STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345151	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Kings Mountain	716 Sipes Street Kings Mountain, NC 28086

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, resident and staff interviews, the facility failed to maintain a resident's dignity when incontinence care was not provided as needed for 1 of 3 residents reviewed for dignity (Resident #139). Findings included: Resident #139 was admitted on [DATE] with diagnoses which included cerebrovascular accident (stroke) and hypertension (high blood pressure). A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #139 was cognitively intact, received a diuretic (a drug that causes the kidneys to make more urine) daily, was always incontinent of bowel and bladder, and was dependent with incontinence care and toileting. An interview with Resident #139 was conducted on 08/05/25 at 11:32 AM. Resident #139 stated that a few weeks ago she had an incontinent episode early in the morning. She asked to be changed, and no one came back to change her. She reported that she laid in wet briefs all day until her daughter arrived sometime after lunch. Resident reported she couldn't remember who the aide was on the shift. Resident stated, I can't do anything for myself, and I don't like laying in my own filth. I couldn't even eat my lunch the smell was so bad. Resident #139 reported this made her feel angry and upset. A telephone interview with Nursing Assistant (NA) #6 was conducted on 08/08/25 at 2:00 PM. NA #6 was familiar with Resident #139 and the incident that occurred on 07/20/25. She reported she was out in the hall with NA #7, when Resident #139's daughter stepped into the hall and asked them who her mother's NA was. NA #6 reported she told the daughter it was NA #5 and asked if one of us could get her to come to the room. NA #6 reported she told her NA #5 was out with another resident and asked if we could help her with something. NA #6 indicated the daughter took her and NA #7 into the room and pulled back Resident #139's blankets and Resident #139's clothes, under pad and sheets were wet. NA #6 indicated she apologized and told the daughter she was unsure of what had happened as Resident #139 was not on her assignment and she had just started her shift. NA #6 reported she told the daughter she would go get some clean linens and would bathe Resident #139. NA #6 reported she told NA #7 to let her get the Unit Manager before she began cleaning up Resident #139. NA #6 stated she could tell Resident #139 had been laying in soiled clothes and sheets for a while as there was a ring where the urine had started to dry. NA #6 indicated she could tell it was urine because of the smell. NA #6 stated she made the Unit Manager aware of the situation on her way to get clean linens and the Unit Manager went to the room to assess the resident. NA #6 reported she had never been aware of Resident #139 refusing care A telephone interview with NA #7 was conducted on 08/08/25 at 2:50 PM. NA #7 was familiar with Resident #139 and the incident that occurred on 07/20/25. She reported she was out in the hall with NA #6, when Resident #139's daughter stepped into the hall and asked them who her mother's NA was. NA #6 told her it was NA #5. NA #7 indicated the daughter asked if one of us could get NA #5 to come to the room. NA #6 told the daughter she was out with another resident and asked if they could help her with something. The daughter them into the room and pulled Resident #139's blankets back and she observed wet clothes, under pad and sheets. She (NA #7) and NA #6 apologized and told her we were unsure of what had happened as Resident #139 was not on either of our assignments and they both had just started our shifts. NA #6 told the daughter she would go get some clean linens and bathe Resident #139. NA #7 explained while NA #6 was gone she removed the pillow from under Resident #139's knees and found a soiled brief. NA #6 notified the Unit Manager of the situation, and she came in to assess the Resident. The interview further revealed they all worked together to get Resident #139 cleaned up and in dry clothes and linens. Resident #139 has never refused care when she was on my assignment. Three attempts were made to contact NA #5 and there was no ability to leave a voicemail, and no return call or text was received. An interview with the Nurse/Unit Manager #7 was conducted on 08/08/25 at 3:00 PM. Nurse #7 stated Resident #139 was always incontinent of bowel and bladder. Nurse #7 reported, that several weeks ago around 3:00 PM, NA #6 told her, Resident #139 was laying in urine. She reported she went to the room and Resident #139's daughter was quite angry because her mother was soaking wet with urine. Nurse #7 reported that upon entering the room, she noticed a strong urine smell and observed Resident #139 lying in bed with wet clothes, under pad and sheets and a soiled brief lying at the foot of her bed. There were rings around her body on the sheets and under pad where the urine had begun to dry. Nurse #7 recalled Resident #139's daughter asked her had Resident #139 been changed at all today. Nurse #7 reported she told Resident #139's daughter she had to assume Resident #139 had not from the looks of her bed. Nurse #7 stated no one had reported to her that Resident #139 had refused care during the shift. Nurse #7 reported

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff, and family interviews, the facility failed to protect private health information for residents when they provided Resident #153's medical records and a list of resident names, room numbers, medical record numbers, and allergies to Resident #43's Representative at a medical appointment. This deficient practice affected 1 of 2 residents reviewed for privacy (Resident #153). The findings included: Resident #153 was admitted to the facility on [DATE] and was discharged on 03/23/25. Resident #43 was admitted to the facility on [DATE]. A review of Resident 43's neurology consultation form dated 08/15/24 revealed that the provider documented sent wrong medical records on Resident #153, as well as allergies for every resident in the facility. A telephone interview was conducted with Resident #43's Representative on 08/07/25 at 8:41 AM. Resident #43's Representative reported he attended a medical appointment for Resident #43 on 08/15/24. The Representative stated that the facility transport staff handed the Representative an envelope prior to the appointment in the waiting room. When Resident #43 was taken to the exam room, the provider asked questions that did not pertain to Resident #43. The Resident Representative reported he and the physician looked at the paperwork in the envelope and it was not Resident #43's information. The Resident Representative indicated the medical office called the facility to get the medical records for Resident #43 and waited almost an hour for the correct forms to be faxed over to the provider. During the telephone interview, the surveyor asked what information was in the envelope, and Resident Representative stated, hold on, I'll tell you and began rustling papers. Resident Representative stated that the papers listed of all the facility resident names, their medical record numbers, their room numbers, and their allergies. The Resident Representative stated the physician order printout which included diagnosis list for Resident #153's was also in the envelope. The Resident Representative confirmed he was still in possession of the information. When asked if the doctor's office had given the information back to him to keep, the Resident Representative said he could not recall and stated he needed to get off of the phone. A telephone interview was conducted with the Neurology Office Supervisor on 08/07/25 at 10:02 AM. Neurology Office Supervisor stated that the provider who had seen Resident #43 on 08/15/24 had retired. The Neurology Office Supervisor indicated that when residents attend medical appointments, the transportation staff bring the relevant health information to the appointment but do not enter the exam room with the residents. The Neurology Office Supervisor stated the provider documented incorrect records were brought to the appointment on the consultation form.A written statement dated 08/15/24 at 9:30 AM written by the Transporter stated, I took some papers off the printer, looked at the first few pages and they were for resident (Resident #43) who I was transporting. An interview with the Transporter was conducted on 08/07/25 at 10:59 AM. The Transporter stated that prior to the appointment for Resident #43, he grabbed the papers off the printer. The Transporter reviewed the papers, and the first few pages belonged to Resident #43. At the appointment, Resident #43's Representative was present, and the Transporter handed the envelope to Resident #43's Representative. The Transporter overheard the receptionist and representative discuss the paperwork, but they did not ask the Transporter any questions. The Transporter stated no files were received back from the resident representative after the appointment and was unsure where the paperwork went. Nurse #4 completed a written statement dated 08/15/24. Nurse #4 attempted to print out the face sheet and order report for Resident #43. Another resident's information was also printed. The transporter agreed to pick up copies from the printer. According to the statement, Nurse #4 received a phone call that AM from the neurology office that the incorrect medical records were sent to the appointment. Information for Resident #43's appointment was faxed to the neurology office. A telephone interview was attempted with Nurse #4 on 08/07/25 at 11:42 AM. Nurse #4 was not available for interview. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the day of Resident #43's appointment, Resident #153's health information was inadvertently sent to the appointment. The health information sent incorrectly included a diagnosis list and physician orders for Resident #153, and a list of all facility residents' names, medical record numbers, room numbers, and the residents' allergies. The Administrator stated that a breach report was filed with the Department of Health and Human Services. The Administrator stated that all facility resident representatives were notified of the information breach. Resident #153's representative was notified of the specific breach of health information. The Administrator stated that Resident #43's Representative retained the medical records. The Administrator reported that the Resident Representative was contacted

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, resident, staff, resident representative, and Nurse Practitioner (NP) interviews, the facility failed to protect the resident's right to be free from abuse for 4 of 30 residents reviewed for abuse (Resident #32, Resident #59, Resident #86, and Resident #125). On 05/09/25, Resident #32 was heard yelling for help when Resident #154 entered Resident #32's room and grabbed her by the neck and pinned her against the wall. Resident #32 was noted to be swatting at Resident #154 to free herself. Resident #154 sustained scratches to left ear. On 04/20/25, Resident #154 balled up his fist and hit Resident #86 in the mouth. Resident #86 sustained a cut to her upper lip with bleeding. On 04/17/25, Resident #32 was heard yelling for help when Resident #154 entered Resident #32's room and grabbed her arm and pulled it. When staff arrived, Resident #32 was noted to be swatting at Resident #154 in an attempt to free herself. Resident #154 sustained scratches to left eye and left lip. On 08/16/24, Resident #156 hit Resident #125 on the left shoulder and placed his hands around her neck causing a 2-centimeter by 2-centimeter (cm) reddened area to Resident #125's left shoulder. The facility also failed to protect the resident's right to be free from sexual abuse for 1 of 30 residents reviewed for abuse (Resident #59). On 08/29/24, Resident #156 and Resident #59 were observed in the hallway. Resident #156 had one hand down the front of Resident #59's brief, and one hand down the back of Resident #59's brief. A reasonable person would expect to be protected from abuse in their own home and would expect to experience mental anguish with feelings such as fear, humiliation, anxiety, anger, and depressed mood after experiencing physical or sexual abuse. This deficient practice was for 4 of 30 residents reviewed for abuse (Resident #32, Resident #59, Resident #86, and Resident #125). Immediate jeopardy began on 05/09/25 when Resident #32 was in her bedroom when Resident #154 entered her room, grabbed her by the neck, and had her pinned against the wall in the corner. The immediate jeopardy was removed on 08/10/25 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the following examples: 1b (Resident #86), 1c (Resident #32), 2a (Resident #59), and 2b (Resident #125) to ensure education and monitoring systems put into place are effective. Findings included: 1a. Resident #32 was admitted to facility on 09/24/24 and resided in a locked memory care unit. Resident #32's diagnoses included Alzheimer's disease, dementia in other diseases with behavioral disturbance, generalized anxiety disorder, and depression. A review of Resident #32's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #32 was severely cognitively impaired, required supervision for all activities of daily living (ADLs), and used a walker for ambulation. Resident #32 received antipsychotics and antidepressants daily. Resident #32 was coded for having adequate hearing and vision, usually able to make herself understood, and able to understand others. A review of Resident #32's care plan initiated 10/14/24 revealed plan for diagnosis of anxiety. Stated goal was Resident #32 would show decreased signs of anxiety. Interventions included allow Resident #32 to verbalize her feelings, monitor for changes in mood, and monitor for adverse reactions to anxiety medications. Hospital discharge instructions prior to admission to facility dated 09/20/24 revealed Resident #154 was admitted to the hospital on [DATE] for evaluation of increased confusion and hallucinations. Resident #154's hospital discharge note indicated a sitter was required during hospital stay but was discontinued 48 hours prior to discharge. Resident #154 required medication for agitation up to 24 hours prior to discharge from the hospital. Behavioral disturbances noted in the hospital discharge note included agitation. Discharge instructions were to continue current medications as ordered after discharge. Resident #154 initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #154 discharged from facility to hospital on [DATE]. Resident #154's diagnoses included unspecified dementia with other behavioral disturbances, depression, generalized anxiety disorder, and insomnia due to other mental disorders. A review of Resident #154's care plans revealed a plan initiated 10/14/24 which noted Resident #154 was verbally and physically aggressive with others (cursing and yelling at staff and other residents, threatening staff, combative with staff). The stated goal was Resident #154 would have little to no episodes of behavior during the next review period. Interventions included: allow resident time to calm down in a safe and quiet place when agitation occurred, redirect Resident #154 when behaviors occurred, notify the provider of mood or behavioral changes, document behaviors, monitor Resident #154 for medication side effects, and notify the psychiatric provider as needed. Another care plan was initiated on 03/24/25 for

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to identify abuse and ensure staff implemented facility's abuse policy and procedures for reporting abuse. This occurred when the facility failed to report allegations of resident-to-resident abuse to the State Survey Agency within the specified time frames. The facility also failed to notify the county Adult Protective Services (APS) of allegations of abuse. This deficient practice affected 4 of 30 residents reviewed for abuse (Resident #32, Resident #59, Resident #86, and Resident #125).The findings included: A review of undated facility policy titled Protocol for Reporting Abuse revealed if a reasonable person suspected that abuse had occurred, staff would immediately notify the administrator or designee, person in charge, and officials including the State Survey Agency and APS no later than 2 hours after the allegation was made if the events of allegation involved abuse or resulted in serious bodily injury. 1. Resident #154 was initially admitted to the facility on [DATE], readmitted on [DATE], and discharged from facility to hospital on [DATE]. Resident #154's diagnoses included unspecified dementia with other behavioral disturbances, depression, generalized anxiety disorder, and insomnia due to other mental disorders. A review of Resident #154's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #154 was severely cognitively impaired. a. Resident #32 was admitted to facility on 09/24/24. Resident #32's diagnoses included Alzheimer's disease, dementia in other diseases, generalized anxiety disorder, and depression. A review of Resident #32's quarterly MDS dated [DATE] revealed Resident #32 was severely cognitively impaired. A facility incident report dated 05/09/25 at 4:31 PM was completed for Resident #154. The incident report revealed Resident #154 entered Resident #32's room and placed hands around Resident #32's neck and pinned Resident #32 in the corner of the room with her back against the wall. Resident #32 noted to be hitting Resident #154 to free herself. Resident #154 sustained scratches to left ear. A facility incident report dated 05/09/25 at 4:50 PM was completed for Resident #32. The incident report revealed Resident #32 was in her room when Resident #154 entered Resident #32's room and cornered Resident #32 against the wall with hands around her neck. A review of facility reported incidents revealed no facility initial investigation or 5-day investigation reports were submitted to the North Carolina Division of Health Service Regulation (DHSR). An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator verbalized due to both Resident #32 and Resident #154 being severely cognitively impaired, it was determined there had been no willful intent from Resident #154 to harm Resident #32 therefore it would not constitute abuse. The Administrator stated after a thorough investigation, and discussion with corporate, it was determined the altercation did not need to be reported to the State Survey Agency or APS. The Administrator verbalized If I felt it needed to be reported, I would have. The Administrator reiterated that without willful intent, no abuse occurred. b. Resident #86 was admitted to facility on 11/08/24. Resident #86's diagnoses included unspecified dementia with other behavioral disturbance, generalized anxiety disorder, and depression.A review of Resident #86's quarterly MDS dated [DATE] revealed Resident #86 was severely cognitively impaired. A facility incident report dated 04/20/25 at 9:02 PM was completed for Resident #86. The incident report revealed Resident #86 was in bedroom when Resident #154 entered Resident #86's room and had fist balled up making contact with Resident #86's face. Incident report described injury to Resident #86 as small area to upper lip with small amount of blood. A facility incident report dated 04/20/25 at 9:02 PM was completed for Resident #154. The incident report revealed Resident #154 had increased agitation. Resident #154 entered Resident #86's room, balled up fist and hit Resident #86 in the mouth. Resident #154 sustained no injury. A review of facility reported incidents revealed no facility initial investigation or 5-day investigation reports were submitted to the DHSR. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator verbalized due to both Resident #86 and Resident #154 being severely cognitively impaired, it was determined there was no willful intent from Resident #154 to harm Resident #86 therefore it would not constitute abuse. The Administrator stated after a thorough investigation, and discussion with corporate, it was determined the altercation did not need to be reported to the State Survey Agency or APS. The Administrator verbalized If I felt it needed to be reported, I would have. The Administrator reiterated that without willful intent, no abuse occurred. c. Resident #32 was admitted to facility on 09/24/24. Resident #32's diagnoses included

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete a thorough investigation after allegations of resident-to-resident abuse occurred. This deficient practice affected 4 of 30 residents reviewed for abuse (Resident #32, Resident #59, Resident #86, and Resident #125).Findings included: The undated facility abuse policy titled [NAME] Oak Management, Inc. Plan for the Prevention of Elder Abuse was reviewed. A section of policy titled Resident to Resident Abuse stated all forms of abuse, including resident-to-resident abuse, must be reported immediately to the Director of Nursing and the facility administrator. Section 6 titled Investigation stated all reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management. The administrator or designee shall investigate the allegation by completing the following: Review the completed documentation forms or any other pertinent documentation related to the allegation. Review the resident's medical record to determine events leading up to the allegation. Interview the person reporting the incident. Interview witnesses to the incident. Interview the resident (if appropriate). Review the medical record to obtain the resident's orientation and decision-making capacity. Interview staff members (on all shifts) who had contact with the resident during the period of alleged incident. Interview other residents, the resident's roommate, family members, and visitors as appropriate.Statements would be obtained from all individuals with potential involvement or knowledge of the incident. Statements should be timed and dated. Following a complete and thorough investigation, a summarized investigation report should be completed by the administrator. Corrective action should be taken pending final summary of the investigation. 1. Resident #154 was initially admitted to the facility on [DATE], readmitted on [DATE], and discharged from facility to hospital on [DATE]. Resident #154's diagnoses included unspecified dementia with other behavioral disturbances, depression, generalized anxiety disorder, and insomnia due to other mental disorders. A review of Resident #154's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #154 was severely cognitively impaired. a. Resident #32 was admitted to facility on 09/24/24. Resident #32's diagnoses included Alzheimer's disease, dementia in other diseases, generalized anxiety disorder, and depression. A review of Resident #32's quarterly MDS dated [DATE] revealed Resident #32 was severely cognitively impaired. A facility incident report dated 05/09/25 at 4:50 PM was completed for Resident #32. The incident report revealed Resident #32 was in her room when Resident #154 entered Resident #32's room and cornered Resident #32 against the wall with hands around her neck. The event form noted Resident #32 exhibited fear after the incident. A facility incident report dated 05/09/25 at 4:31 PM was completed for Resident #154. The incident report revealed Resident #154 entered Resident #32's room and placed hands around Resident #32's neck and pinned Resident #32 in the corner of the room with her back against the wall. Resident #32 noted to be hitting Resident #154 to free herself. Resident #154 sustained scratches to left ear. A review of skin assessment form dated 05/09/25 for Resident #32 revealed no bruising or injury noted after the 05/09/25 incident. There was no skin assessment form available for review for Resident #154 after the altercation. No skin assessment forms for other cognitively impaired residents residing on the memory care unit were available for review. No resident interviews were available for review. A handwritten untimed statement dated 05/09/25 written by Nurse Aide (NA) #1 revealed NA #1 heard Resident #32 yelling help me from Resident #32's room. NA #1 entered Resident #32's room and observed Resident #154 had Resident #32 by the neck. An untimed written statement dated 05/09/25 from the Infection Preventionist revealed Resident #154 had been in Resident #32's room with his hands around her neck. The Infection Preventionist wrote Resident #154 and Resident #32 were separated, and Resident #154 immediately entered another resident's room. Staff redirected Resident #154 to his room. No investigation summary by the Administrator or designee was available for review. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator stated there were no concerns about how the investigation was conducted and confirmed no other investigation materials were available. b. Resident #86 was admitted to facility on 11/08/24. Resident #86's diagnoses included unspecified dementia with other behavioral disturbance, generalized anxiety disorder, and depression. A review of Resident #86's quarterly MDS dated [DATE] revealed Resident #86 was severely cognitively impaired. A facility incident report dated 04/20/25 at 9:02 PM was completed for Resident #86. The incident report revealed Resident #86 was in the bedroom when Resident #154 entered Resident #86's room and

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	345151	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Kings Mountain	716 Sipes Street Kings Mountain, NC 28086

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Hospital Case Manager, Resident's Representative, and staff interviews, the facility failed to allow a resident to return to the first available bed at the facility after being sent to the hospital for a medical and psychiatric (psych) evaluation. The resident remained in the hospital despite being medically cleared to return to the nursing home after 5 days. This deficient practice was evidenced for 1 of 3 residents reviewed for transfer and discharge (Resident #154).Findings included: Resident #154 was admitted to the facility on [DATE] and discharged to the hospital on 5/9/2025. Resident #154 was admitted with diagnoses that included spinal stenosis, muscle weakness, dementia with other behavioral disturbance, depression, generalized anxiety disorder, unspecified glaucoma and resided in the locked unit. Review of Resident #154's face sheet indicated a family member was Resident #154's emergency contact, Resident Representative (RR), and responsible party. A review of progress notes for Resident #154 revealed a note dated 05/09/25 at 4:31 PM Resident #154 had an altercation with Resident #32 in Resident #132's room. Resident #154 noted with his hands around Resident #32's neck. Resident #154 entered another resident's room after staff redirected him out of Resident #32's room. The Administrator and Resident #154's Representative notified. One-on-one staff assigned to Resident #154. A progress note dated 05/09/25 at 6:07 PM noted the on-call provider was notified of incident and Resident #154 exited the building at 6:01 PM via Emergency Medical Services for the hospital. A progress note dated 05/09/25 at 6:41 PM revealed Resident #154 discharged out via involuntary commitment. Resident #154 discharged due to change of condition and endanger to resident and others related to incident with Resident #32. A review of facility incident report for Resident #32's dated 05/09/25 at 4:50 PM completed by Nurse #2 because of a resident-to-resident altercation with Resident #154. The incident report revealed Resident #32 was in her room when Resident #154 entered Resident #32's room and cornered Resident #32 with hands around her neck. The event form noted Resident #32 exhibited fear after the incident. Interventions for Resident #32 included redirection and simplifying the environment. Review of Resident #154's discharge Minimum Data Set (MDS) dated [DATE] revealed Resident #154 was severely cognitively impaired and indicated physical behavioral symptoms directed toward others, wandering behavior, coded as unplanned discharge with return anticipated. Review of Resident #154's Hospital Records and Hospital Case Manager notes dated 5/9/2025 to 6/2/2025 revealed the following:5/10/2025: Hospital Case Management met with daughter outside resident room. Resident is a Long-Term Care (LTC) resident at a local facility and if possible, the family wishes for resident to return there. Hospital Case Manager called and spoke to the Corporate Regional Coordinator for the local facility, and she will check with the facility to see if resident can return to the facility.Hospital Case Manager called and spoke to the Admissions Nurse from the local facility concerning the ability of resident returning to the facility. The Admissions Nurse states that she did not know, and it would be up to administration, and they have not made a decision. Hospital Case Management will follow up for a decision. Resident was not medically ready for discharge.5/13/2025: Sitter at bedside. Hospital Case Manager spoke to Corporate Regional Coordinator regarding resident returning for LTC/locked unit at discharge. Per Corporate Regional Coordinator, management is discussing the resident returning at a corporate level due to his behavior at the facility and she will notify Hospital Case Management once a decision has been made. Hospital Case Management following.5/13/2025: Administrator at local facility contacted Hospital Case Management to discuss resident. Administrator informed Hospital Case Management of resident behaviors at the facility and is unable to accept this resident at this time. Administrator has requested a psych eval stating that unless psych sees him and a major condition change is made with the resident, they cannot take him back. Hospital Case Management informed MD of above and psych has been consulted. Psych plans to see resident later today. Hospital Case Management will follow.5/14/2025: Medically ready for discharge5/15/2025: Sitter remains in place and psych is making medication adjustments. RR is aware that resident may not be able to return to local facility unless improvement has been made with the medication adjustments and resident no longer exhibits aggressive behaviors. Per staff resident has not been aggressive or combative since this admission. Hospital Case Management will allow time for resident to improve and will fax out for placement and follow up with local facility on Monday. Hospital Case Management informed family that locked units are limited and recommended they discuss alternate plans for the resident such as private sitters and/or staying with family.5/19/2025- Virtual sitter in place. Hospital Case

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, resident and staff interviews, the facility failed to provide incontinence care to a resident when needed and was alerted by a family member that Resident #139 had laid in a urine soaked brief, clothes, under pad and sheets for several hours. This deficient practice was for 1 of 3 residents reviewed for providing activities of daily living care (Resident #139). Findings included:Resident #139 was admitted on [DATE] with diagnoses which included cerebrovascular accident (stroke), hypertension (high blood pressure). A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #139 was cognitively intact, received a diuretic (a drug that causes the kidneys to make more urine) daily, was always incontinent of bowel and bladder, and was dependent with incontinence care and toileting. An interview with Resident #139 was conducted on 08/05/25 at 11:32 AM. Resident #139 stated that a few weeks ago she had an incontinent episode early in the morning. She asked to be changed, and no one came back to change her. She reported that she laid in wet briefs all day until her daughter arrived sometime after lunch. Resident reported she couldn't remember who the aide was on the shiftA telephone interview with Nursing Assistant (NA) #6 was conducted on 08/08/25 at 2:00 PM. NA #6 was familiar with Resident #139 and the incident that occurred on 07/20/25. She reported she was out in the hall with NA #7, when Resident #139's daughter stepped into the hall and asked them who her mother's NA was. NA #6 reported she told the daughter it was NA #5 and asked if one of us could get her to come to the room. NA #6 reported she told her NA #5 was out with another resident and asked if we could help her with something. NA #6 indicated the daughter took her and NA #7 into the room and pulled back Resident #139's blankets and Resident #139's clothes, under pad and sheets were wet. NA #6 indicated she apologized and told the daughter she was unsure of what had happened as Resident #139 was not on her assignment and she had just started her shift. NA #6 reported she told the daughter she would go get some clean linens and would bathe Resident #139. NA #6 reported she told NA #7 to let her get the Unit Manager before she began cleaning up Resident #139. NA #6 stated she could tell Resident #139 had been laying in soiled clothes and sheets for a while as there was a ring where the urine had started to dry. NA #6 indicated she could tell it was urine because of the smell. NA #6 stated she made the Unit Manager aware of the situation on her way to get clean linens and the Unit Manager went to the room to assess the resident. NA #6 reported she had never been aware of Resident #139 refusing care A telephone interview with NA #7 was conducted on 08/08/25 at 2:50 PM. NA #7 was familiar with Resident #139 and the incident that occurred on 07/20/25. She reported she was out in the hall with NA #6, when Resident #139's daughter stepped into the hall and asked them who her mother's NA was. NA #6 told her it was NA #5. NA #7 indicated the daughter asked if one of us could get NA #5 to come to the room. NA #6 told the daughter she was out with another resident and asked if they could help her with something. The daughter them into the room and pulled Resident #139's blankets back and she observed wet clothes, under pad and sheets. She (NA #7) and NA #6 apologized and told her we were unsure of what had happened as Resident #139 was not on either of our assignments and they both had just started our shifts. NA #6 told the daughter she would go get some clean linens and bathe Resident #139. NA #7 explained while NA #6 was gone she removed the pillow from under Resident #139's knees and found a soiled brief. NA #6 notified the Unit Manager of the situation, and she came in to assess the Resident. The interview further revealed they all worked together to get Resident #139 cleaned up and in dry clothes and linens. Resident #139 has never refused care when she was on my assignment. Three attempts were made to contact NA #5 and there was no ability to leave a voicemail, and no return call or text was received. A review of Resident #139's skin assessment dated [DATE] done after the incident, revealed redness to bilateral buttocks. An interview with the Nurse/Unit Manager #7 was conducted on 08/08/25 at 3:00 PM. Nurse #7 stated Resident #139 was always incontinent of bowel and bladder. Nurse #7 reported, that several weeks ago around 3:00 PM, NA #6 told her, Resident #139 was laying in urine. She reported she went to the room and Resident #139's daughter was quite angry because her mother was soaking wet with urine. Nurse #7 reported that upon entering the room, she noticed a strong urine smell and observed Resident #139 lying in bed with wet clothes, under pad and sheets and a soiled brief lying at the foot of her bed. There were rings around her body on the sheets and under pad where the urine had begun to dry. Nurse #7 recalled Resident #139's daughter asked her had Resident #139 been changed at all today. Nurse #7 reported she told Resident #139's daughter she had to assume Resident #139 had not from the looks of her bed. Nurse #7

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and Nurse Practitioner and staff interviews, the facility failed to accurately assess 3 of 3 severely cognitively impaired residents for bilateral half side rails on their beds (Resident #2, Resident #64, and Resident #77). The findings included:1. Resident #2 was admitted to the facility on [DATE] with diagnoses which included dementia with psychotic disturbance, gastrostomy tube, and atrial fibrillation.Review of Resident #2's consent for use of bed rails dated 08/07/22 revealed the facility received telephone consent from the resident's responsible party (RP) but the consent was not signed by the RP or the nurses receiving consent.Review of Resident #2's care plan dated 07/15/25 revealed a focus area for activities of daily living (ADL) deficits related to generalized weakness and cognitive loss secondary to dementia, congestive heart failure (CHF), atrial fibrillation, and stroke with hemiplegia (paralysis on one side of body). The goal was for the resident to be able to participate in some aspects of ADL care with staff assistance through the next review date. The interventions included: padded bilateral half side rails as ordered.Resident #2's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired, unable to make her needs known and staff had to anticipate her needs daily. The assessment also revealed she required extensive assistance of 2 staff members for bed mobility and she was on a turning and repositioning program.Review of a Care Area assessment dated [DATE] for cognitive loss revealed resident had an abdominal binder over her gastrostomy tube, bed bolsters, foot buddy, geri sleeves, high back wheelchair, and padded bilateral half side rails for safety. Review of Resident #2's medical record revealed she had side rail assessments completed on:a. 07/22/25 - padded half side rails - able to remove on command consistently - no; factors/symptoms/medical symptoms - poor safety awareness and weakness as evidenced by disease process; reason for device use - decrease risk of injury, enable/increase bed mobility, enable/increase independence, enables resident to reposition self, provides tactile barrier and repositioning/support; device assists in improving functional status - yes; restricts freedom of movement - no; select device classification - enabler.b. 04/17/25 - padded half side rails - able to remove on command consistently - no; factors/symptoms/medical symptoms - poor safety awareness, weakness as evidenced by disease process; reason for device use - decreased risk of injury, enable/increase independence, enables resident to reposition self, and provides tactile barriers; device assists in improving functional status - yes; restricts freedom of movement - no; select device classification - enabler.c. 10/22/24 - padded half side rails - able to remove on command consistently - no; factors/symptoms/medical symptoms - poor safety awareness, weakness as evidenced by disease process; reason for device use - decreased risk of injury, enable/increase independence, enables resident to reposition self, and provides tactile barriers; device assists in improving functional status - yes; restricts freedom of movement - no; select device classification - enabler.Review of Resident #2's physician orders dated 08/01/25 revealed an order for padded bilateral half side rails to bed to assist in bed mobility related to muscle weakness related to dementia.Observation of Resident #2 on 08/04/25 at 9:23 AM revealed her lying in bed in her room with half side rails up on either side of her bed. The side rails were padded with gray pool noodle type material and electrical tape. The top of both rails was padded and the rest of the rail was open and metal. The resident was mumbling incoherently and unable to answer questions or follow any directions.Observation of Resident #2 on 08/05/25 at 10:03 AM revealed her lying in bed in her room with half side rails up on either side of her bed. The side rails were padded with gray pool noodle type material and electrical tape. The resident was mumbling incoherently and unable to answer questions or follow any directions.Observation of Resident #2 on 08/06/25 at 4:39 PM revealed her lying in bed in her room with her side rails up on either side of her bed. The Risk Nurse and the Director of Nursing (DON) were in to the room to do a side rail assessment, and the resident was upset and mumbling and unable to follow directions to turn and hold herself over or hold onto the side rail with her hand. The DON stated they would attempt the evaluation later when the resident was not upset.Observation of Resident #2 on 08/06/25 at 5:53 PM revealed her lying in bed in her room with her side rails up on either side. The Risk Nurse and DON instructed the resident to turn on her side and hold onto the side rail and she was unable to turn on her side and had to be turned by the nurses and was unable to hold onto the side rail to hold herself over on her side. The resident made no attempt to put her hand on the rail or hold onto the rail to hold herself over on her side. The DON stated the resident was not appropriate for side rails and they would be removed from her bed.An interview on 08/06/25 at 6:15 PM with the interim

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, pharmacy and Nurse Practitioner (NP) interviews, the facility failed to prevent a drug regimen free from unnecessary drugs for 1 of 17 residents reviewed for unnecessary medications. Resident #142 was administered a tuberculosis skin test using tubersol. Record Review indicated to only perform a screening as Resident #142 had an allergy to tubersol. The findings included: 1. Resident #142 was admitted to the facility on [DATE] with diagnosis that included vascular dementia, hypertension, and unspecified respiratory tuberculosis. Record review of admission paperwork dated 03/04/21 revealed Resident #142 had listed an allergy to tubersol (an intradermal solution used to perform a Mantoux test which test for dormant or active tuberculosis (TB)). No origin of allergy or reaction was noted on paperwork. Review of physician order dated 08/01/21 revealed Resident #142 was to receive TB screening sheet annually on March 1. Review of Resident #142 March 2025 Medical Administration Record (MAR) revealed Resident #142 was to receive a TB screening sheet. Review of nursing note dated 03/01/2025 at 7:51PM by Nurse #10 indicated in part that Resident #142 was given a Mantoux test in right mid forearm around 12 pm on her shift, after which she realized Resident #142 had an allergy to tubersol. NP was immediately notified and at that time Resident #142 was showings no signs or symptoms of adverse reactions. NP gave an order for as needed antihistamine. The responsible party (RP) was notified and inquired about previous adverse reaction to the tubersol. RP stated in the past he had a mild skin reaction to the tubersol given. RP made aware that Resident #142 would be closely monitored. Review of nursing note dated 03/02/2025 at 3:47 PM by Nurse #10 indicated in part that Resident #142 was assessed and a round slightly pink area noted at the injection site approximately 5x4 centimeters slightly raised. Resident #142 was stable with no other concerns. Nurse #10's note stated she notified the NP and got new orders for ice to the area as needed and a chest x-ray. Nurse #10's notes also indicated she called the RP to make them aware of the changes. Review of nursing note dated 03/05/25 indicated the injection site to right forearm continues with discoloration but has decreased in size. Record review on 03/03/25 of chest x-ray results revealed no definite acute infiltrate, pheumothorax, congestion or pleural effusion and no Tuberculosis seen. Nurse #10 was not available for interview. An interview with the Director of Nursing (DON) on 08/07/25 at 9:25 AM revealed she started in her position with the facility in April 2025 and discovered medication errors were a concern for the facility. She reported she began a new program to reduce the medication errors. She reported that she had begun doing audits on all medical administration records (MAR) and if a medication aide made a medication error once it was an immediate write up, if the medication aide had a second medication error offense they were removed from the position and had to be retrained, if a medication error was made by a nurse, the first offense was a write up and the second offense was termination. The DON reported she had reviewed the medication administration policy with all staff responsible for giving medications. An interview with a pharmacist on 08/07/25 at 12:15 PM indicated that anytime a medication is given to someone who has a listed allergy to the medication there could be a significant risk to that person. She reported that allergies are marked on the resident's charts and on the MAR and should be checked before administering any medications. An interview with the NP on 08/07/25 at 1:10 PM revealed she had been made aware of the medication given in error. She reported she expected nurses and medication aides to check orders twice before administering medications of any kind. The NP stated they monitored Resident #142 closely for several days after the tubersol was administered and he had no adverse reactions. An interview with the Administrator on 08/07/25 at 1:40 PM revealed she was familiar with Resident #142 and him receiving a medication that was listed as being allergic to. She stated she realized medication errors had been a problem for several months within the facility and she contributed that to the DON position being filled with multiple, temporary DON's from October 2024 to April 2025. She reported the current DON had made it a priority and had put measures in place to reduce the error rate.