**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**WHITE OAK MANOR - KINGS MOUNTAIN**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

716 SIPES STREET

KINGS MOUNTAIN, NC  28086

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>E 000</td>
<td>An unannounced COVID-19 Focused Survey was conducted on 9/14/2020. The Facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart - B - Requirements for Long Term Care Facilities. Event ID # DOCV11.</td>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>An unannounced COVID-19 Infection Control Survey was conducted on 9/14/2020. The facility was found in compliance with 42 CFR 483.80 Infection Control Regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID#DOCV11. Seven complaint allegations were investigated. All seven allegations were unsubstantiated. Event ID #DOCV11.</td>
<td></td>
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</tbody>
</table>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

09/25/2020

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOCV11

Facility ID: 923555

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