checks. *A hand written note dated 12/27/18 at 12:45 PM signed by the DON stated Resident #1's family member stated Resident #2 was sitting on the bed in Resident #1's room his second Sunday at the facility. She reported this on 12/27/18. Resident #1's from his second Sunday at the facility. She reported this on 12/27/18. Resident #1's room his second Sunday at the facility. She reported this occurred twice. A second note, no date but noted at 10:45 AM, revealed Resident #1's family member called and stated Resident #1 stated he was guilty of the offense of putting his fingers inside of the resident. He stated Resident #2 was fully clothed, had a brief on and was unable to speak. The plans noted included that the social worker discussed concerns with Resident #1's representative, his wife and the physician; he was placed on 30 minute monitoring for location; he was moved to anditer unit; and he was placed on Paxil (an antidepressant). The DON was interviewed on 01/09/19 at 2:00 PM. The DON stated Resident #2 having no signs or symptoms of bruising, blood or discharge and staff reports that he was not seen near her prior to his allegations. Once she determined this allegation (di not happen she placed him on 30	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIA		COMPLETION
On 01/09/19 at 1:52 PM Nurse #4 was	F 600	Interview on 01/09/19 Nurse #3, the supervirevealed she had beer Resident #1 was sayi Resident #2 and that minute checks. *A hand written note of signed by the DON st member stated Resid bed in Resident #1's of the facility. She report Resident #1's family of occurred twice. A sect at 10:45 AM, revealed member called and st was guilty of the offer inside of the resident. fully clothed, had a br speak. The plans not worker discussed con representative, his wit was placed on 30 min he was moved to ano on Paxil (an antidepre The DON was intervice PM. The DON stated to her that he had his She stated she talked on the night shift and to the allegations. The the body audit of Res symptoms of bruising staff reports that he w to his allegations. One allegation did not hap minute checks for loca	at 2:59 PM via phone with sor the evening of 12/27/18, in aware of the allegations ing about what he did to he had been placed on 30 dated 12/27/18 at 12:45 PM ated Resident #1's family ent #2 was sitting on the room his second Sunday at ted this on 12/27/18. member reported this cond note, no date but noted d Resident #1's family ated Resident #1 stated he use of putting his fingers He stated Resident #2 was ief on and was unable to red included that the social icerns with Resident #1's fe and the physician.; he nute monitoring for location; ther unit; and he was placed essant). weed on 01/09/19 at 2:00 Resident #1 did verbalize fingers inside Resident #2. I to the supervisor and staff was unable to obtain proof e DON based this proof off ident #2 having no signs or , blood or discharge and vas not seen near her prior ce she determined this pen she placed him on 30 ation to be on the safe side.	F 600				

Facility ID: 923554

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	FORM	M APPROVED 0. 0938-0391					
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
	345238 B.						C / 14/2019
NAME OF PI	AN OF CORRECTION IDENTIFICATION NUMBER: 345238 E OF PROVIDER OR SUPPLIER TE OAK MANOR - CHARLOTTE D ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE OA	K MANOR - CHARLOTT	E					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	interviewed. She statt on 12/27/18 first shift. #2 brought Resident # attention, she notified statements. She did m did she hear him mak An attempt to intervier 01/09/19 at 12:58 PM did not follow direction and no questions. She Interview with the Adm 11:53 AM revealed the Resident #1 had tried Resident #2, she wou him. She further state allegation because Re could not perform ma interview and that his occurred because he family indicated there behaviors they knew of up interview on 01/09 administrator stated th because Resident #1 Resident #2 had no p body audit completed As a precaution, the A developed a Quality In 12/27/18 which was p 1. review concerns wi Resident #2's families 2. place resident (#1) location; 3. male resident (#1)	 and she was the supervisor Once the NA #1 and NA #1's allegation to her the DON and got written not talk to Resident #1 nor the the allegations. w Resident #2 was made on She was nonverbal and ins to shake her head to yes the started dancing. ministrator on 01/09/19 at at she believed that if anything inappropriate with anything inappropriate with anything inappropriate with anything be provided that there was nothing to the esident #1 was delusional, rital duties per family talk about sexual things had a pituitary tumor. The was no sexual criminal of previously. Upon follow /19 at 4:09 PM the he allegation did not occur was delusional and hysical evidence upon a 12/27/18. Administrator stated they improvement Plan dated provided. This plan included: th Resident #1 and s; on 30 minute monitor for moved to south 	F	600			

Facility ID: 923554

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345238	B. WING		_	(01/) 14/2019	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-		
WHITE OA	K MANOR - CHARLOTT	E		4009 CRAIG AVENUE CHARLOTTE, NC 2821	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Review of Resident # on 12/28/18 the physi at the request of nurs increasing sexual beh Resident #1 stated he anyone but admitted for room of a female resid occasion and stated he The physical exam no intact, speech fluent. (person and place). " Fluoxetine HCL (an ar for sexual behaviors. computerized physicial Medication Administra order had a start date actually administered Review of documenta 30 minute checks wer and documented begi 01/04/19. Documenta increments (i.e. 1:00 2:00 PM, etc.). The care plan for Res 12/28/18 with a goal thave nor vocalize del Interventions included the need of medicatio drive, visit with the resident of the implications of the he takes his medication	creased sexual behaviors. 1's medical record revealed cian examined Resident #1 ing staff regarding haviors. The physician noted a did not physically touch to attempting to enter the dent on more than one he shouldn't have done that. oted :motor intact, sensory Alert and oriented x 2 The physician ordered ntidepressant) 20 mg daily Review of the an orders and the ation Records (MAR) this beginning 01/01/19. Attion provided by the facility, re initiated for Resident #1 inning 12/27/18 through ation was noted for half hour PM - 1:30 PM, 1:30 PM - Sident #1 was updated on hat Resident #1 would not usions of a sexual nature. A the physician to evaluate in to decrease his sexual sident and allow him to plings, visit and remind him false allegations and ensure ons.	F 600					
	he takes his medication Review of the nursing							

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	-					FORM	M APPROVED
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345238	B. WING				C / 14/2019
NAME OF P	NDP FLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345238 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CARIG AVENUE STREET ADDRESS, CITY, STATE, ZIP CODE 04110 SUMMARY STATEMENT OF DEFICIENCES PROVIDER, OR SUPPLIER 04110 SUMMARY STATEMENT OF DEFICIENCES IDENTIFICATION VISITE REFORECED BY DILL 04110 FEOD DEFICIENCES IDENTIFICATION VISITE REFORECED BY DILL PROVIDES (ADDRESTING ATCHING NO SHOULD) 04110 SUMMARY STATEMENT OF DEFICIENCES IDENTIFICATION VISITE REFORECED BY DILL PROVIDES DIANOF CORRECTION STOLED ATCHING NO SHOULD) 0701703710 BEGULATORY OR LSC IDENTIFIVING INFORMATION) F 600 F 600 Continued From page 17 South unit on 12/28/18. Nursing notes dated F 600 ormanets from the Christmas tree in the south parking the belongings, removing to rooms, taking their belongings, removing to rooms, taking their belongings, removing to rooms, taking this telephone without permission. After being assisted back to bed, Resident #1 was aen by psychiatric services on Ol/10/3/19. The note stated Resident #1 was noted Resident #1 was aen by psychiatric services on Ol/10/3/19. The note stated Resident #1 sepech was at normal rate and volume although monotone and his affect was restricted but treactive. His thought process was simple at times and he seemed superficially connected. There was no additory or visual Halluchatitons r						
WHITE OA	AK MANOR - CHARLOTT	E					
PREFIX	(EACH DEFICIENC)	MEDICAID SERVICES OMB NO. [x1] PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING [x3] DATE S COMMEL A BUILDING 345238 B. WING [C2] COMELCOMEL COMELCOMEL COMELCOMEL COMELCOMEL COMELCOME	(X5) COMPLETION DATE				
F 600	south unit on 12/28/18 01/03/19 at 6:53 AM r Resident #1 exhibited including wandering in rooms, taking their be ornaments from the C parlor, getting out of th his wheelchair and sit roommates bed using permission. After bein Resident #1 was agai give personal care to Resident #1 was agai give personal care to Resident #1 was seen 01/03/19. The note s was at normal rate an monotone and his affer reactive. His thought times and he seemed There was no auditor recently and no delus judgement were poor remote memory were were to discontinue S start Depakote 125 m The Administrator was Jeopardy on 01/10/19 The facility provided a immediate jeopardy re AM as follows: White Oak Manor - C safety of residents fro On 12/27/18, Resider	 8. Nursing notes dated revealed during the shift, a multiple behaviors in and out of other resident alongings, removing Christmas tree in the south orded and self transferring to this go the foot of his is telephone without in noted out of bed trying to his roommate. It was noted constant redirecting. an by psychiatric services on tated Resident #1's speech ind volume although ect was restricted but process was simple at a superficially connected. If superficially connected intact. Recommendations ions. His insight and intact. Recommendations deroquel (Quetiapine) and ig twice a day. as informed of Immediate the at 4:40 PM. an acceptable allegation of emoval on 01/12/19 at 11:23 	F	60			

Facility ID: 923554

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345238	B. WING		_		C 14/2019
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		-	4	1009 CRAIG AVENUE			
WHITE OA	AK MANOR - CHARLOTT	E		CHARLOTTE, NC 28211	l		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	her in her room. He co work but he indicated enjoyed each other. F were married and had # 1 was placed on 30 checks. The 30-minut documented on a spre- immediately assessed and Social Services E body audit that took 3 difficulty to examine th clenching of her thigh that resident was toud resident. Resident # 2 to say anything about about her. Resident # Representatives were On 1/4/19, Resident # Resident # 3. Resider toward the left of Res	asked him to make love with ould not get his penis to he used his finger and they Resident # 1 stated they d children together. Resident -minute location monitoring we location monitoring was eadsheet. Resident # 2 was d by DON, Licensed Nurse Director, which included a staff members due to the he resident with her s. There was no indication ched or harmed by another 2 is non-verbal and is unable Resident # 1's comments a 1 and # 2's Resident e notified. f 1 was noted lying in bed of nt # 1 was lying on top, ident # 1 with his pants	F 600				
	brief was noted undor right side of Resident immediately removed # 3's room, and Resid the nursing staff. Polic reported to the State. Investigator conducte then Resident # 3 was for further evaluation. immediately placed of with a staff member a discharge from the fac On 12/27/18 and 1/4/ checked by observation that were in the proxim and those residents w	Resident # 1 from Resident lent # 3 was assessed by ce was notified, and Police and Crime Scene d their investigation, and s transferred to the hospital Resident # 1 was n one-on-one monitoring					

Facility ID: 923554

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	-	D HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY PLETED
		345238	B. WING				C 14/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WHITE O	AK MANOR - CHARLOTT	E					
(X4) ID PREFIX TAG	(EACH DEFICIENC	& MEDICAID SERVICES OMB (x1) PROVIDERSUPPLIENCLA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) DL A BUILDING 345238 B. WING CC TTE STREET ADDRESS, CITY, STATE, ZIP CODE 000 CRAIG AVENUE CHARLOTTE, NC 28211 STATEMENT OF DEFICIENCIES VOW UST EE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ge 19 rt conducted interviews with enis throughout the facility. tions consisted of the ne touched you an er including sexual, has su in an inappropriate manner, has anyone tifed to climb in and did you see anything ate to anyone else. All wered with a no. vo variances were noted ents. e Abuse/Neglect Policy was of all current staff in all ompleted on 1/11/19. Newly -educated during their specific le Staff Development all Services Director. The cy will be reviewed annually noeded throughout the hour report and Quality toocumentation sheets were ent and address any alization of sexual behavior staff. ID totonaire was developed appropriateness that included and verbalizations, and will be y care plan meetings and ID		(X5) COMPLETION DATE			
F 600	Services Department interviewable residem The interview question following: has anyone inappropriate manner anyone talked to you including sexually, hat the bed with you, and sexually inappropriate questions were answe Non-interviewable res Licensed Nursing stat or clothing disturbance normal demeanor. Not during the assessment Re-education on the <i>J</i> started on 1/04/19 of departments, and cor hired staff will be re-e job orientation by the Coordinator or Social Abuse/Neglect Policy with all staff and as ne calendar year. On 1/11/19, the 24-ho Improvement (QI) door modified to document observation or verball reported by facility stat On 1/11/19, a question regarding sexual inapp physical interaction at implemented during of Resident Council meet The Social Services D	conducted interviews with ts throughout the facility. Ins consisted of the e touched you an including sexual, has in an inappropriate manner, s anyone tried to climb in did you see anything e to anyone else. All ered with a no. sidents were assessed by 3 if to determine any distress es or change from their o variances were noted hts. Abuse/Neglect Policy was all current staff in all npleted on 1/11/19. Newly ducated during their specific Staff Development Services Director. The will be reviewed annually eeded throughout the our report and Quality cumentation sheets were and address any zation of sexual behavior aff. nnaire was developed propriateness that included nd verbalizations, and will be are plan meetings and etings.	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/10/2019 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345238	B. WING					C 14/2019
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE			
WHITE OA	AK MANOR - CHARLOTT	E			4009 CRAIG AVENUE CHARLOTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 600	they may have observed residents that are normonitored for change that would possibly in abuse, particularly forverbal or physical. The allegations of sexual a and the investigation monitoring will be connursing (DON) and/or All indications or suspereported to the Administaff, and appropriate agency and a thoroug completed. The Quality Improvem informed on 12/27/19 Resident # 2 and on 2 involving Resident # 2 and on 2 involving Resident # 3 monitoring will be disc Friday during Quality meetings and any ide be further discussed a meeting with the team made as indicated. The order of credible all and 1/11/19 respective process as it was inforced and the streng supering su	cting themselves or that wed. Another 5 random h-interviewable will be s in behavior or demeanor dicate any mistreatment or sexual interactions whether e monitoring will identify any abuse, and assure reporting is complete thoroughly. The npleted by the Director of r designee. bicion of sexual abuse will be histrator and DON by facility ly reported to the state gh investigation will be ment (QI) committee was with the situation involving 1/4/19 regarding the incident 3. Results from the cussed Monday through Improvement (QI) morning ntified issues or trends will at the Quality Assurance n and recommendation he QA committee was egation on 1/9/19, 1/10/19, ely throughout the survey med to the facility. The QA he Attending Physician, Social Services department, rvisors, Dietary, Activities, tment, Restorative Nurse, urses.	F	600				

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	-					FORM	D: 04/10/2019 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		AND HUMAN SERVICES & MEDICAID SERVICES (1) PROVIDERSUPPLIERCULA DENTIFICATION NUMBER: A BUILDING 345238 B. WING THE 345238 B. WING DTTE STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 DTTE DTTE D PROFINE STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTTE, NC 28211 STREET ADDRESS, CITY, STATE, ZIP CODE 4000 CRAG AVENUE CHARLOTT, NC 28211 STATE 50 50 50 50 50 50 50 50 50 5		C 14/2019			
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WHITE OA	K MANOR - CHARLOTT	E					
					,		
(X4) ID PREFIX TAG	CORRECTION IDENTIFICATION NUMBER: 345238 345238 COVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 The DON is responsible for ongoing compliance of F600. The facility's credible allegation of IJ removal wa verification that Resident #1 was no longer in th building. Interviews with alert and oriented residents were conducted and no one expresse they had been abused and family members were interviewed and voiced no concerns. Administrative and nursing staff verified that training had been provided regarding the abuse policy and need to protect residents, investigate allegations and report to the state agency. This was verified as also being provided to all departments. Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §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, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, th facility failed to implement their abuse policy an procedure to protect residents from abuse and	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 600	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345238 ROVIDER OR SUPPLIER K MANOR - CHARLOTTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 The DON is responsible for ongoing compliance of F600. The facility's credible allegation of IJ removal was verified on 01/14/19 at 6:04 PM and based on verification that Resident #1 was no longer in the building. Interviews with alert and oriented residents were conducted and no one expressed they had been abused and family members were interviewed and voiced no concerns. Administrative and nursing staff verified that training had been provided regarding the abuse policy and need to protect residents, investigate allegations and report to the state agency. This was verified as also being provided to all departments. Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §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, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure to protect residents from abuse and to investigate and re	ole for ongoing compliance	F6	500			
F 607 SS=D	verified on 01/14/19 a verification that Resid building. Interviews w residents were condu they had been abused interviewed and voice Administrative and nu training had been pro- policy and need to pro- allegations and report was verified as also b departments. Develop/Implement A CFR(s): 483.12(b)(1)- §483.12(b) The facility implement written poli §483.12(b)(1) Prohibit neglect, and exploitation misappropriation of re §483.12(b)(2) Establis to investigate any succ §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on record revi facility failed to impler procedure to protect r	t 6:04 PM and based on ent #1 was no longer in the ith alert and oriented cted and no one expressed d and family members were d no concerns. rsing staff verified that vided regarding the abuse otect residents, investigate t o the state agency. This eing provided to all buse/Neglect Policies (3) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures th allegations, and training as required at is not met as evidenced ew and staff interviews, the ment their abuse policy and esidents from abuse and to	F	607	The facilities corrective actions for thos		2/6/19
	investigate and report	allegations of abuse for 1			resident sited in F-600 and F-607 are a		

Event ID: BPFU11

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(X3) DATE SURVEY COMPLETED C 01/14/2019
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(X5) BE COMPLET IATE DATE
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Facility ID: 923554

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED: 04/10 FORM APPR OMB NO. 0938-	OVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345238	B. WING		C 01/14/2019	9
NAME OF PR	ROVIDER OR SUPPLIER	•	- 1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WHITE OA	K MANOR - CHARLOTT	E		4009 CRAIG AVENUE		
				CHARLOTTE, NC 28211	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLI	ETION
F 607	Continued From page	e 23	F 60	7		
	*Interview the resider residents, visitors as E. Statements will be identified as having p knowledge of the alle shall include but not I contact and or observ- interaction with the al at the time of the alle other person's activiti the alleged victim (ind others). F. Following a comple- investigation on the a will be finalized summ H. Preliminary report followed and the resu- will be reported to ap state agencies as req *Under section VII Re- the abuse policy and B. Upon receipt of an Administrator or desig agency(s). C. The report of the in telephoned or faxed to agency. D. The facility will foll- procedure as outlined E. following the invess be filed with the appro-	nt's roommate other appropriate. obtained from individuals otential involvement and/or ged incident. Statements imited to the time frame of vation of the alleged victim, leged victim and or act ivies ged incident, observation of es and/or interaction with cluding staff, family or ete and thorough illeged abuse a written report narizing the investigation. Ing requirements will be ilts of the final investigation propriate individuals and quired by law. eporting and Response in procedure included in part: allegation of abuse, The gnee will notify the State nitial investigation will be to the appropriate State ow the investigation d. tigation, a five day report will opriate State agency estigation, corrective action		All staff are annually re-inservic facilities Abuse Policy and as ne assure compliance with F-600 a This will be an ongoing measure Resident interviews are being c with five residents on a weekly b the Social Services Director. Th interviews started on 1/12/2019 continue through 3/3/2019. The Services Director asks question regarding being touched or spol sexual manner, seeing or hearin inappropriate behavior between and/or residents, and invasion of The Assistant Director of Nursin conducting five observations on non-interveiwable residents beg 1/11/2019 and ending on 3/1/20 observations included looking fo signs/symptoms of distress, disa clothing or belongings, and asso residents baseline. The results interviews/observations are use identify concerns that are to be immediately to the Administrato Director of Nursing. They are a discussed in the morning QI me documented on the QI Abuse M form. The facilities systemic changes monitoring tools also aid in iden residents who have the potentia affected as those sited in F-600	eeded to and F-607. e. onducted basis by nese and will e Social is ken to in a ng sexually staff of privacy. ng is ginning on 019. These or array of essment of these d to reported r or lso eetings and lonitoring and tifying al to be	
		dmitted to the facility on		F-607. Interviews are being cor during every care plan meeting resident and/or resident represe	nducted with the	
	12/13/18 with diagnos	ses of disorientation, benign tary gland, unspecified		These interviews began on 1/15 include questions regarding being	5/2019 and	

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TATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) [DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	OMPLETED
						С
		345238	B. WING			01/14/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	K MANOR - CHARLOTT	F		4009 CRAIG AVENUE		
		-		CHARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		
F 607	Continued From page	e 24	F 60	70		
		order and depressive		or spoken to in a sexual manne	er. seeina	
		orders dated 12/13/18		or hearing sexually inappropria		
		-umarate (an antipsychotic		between staff and/or residents,		
		ams (mg) every day at		invasion of privacy. The same		
	· ·	ed dementia with behavioral		are also being asked during Re		
		oine (an antidepressant		Council meetings every month		
		ke one tablet at bedtime for		with the meeting on 1/15/2019.		
		order unspecified; and		1/12/2019, a revised 24 hour re		
		nt for mild to moderate at bedtime for unspecified		developed to identify any verba physical statements of abuse.		
	dementia with behavi			Coordinators and/or licensed u		
		oral disturbance.		staff are required to sign and a	•	
	Occupational therapy	(OT) notes dated 12/18/18		no allegations of abuse occurre		
	at 4:55 PM stated Re			their shift. These signature page		
		g skills demonstrating the		collected and reviewed by the l	-	
	-	brakes appropriately. The		Nursing and QI team on a daily		
	OT aide used 12 perc	cent verbal cues for safety		any event that could be reported	d. The	
	awareness and prope	er hand placement and		weekend nursing management	staff have	
		stand by assistance during		been educated on the revised 2	24 hour	
		vith rolling walker. Resident		report, with these reports being		
		ge door and maneuver		every Monday during morning		
	rolling walker with sta	and by assistance.		meetings. Staff is aware to rep		
	Dogidopt #110 odreite	ion Minimum Data Cat		suspected or alleged abuse to		
		ion Minimum Data Set 8 coded him with being		Administrator and/or Director o immediately. A QI abuse moni	0	
		erstanding, having intact		was also developed to assist in	-	
		are 1 to 3 days during the		or finding patterns through repo	•	
		uiring extensive assistance		grievances, occurrence reports		
		nsfers, walking, dressing,		hour report, and resident	,	
	and toileting, and limi			interviews/observations. The fa	acility has	
	locomotion and eating			in place a monitoring rook for s	-	
				abuse allegations to assist in		
	-	ted on 12/20/18 in order to		documenting an reports to DHS		
	-	that the resident makes		regardless of the type of allega		
		nts of a sexual nature to		help with identifying trends or p		
		al was that Resident #1		The use of this monitoring tool		
		ise in making inappropriate		1/13/2019 and will continue thr	-	
	resident in a profession	ions included redirect the		3/9/2019. All reported allegation completed per regulation timefi		

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345238			C 01/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/14/2019
	AK MANOR - CHARLOTT	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 607	family as needed. The Care Area Assess dated 12/21/18 stated which affected his cog also impact cognition nursing notes indicted confusion. The OT notes dated Resident #1 was impra- allowing for improvern body dressing. He was facility. The CAA for behavior residents cognitive sta contribute to his behaved diagnosis for dementid disturbances and is ta Although the resident symptoms that may in was not an immediated at this time. Review of the nursing revealed on 12/27/18 Nursing wrote that Re- staff to be saying he far another resident in the liked it. The resident inappropriate with star- residents. Family was that prior to admission	comments, refer to needed and liaison with sment (CAA) for cognition d Resident #1 had dementia gnition. His mood state can . Over the look back period, d times of disorientation and 12/26/18 at 10:31 AM stated roved standing tolerance nents with toileting and lower as able to propel through the rs dated 12/27/18 stated the atus problems may also avioral symptoms. He has a ia with behavioral aken medication for this. displays behavioral mpact himself or others, he e threat to himself or others a notes for Resident #1 at 1:11 PM the Director of esident #1 was reported by had used his fingers on eir private area and that she had been verbally	F 607	 reports made to DHSR will be disc in morning QI meetings. After 3/3/2019, the QA committee continue to monitor on an ongoing the results of the plan of care abus questionnaire weekly, the resident abuse questionnaire monthly, and hour report daily. The QA commit review this information to identify a patterns and/or trends and develo interventions to assure compliance F-607. These will be presented to committee by the DON. The date of corrective action comp was 2/6/2019. 	will basis se t council the 24 tee will any p e with the QA

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		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345238	B. WING				C 14/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE O	AK MANOR - CHARLOTT	E			1009 CRAIG AVENUE CHARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	limitations of the resid he would not be able resident. However, h minute monitoring by delusions that the fem wife." The next nursing note identified the female of Resident #2. a. Resident #2 was a 12/31/15 with diagnos and major depressive CAA dated 08/28/18 s and exhibited impaire She was nonverbal d occasional smiles. H impaired as related to information. She reco phases of care with h staff cueing and hand stand and ambulate w and walked on and of given as needed for r Her most recent MDS coded her with unclea understanding, some being able to assess ambulatory, and requi most activities of daily In Resident #2's nurs dated 12/27/18 at 2:0 of Nursing stated a m statements that he ha contact with a female	dent's physical body habitus, to do anything to another e is placed on q (every) 30 staff. The resident also had hale resident is his new e dated 12/27/18 at 1:35 PM resident involved as dmitted to the facility on see of unspecified dementia e disorder. Her cognition stated Resident #2 was alert ed ability to communicate. uring the interview with er communication was o understanding and relating eived assistance in all er participation involving ls on assistance. She could with and without assistance eff the unit with assistance edirection and safety. S, a quarterly dated 10/30/18 ar speech, sometimes times being understood, not her cognition, being iring limited assistance with y living skills. ing notes was an entry 1 PM written by the Director iale resident made ad inappropriate physical	F	607			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 04/10/2019 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345238	B. WING		_	01/ ⁻	, 14/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WHITE O	AK MANOR - CHARLOTT	E		009 CRAIG AVENUE CHARLOTTE, NC 28211	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 607	female resident and m redness, bruising or d resident clamped her assessed. It appeare fixated on the female was placed on 30 min nursing note written b dated 12/28/18 at 12: resident as Resident as Review of the facility's incident between Res provided by the Direc did not include an occ report, did not include agency notification of summary and findings evidence of the invest following written state interviews made by th *A hand written stater AM signed by Nurse / AM he went to check last night he went into "he tried to stick the h he just used his finger On 01/09/19 at 1:40 F confirm his written state when Resident #1 tol fingered Resident #2, her name. NA #1 state him he tried to put his inside Resident #2 bo He further stated that inappropriate between	was conducted on the to signs or symptoms of lischarge were noted. The thighs together when d that the male resident had resident. The male resident nute checks. The next y the Social Service Director 15 PM identified the male #1. s investigation of the alleged ident #1 and Resident #2, tor of Nursing on 01/09/19, currence report/incident e evidence of the state the allegation or the report s. The facility provided their tigation which included the ments and follow up he surveyor: nent dated 12/27/18 at 7:06 Aide (NA) # 1 stated that at 7 on Resident #1 who stated to Resident #2's room and head in and it wouldn't fit so r."	F 607				

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CENTER	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		FORM	0: 04/10/2019 1 APPROVED 0: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
		345238	B. WING		_		_ 14/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WHITE OA	K MANOR - CHARLOTT	E		4009 CRAIG AVENUE CHARLOTTE, NC 2821 ²	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page supervisor.	28	F 607				
	AM signed by NA #2 s noticed Resident #1 v Resident #1 was imm he said he was feedin that's not all I did." H front of the nurse (Nu	nent dated 12/27/18 at 8:30 stated during breakfast, she vas in Resident #2's room. ediately asked to leave and ig Resident #2 "and he said e then stated to NA #2 in rse #2) that he stuck his na yesterday and that she gain.					
	via phone to confirm t #2 stated she saw Re bed the morning of 12 referred to Resident # stated he stuck his fin stated that he was be days following his adr days he could transfe himself. She stated h	2 as his wife and then ger inside of her. NA #2 dridden the first couple of nission but after the first few r himself and walked by e had called out to female ome here." She stated she,					
	signed by Nurse #2 s NA called her to be a	dated 12/27/18 at 8:30 AM tated while at the med cart witness to what the resident stuck his middle finger d she liked it.					
	to confirm the written Resident 2 did not ver Resident #2 wandere halls and they try to w Resident #1 became residents in a flirtation	wed on 01/09/19 at 1:31 PM statement. Nurse #2 stated rbalize anytime. She stated d independently around the vatch her for elopement risk. more vocal to staff, not is manner. Nurse #2 stated rse aide called to her to					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DAT	O. 0938-0391 E SURVEY IPLETED
345238 B. WING	0.	C / 14/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE OAK MANOR - CHARLOTTE 4009 CRAIG AVENUE CHARLOTTE, NC 28211		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROI) BE	(X5) COMPLETION DATE
F 607 Continued From page 29 F 607 witness what Resident #1 was saying which was that he stuck his finger and motioned to indicate inside the resident. She does not recall Resident #2 acting any differently following this accusation. *A hand written statement dated 12/27/18 at 9:00 PM by Nurse #1 who stated she caught Resident #1 trying to go into Resident #2's room and shut the door. Nurse #1 noted she removed Resident #1 and reported the incident to Nurse #3. At first Resident #1 did not answer the nurse's question as to why he tried to shut the door and later stated he wanted to put her to sleep. Nurse #1 was interviewed via phone on 01/10/19 at 1:50 PM to confirm her written statement. Nurse #1 stated that she caught Resident #1 going into Resident #2 store and he was trying to shut the door when he caught thm. This occurred in the evening on 12/27/18. When she asked him what he was doing to be going to jail and immediately said never mind. She stated she wrote her statement on her own and left it for the next shift after informing her supervisors. *A hand written note dated 12/27/18 at 12:45 PM signed by the Director of Nursing (DON) stated Resident #1's daughter stated Resident #1's condition who. A supervisor is sitting on the bed in Resident #1's caughter reported this occurred twice. A second note, no date but noted at 10:45 AM, revealed Resident #1's tade the was guilty of the offense of putting his fingers inside of the resident. He stated here was unable to speak.		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345238	B. WING				C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WHITE OA	AK MANOR - CHARLOTT	E		4009 CRAIG AVENUE CHARLOTTE, NC 2821	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER' (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	discussed concerns w representative, his wir placed on 30 minute r was moved to anothe Paxil (an antidepressa *A hand written note, by the DON, indicated completed on Reside Service Director and I periarea/rectal area s or discharge was note The DON was intervie PM. The DON stated to her that he had his She stated she talked on the night shift and to the allegations. She side, she placed him location. She stated to could have occurred s allegation or follow the event did not happen evidence from Reside The facility provided t improvement plan dat discussing concerns of Resident #2's family; minute monitoring for Resident #1 to anothe #1 on an antidepressa	ded that the social worker vith Resident #1's fe and the physician; he was monitoring for location; he r unit; and he was placed on ant). dated 12/27/18 at 12:45 PM d a skin assessment was nt #2 by the DON, social East supervisor noting her howed no bruising, bleeding ed. ewed on 01/09/19 at 2:00 Resident #1 did verbalize fingers inside Resident #2. I to the supervisor and staff was unable to obtain proof e stated to be on the safe on 30 minute checks for that there was no way this so she did not report the e abuse policy because the based on no physical ent #2's body audit. heir developed quality ted 12/27/18 which included with Resident #1 and placing Resident #1 on 30 his location; moving er unit; and placing Resident ant for increased sexual w Resident #2 was made on	F 60				
PRÉFIX TAG	(EACH DEFICIENC REGULATORY OR L Continued From page The plans noted inclu discussed concerns w representative, his wir placed on 30 minute r was moved to anothe Paxil (an antidepressa *A hand written note, by the DON, indicated completed on Resider Service Director and I periarea/rectal area s or discharge was note The DON was intervie PM. The DON stated to her that he had his She stated she talked on the night shift and to the allegations. She side, she placed him location. She stated fi could have occurred s allegation or follow the event did not happen evidence from Reside The facility provided t improvement plan dat discussing concerns of Resident #2's family; minute monitoring for Resident #1 to anothe #1 on an antidepressa behaviors. An attempt to intervie 01/09/19 at 12:58 PM	A MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) a 30 ded that the social worker with Resident #1's fe and the physician; he was monitoring for location; he r unit; and he was placed on ant). dated 12/27/18 at 12:45 PM d a skin assessment was nt #2 by the DON, social East supervisor noting her howed no bruising, bleeding ed. weed on 01/09/19 at 2:00 Resident #1 did verbalize fingers inside Resident #2. I to the supervisor and staff was unable to obtain proof e stated to be on the safe on 30 minute checks for that there was no way this so she did not report the e abuse policy because the based on no physical ent #2's body audit. heir developed quality ted 12/27/18 which included with Resident #1 and placing Resident #1 on 30 his location; moving er unit; and placing Resident ant for increased sexual	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		COMPLETIC

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345238	B. WING		_		C 14/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	• • •	
WHITE OA	K MANOR - CHARLOTT	E		009 CRAIG AVENUE HARLOTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	was discharged to the 01/09/19. No intervie conducted. On 01/09/19 at 1:52 F interviewed. She stat on 12/27/18 first shift nurse aide brought th was making to her att and got written staten Resident #1 nor did s allegations. A follow u on 01/10/19 at 8:45 A asked about interactio and #2 previous to the On 01/09/19 at 4:09 F that Resident #1 was and she knew nothing Resident #1 and Resi #2's body audit shows stated that she placed monitoring on 12/27/1 documentation) as a monitoring was effect The DON was intervie 12:30 PM and provide she interviewed that p way Resident #1 and Resi anamed Nurse #6 and named NA #1 and Resi	he started dancing. onger in the facility as he a hospital for surgery on w with Resident #1 could be PM Nurse #4 was led she was the supervisor on the East side. Once the e allegations Resident #1 ention, she notified the DON nents. She did not talk to he hear him make the up interview with Nurse #4 M revealed she was not ons between Residents #1 e morning of 12/27/18. PM the Administrator stated delusional and confused g occurred between dent #2 because Resident ed no trauma. She further d Resident #1 on 30 minute 8 (at 10:00 AM per the precaution and she felt this ive. ewed again on 01/10/19 at ed the names of the staff proved to her there was no aulted Resident #2. She Nurse #4. Additionally she isident #1.	F 607				
	staff as follows:	were conducted with these first shift, was interviewed on					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/10/2019 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345238	B. WING					C 14/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
WHITE O	AK MANOR - CHARLOTT	E			009 CRAIG AVENUE CHARLOTTE, NC 28211			
(X4) ID PREFIX TAG					(X5) COMPLETION DATE			
F 607	him regarding interact and #2 previous to Re sexual behavior the m *Nurse #4, who worke on 01/10/19 at 8:45 A administrative staff ha interactions between #2 over the previous of *Nurse #6, who worke interviewed via phone Nurse #6 denied that about any interaction Residents #1 and #2. learned of the allegati supervisory report. An interview was com Service Director (SSE She stated that she h bragging about what f #2. She assisted in th and stated she would residents who were ca the same assignment stated during follow u 3:53 PM that she "eye directly around Reside no resident was interv attempt to interview a stated she knew her r have been able to tell observing them. She many or who she eye not eyeball or try to in surrounding Resident	NA #1 stated no one any interactions known to tions between Residents #1 esident #1 reporting his norning of 12/27/18. ed first shift, was interviewed M. She stated that no ad asked her about Resident #1 and Resident day of 12/26/18. ed third shift, was e on 01/10/19 at 11:49 PM. the DON questioned him he knew of between He further stated he ion 2 to 3 days later during ducted with the Social 0) on 01/10/19 at 12:31 PM. eard that Resident #1 was he allegedly did to Resident he body audit of Resident #2 have checked with the ared for by the aide who had as Resident #2. SSD p interview on 01/10/19 at e balled" those residents ent #2's room. She stated viewable so she did not ny other resident. She residents well and would if they were traumatized by was unable to say how balled. She stated she did	F	607				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED		
		345238	B. WING				C 14/2019		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
WHITE OA	K MANOR - CHARLOTT	E			009 CRAIG AVENUE CHARLOTTE, NC 28211				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	BE ATE	(X5) COMPLETION DATE			
F 607	 Continued From page 33 Interview with the Administrator on 01/09/19 at 11:53 AM revealed that she did not believe that Resident #1 was capable of assaulting Resident #2 and that Resident #2 would have fought back if Resident #1 tried anything inappropriate. She stated abuse did not occur and there was no 		F	607					
	need to launch a form the incident to the hea investigations per the	nal investigation and report							
	occurred on 01/09/19 that she saw him initia twice more, once afte sexual behaviors. She alert and oriented but of vascular dementia. included that he was sex with Resident #3. that he can ambulate has had 2 children by same time which the physician stated she until talking with thera Resident #1 could ha meaning he does son	was unaware he could walk upy last week. When asked if ve delusions of grandeur, nething but talks about it in							
	occurred and she star incompetent. Interviews were cond with Resident #1 and shifts as follows: *On 01/10/19 at 8:35 worked day shift on 1 administrative staff as	ucted with staff who worked #2 on 12/26/18 on all three AM, NA #5 stated she 2/26/18 and stated no							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION		SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:			G		PLETED
							с
		345238	B. WING			01/	/14/2019
NAME OF PI	ROVIDER OR SUPPLIER	•	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
		_			4009 CRAIG AVENUE		
WHITE OF	K MANOR - CHARLOTT	E			CHARLOTTE, NC 28211		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF				COMPLETION DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IAIE	DAIL
					`		
F 607	Continued From page	24		~~			
F 007			F	60)/		
	during her shift on 12						
		AM, NA #6 stated she					
		shift and that she had					
		the accusations Resident #1 g Resident #2 and that no					
	one asked her question	-					
	interactions between						
		AM a phone call was made					
		she worked second shift on					
	12/26/18. She stated	no administrative staff					
	asked her about knov	vn interactions between					
	Residents #1 and #2	on 12/26/18.					
	*On 01/10/19 at 9:43	AM a phone interview with					
		 NA #9 stated she worked 					
	the evening of 12/26/						
		lestioned her about any					
		between Residents #1 and					
	#2 during her shift on						
		M, NA #10 stated she on 12/26/18 and recalled					
		naviors of Resident #1.					
	*On 01/10/19 at 1:27						
		e. She stated she was the					
		nt of 12/26/18 and stated					
		staff had asked her about					
	any interactions she r	nay have witnessed					
	between Resident #1	and Resident #2 during her					
	shift.						
		PM a phone interview with					
		worked with Resident #2 on					
		vening shift. She stated she					
	· · ·	administration about any					
		between Residents #1 and					
	#2 on 12/26/18.	PM a phone interview with					
	NA #12 revealed she	PM, a phone interview with worked the night of					
		hat no one had asked her					
		she observed between					
	•	ident #2 that night. She					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345238	B. WING		_		C 14/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WHITE O	AK MANOR - CHARLOTT	E		009 CRAIG AVENUE HARLOTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
F 607	allegation. *On 01/10/19 at 11:49 Nurse #6 revealed he 12/26/18. He stated in about any observation or Resident #2. *On 01/10/19 at 11:57 phone interview that s 12/26/18. She furthen staff asked her about between Residents # b. Review of an occur at 12:08 AM revealed cognitively impaired F socially inappropriate to resident altercation Nurse Aide (NA) #3 w assigned to resident of summary stated Resid top of Resident #3 with #3's brief was open o residents were separa Resident #3 revealed in the vaginal area. Interview with Nurse # revealed she was the during the third shift b 11:00 PM and ending Nurse #5 stated that s #3's room on 01/04/19 saw Resident #1 lying his pants partially dow as if he was trying to	ew no details about the P PM a phone interview with worked the night shift of no one asked him questions hs he made of Resident #1 P PM NA #14 stated during a she worked the night of r stated no administrative any observations she saw 1 and #2 that night. Trence report dated 01/04/19 that Resident #1 was in Resident #3's room with behavior involving resident . This was witnessed by rith NA #4 and Nurse #5 care. The investigation dent #1 was noted lying on th his penis out. Resident	F 607				

If continuation sheet Page 36 of 41

	MENT OF HEALTH AN					RINTED: 04/10/2019 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		345238	B. WING			C 01/14/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATI	E, ZIP CODE	
		-	4	009 CRAIG AVENUE		
WHITE O	AK MANOR - CHARLOTT	E	0	CHARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 607	Interview with NA #4 or revealed he had put r pajama pants and a b 11:30 PM on 01/03/19 Resident #3's room w sitting on the edge of over Resident #3, with On a follow up phone 9:33 AM, Nurse #5 st last seen Resident #1 check around 11:45 F station. It was the nu conduct the 30 minute Interview via phone w 1:49 AM revealed tha Resident #3 beginning through 7:00 AM on 0 she began her norma 01/04/19 with Residen entered the resident's back the curtain she s Resident #3. Residen and pushing Residen stated Resident #3's of periarea was "very m was also exposed and hand positioning hims obvious to her he was with Resident #3. Sh nurse and started to s the time he did not sa afterwards Resident # was and how Resident enjoyment. Resident me die this wayI do	on 01/09/19 at 3:51 PM esident #1 in bed wearing rief between 11:15 PM and 0. Then he was called to here he saw Resident #1 Resident #3's bed leaning in his penis exposed. interview on 01/11/19 at ated she thought she had for his 30 minute location PM sitting at the nursing rse's responsibility to e checks on Resident #1. ith NA #3 on 01/10/19 at t she was assigned to g 11:00 PM on 01/03/19 11/04/19. She stated that I rounds around midnight on int #3. NA #3 stated she room and when she pulled saw Resident #1 on top of it #3 was asking for help t #1's head away. NA #3 dress was up and her uch exposed." Resident #1 d he had his penis in his self. NA #3 stated it was a trying to have intercourse e immediately yelled for the separate the residents. At y what he was doing, but f1 was saying how good it mt #3 squealed with #3 kept repeating 'Don't let in't want to die this way.' NA is seen Resident #1 before	F 607			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/10/2019 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY PLETED
		345238	B. WING		_		C 14/2019
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
WHITE OA	K MANOR - CHARLOTT	E		009 CRAIG AVENUE HARLOTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 607 F 842 SS=D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 607		EFICIENCY)		2/6/19
	all information contain						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345238	B. WING				C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WHITE OA	AK MANOR - CHARLOTT	E			4009 CRAIG AVENUE CHARLOTTE, NC 28211		. 0938-0391 SURVEY LETED
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION
F 842	records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to heal by and in compliance §483.70(i)(3) The facil record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yeal legal age under State §483.70(i)(5) The meri (i) Sufficient information (ii) A record of the ress (iii) The comprehensiv provided;	release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance stactivities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services r preadmission screening valuations and cted by the State; 's, and other licensed	F	842	2		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345238		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 01/14/2019		
							NAME OF PI
				40	009 CRAIG AVENUE		
WHITE OA	K MANOR - CHARLOTT	Ē		с			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 842	Continued From page	a 30		842			
1 012			Г	042			
		logy and other diagnostic equired under §483.50.					
	-	Γ is not met as evidenced					
	by:						
	•	iew and staff interviews, the			White Oak of Charlotte ensures medi	cal	
	facility failed to docur	ment observed inappropriate			records are complete and accurate.	Гhe	
		e medical record for 1 of 3			facility ensures an occurrence involvir	ng a	
	· ·	viewed for medical record			resident will be documented in the		
	accuracy. (Resident	#1).			resident's medical record.		
	The findings included	l:			On 1/16/2019, the DON made an entr	y for	
					the 1/4/2019 occurrence involving		
		nitted to the facility on			Resident #3.		
		ses of disorientation, benign tary gland, unspecified			All other residents, including current a	nd	
		order and depressive			newly admitted residents, who have a		
	disorder.				occurrence will have documentation in		
					their medical record regarding the		
	Resident #1's admiss	sion Minimum Data Set			occurrence.		
		8 coded him with being					
		erstanding, having intact			Clinical staff, including Physician's,		
		are 1 to 3 days during the			Physician Extenders, Licensed Nurse	S,	
		uiring extensive assistance			Social Workers, Dietician, Activity		
	and toileting, and limi	nsfers, walking, dressing, ited assistance with			Professionals, and Therapists were re-educated on documenting occurrer		
	locomotion and eating				in the resident's medical record by the		
		3.			SDC on 1/30/2019, 1/31/2019, 2/1/20		
	Review of an occurre	ence report dated 01/04/19 at			2/3/2019, 2/4/2019, and 2/5/2019. N		
		nat Resident #1 was in			hired clinical staff will receive this		
		vith socially inappropriate			education during their job specific		
		sident to resident altercation.			orientation with the SDC and annually	,	
		by Nurse Aide (NA) #3 with			thereafter.		
		assigned to resident care.					
		nmary stated Resident #1			The DON and/or ADON will monitor		
		pp of Resident #3 with his #3's brief was open on the			progress in the medical record of 5 residents daily starting on 1/22/2019 a	bnd	
	-	ents were separated and a			ending on 3/22/2019 and as needed	an lu	
		nt #3 revealed no redness, or			thereafter. The DON and/or ADON		
	blood noted in the va				choose records based on information	00	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345238		(X2) MULTIPL A. BUILDING		TE SURVEY MPLETED		
		B. WING		01/14/2019		
NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - CHARLOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 4009 CRAIG AVENUE CHARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 842	The facility immediate including written state Resident #3. A body Nurse #5 and Nurse # bleeding no discharge noted on the right side "excoriation". Review of Resident # no nursing notes from PM which stated he w watched at all times to The nursing notes for described Resident # removing Christmas of and mantel which resident controls balance and falling. Review of ongoing nu 7:53 AM through 01/0 mention any contact w residents but occasio to one sitter with him. On 01/10/19 at 3:42 F reviewed Resident #1 there was nothing wri any behaviors by Resi #3. She stated there documentation and th written in the occurrent Nursing verified that the states and the states the states of the states of the states and the states of the	ely began an investigation ements and a body audit of audit picture signed by #6 on 01/04/19 stated no e noted at 12:15 AM but also e of her labia was at smedical record revealed in between 01/03/19 at 5:30 was disruptive and must be hrough 01/04/19 at 7:53 AM. 01/04/19 at 7:53 AM 1 being in the parlor, decorations from the tree suited in him losing his aursing notes from 01/04/19 at 09/19 at 7:13 AM did not with Resident #3 or other nally indicated he had a one PM, the Director of Nursing I's nursing notes and stated itten in the notes indicating sident #1 towards Resident should have been some hat it was most likely only nce report. The Director of the occurrence reports for ident #3 were not part of the	F 843	 the 24 hour report, including wee weekend reports. This is to ensure documentation of occurrences impresidents are documented in the resident's medical record. Results from the monitoring will be discussed Monday through Friday morning QI meeting and any ider issues or trends will be further dis at the Quality Assurance meeting team and recommendations mad indicated. The DON will present to the QA committee quarterly an needed. Duration of inclusion in process will be through 3/22/2019 randomly thereafter. After 3/22/2019, the QA committee continue on an ongoing basis to refive occurrences weekly to assure are made in the resident's medica. The DON or designee will chose occurrences as stated above. The of the reviews will be discussed in daily Monday through Friday more meetings. The QI team will evaluate the team set of the assure compliance of F-842 	re volving e y in tified scussed with the e as findings d as the QA d as the PA d as the P	

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