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

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

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with the Nurse Practitioner (NP) and staff, the facility failed to prevent a resident with severe cognitive impairment, wandering and exit seeking behavior and at high risk for falls, from exiting the facility unsupervised without staff's knowledge. On two consecutive nights Resident #89 exited the facility through an unlocked emergency exit door near the back of the facility that was in working order, but the door had been manually unlocked, and the door alarm had been turned off with a key and therefore did not alarm. On 6/28/25 at an undetermined time early in the morning (it was still dark outside) Nurse #1 noticed Resident #89 was not walking in the hallway and was not in his room. Nurse #1 approached Nurse Aide #1 who was on the end of the hallway near the emergency exit door and reported she had not seen Resident #89 but had heard a door slam near the emergency exit. Nurse Aide #1 indicated another resident that resided in a room near the emergency exit door was known to slam her door and since the emergency door alarm did not go off, she assumed that was what she had heard. Nurse #1 exited through the emergency exit door and walked for 5 to 7 minutes from the back of the facility around to the front where he located Resident #89 standing at the main entrance. Nurse #1 estimated the resident was outside unsupervised for approximately 10 minutes. Nurse #1 thought the emergency exit door locked automatically and was not aware the emergency door alarm had been turned off with a key and did not check the door after the incident or before the end of his shift to ensure it was locked. On 6/29/25 at approximately 1:30 AM Resident #89 was observed in bed and at approximately 2:00 AM Nurse #1 noticed the resident was not in bed and walked immediately to the emergency exit door. He observed the resident through the glass window on the door outside walking away from the building and redirected him back inside. The emergency exit door was again unlocked and did not alarm when Nurse #1 exited through the door to retrieve the resident. When exiting the emergency door if you walked straight ahead and did not follow the sidewalk path, approximately 8 feet in front of the door was a concrete drain box (a concrete structure around a water drain underground). The concrete box opening was approximately 3 feet by 3 feet had no safety covering and was 3 to 4 feet deep into the ground. The sidewalk path outside of the emergency exit door curved immediately to the left up an inclined hill and the sidewalk then turned left and ran directly parallel to a two-lane road that had a posted speed limit of 30 miles per hour. The sidewalk ran along the road for approximately 142 feet and then turned left running along the main driveway used to enter the facility's parking lot and continued in front of the building approximately 180 feet to the main entrance door. Resident #89 was not injured; however, there was a high likelihood of serious harm, injury, or death. This deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #89). Immediate jeopardy began on 6/28/25 when Resident #89 exited the facility unsupervised and without staff knowledge. Immediate jeopardy was removed on 4/11/26 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure all staff and providers are aware of the elopement, education is completed and monitoring systems put (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	into place are effective.The findings included:Resident #89 was admitted to the facility on [DATE] with diagnoses including dementia with psychotic disturbance, intracranial injury without loss of consciousness (mild traumatic brain injury), abnormalities of mobility and gait, muscle weakness, insomnia, and orthostatic hypotension (sudden drop in blood pressure when standing).The care plans initiated on 1/28/25 indicated Resident #89 had problem areas including cognitive decline, wandering and exit seeking behaviors, was at risk for falls, and had a diagnosis of insomnia with sleep pattern disturbance. The interventions included administering medications as ordered, monitoring for medication side effects (mood/behavior changes, excessive daytime sleepiness, dizziness and ineffectiveness of medication), wearing a wander guard bracelet, redirecting attempts to exit the facility, encouraging adequate rest periods, discouraging long naps during the day, ensuring proper foot wear was worn, frequent checks by staff, monitoring environment for safety and making adjustments as needed, assessing possible contributing factors of falls including blood pressure (standing and sitting), and notifying the physician of any medication side effects and/or changes in behaviors.Resident #89 had a physician's order dated 1/29/25 for a wander alarm bracelet due to wandering/exit seeking behaviors. A nurse's note dated 4/29/25 at 6:25 AM written by Nurse #1 revealed Resident #89 was confused roaming the building looking for an exit sign to attempt to leave and was very difficult to redirect.A nurse's note dated 4/29/25 at 6:39 AM written by Nurse #1 indicated Resident #89 was confused and kept roaming the building. Resident #89 continuously attempted to exit the building aggressively telling staff, I have to go and was very difficult to redirect. An elopement risk assessment dated [DATE] revealed Resident #89 had a history of wandering and exit seeking behaviors and exhibited these behaviors within the last 90 days. Resident #89 had risk factors related to elopement which included walking independently, cognitive impairment, poor decision-making skills and verbalizing a desire to leave the facility and/or go home. The assessment score was 3 (lowest risk 0 - highest risk 5) indicating Resident #89 was at a moderately high risk for elopement and to continue current safety interventions that were in place. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #89 was severely cognitively impaired, exhibited wandering behaviors one to three days during the assessment period and wore a wander/elopement alarm daily. The MDS assessment further revealed Resident #89 required supervision to touching assistance walking 10 feet, partial to moderate assistance walking 50 feet with two turns, and supervision to touching assistance walking 150 feet and was not coded for any falls in the past 30 days. Resident #89's active physician orders as of 6/28/25 included the following: Trazodone (anti-depressant medication used for insomnia) 50 milligrams (mg) once a day at bedtime.Melatonin (a supplement used for insomnia and to regulate the sleep-wake cycle) 3 mg once a day at bedtime.Midodrine (medication for low blood pressure) 5 mg three times a day.A nurse's note dated 6/28/25 at 7:06 AM written by Nurse #1 revealed Resident #89 was wandering throughout the night and redirected back to his room several times. Resident #89 was successful in exiting the facility through the emergency exit door on the west hallway and was located by staff standing outside at the main entrance. Resident #89 was escorted back to his room and assessed with no injuries noted. A phone interview conducted with Nurse #1 on 4/08/26 at 9:24 AM revealed he worked from 7:00 PM to 7:00 AM on Fridays and Saturdays and was assigned to Resident #89 on 6/27/25 and 6/28/25. He stated Resident #89 was cognitively impaired, wandered the hall every night and was exit seeking at times. He stated when Resident #89 was exit seeking he continuously pushed on the emergency door to see if it would open. Nurse #1 revealed Resident #89 ambulated independently but was at risk for falls due to orthostatic blood pressure and poor balance. He stated Resident #89 did not use a walker or wheelchair but would hold on to stationary items like furniture and handrails to stabilize himself and would lean against a wall as needed to rest. Nurse #1 on revealed when his shift began on 6/27/25 at 7:00 PM Resident #89 was exhibiting his normal wandering and exit seeking behaviors which included verbalizing he had somewhere to go and needed to leave. Nurse #1 stated on 6/28/25 in the early morning, he did not recall the exact time, but it was still dark outside, he (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	noticed Resident #89 was not walking in the hallway and was not in his room. He indicated Resident #89's assigned Nurse Aide (NA), NA #1, was on the other end of the hallway near emergency exit door and reported she had not seen Resident #89 but that she had just heard the exit door close. Nurse #1 revealed when he pushed on the emergency exit door it was still unlocked and opened immediately and did not alarm. Nurse #1 stated he assumed Resident #89 exited the building when NA #1 heard the exit door slam shut and he (Nurse #1) exited the door just a few minutes later, and walked for 5 to 7 minutes from the back of the building around to the front where he located Resident #89 standing at the main entrance, so he estimated Resident #89 was outside unsupervised for approximately 10 minutes before he located him at the main entrance, but where Resident #89 walked during that time was unknown. He stated Resident #89 was wearing light colored sweatpants, a red sweatshirt and shoes. Nurse #1 stated he walked Resident #89 back into the facility through the door at the main entrance and Resident #89's wander alarm bracelet triggered the alarm on the door; he entered a code in the keypad to turn off the alarm and then escorted Resident #89 back to his room. Nurse #1 indicated he assessed Resident #89 and he was not injured and his vital signs were within normal limits. Nurse #1 stated if the push bar on the emergency exit door was held for 15 seconds the door unlocked and opened without alarming and he thought that was how Resident #89 was able to open the door. Nurse #1 indicated he thought the emergency exit door locked automatically and the alarm re-engaged after the door was closed for an extended period of time, so he did not check the door after the incident or before the end of his shift to ensure it was locked. Nurse #1 further stated he was unaware the alarm was turned on and off with a key and could not say what staff had a key to the alarm. Nurse #1 revealed he documented in a nurse's note that Resident #89 exited the facility and reported it to Nursing Supervisor #1 and the oncoming nurse (Nurse #2) at shift change, but no additional monitoring or interventions were implemented at that time. A phone interview was conducted with NA #1 on 4/08/26 at 1:42 PM. NA #1 revealed she worked third shift (11:00 PM to 7:00 AM) on 6/27/25 and was assigned to Resident #89. NA #1 revealed Resident #89 wandered the hall all night every night, went in and out of other resident's rooms and had to be redirected back to his room several times. She indicated when she redirected Resident #89 back to his room, she encouraged Resident #89 to lay down in bed and rest, but he typically would only lay down for a few minutes. NA #1 revealed Resident #89 was exit seeking at times (not every night) and would push on the emergency exit door attempting to leave the facility. NA #1 indicated when her shift began on 6/27/25 at 11:00 PM Resident #89 was wandering as he normally did, but she had not seen him pushing on the emergency exit door or exhibit exit seeking behavior. She stated she did not recall the exact time but in the early morning on 6/28/25 she heard a door slam near the emergency exit door on the west hall. She indicated the resident that resided in the room next to the emergency door was known to slam her room door closed and since the alarm on the emergency door did not go off, she assumed that was what she heard. NA #1 revealed a few minutes later, Nurse #1 approached her looking for Resident #89 and she reported hearing a door slam near the emergency exit. NA #1 indicated when Nurse #1 pushed on the emergency exit door it was unlocked, opened and did not alarm. NA #1 stated Nurse #1 proceeded to look for Resident #89 outside while she began looking for him in the facility. NA #1 indicated Nurse #1 found Resident #89 standing at the front of the building uninjured and walked him back to his room. NA #1 indicated she thought a staff member on a previous shift had left the emergency door unlocked and turned off the alarm but was unable to provide any further details as to who the staff member was or why they would have used that door to exit the building. NA #1 revealed she had never used the emergency door to exit the building and did not know how to unlock the door or turn off the alarm. NA #1 stated she did not recall any additional monitoring being initiated for Resident #89 after the incident on 6/28/25. A phone interview was conducted with Nurse #2 on 4/08/26 at 4:37 PM. Nurse #2 stated she was assigned to Resident #89 on 6/28/25 from 7:00 AM to 7:00 PM. She stated Nurse #1 reported to her at shift change on 6/28/25 that Resident #89 had exited the facility earlier that morning through the emergency exit door on the west hall, which was unlocked (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	however sometimes it took a while to get things done. He stated when the incident occurred with Resident #89 on 6/28/25 and 6/29/25 the concrete drain box was uncovered and a safety hazard. The Maintenance Director indicated on 4/10/26 he installed a safety cover over the drain box.A review of the weather records for [NAME], North Carolina found on the Weather Underground website revealed on 6/28/25 at 2:00 AM the temperature was 77 degrees Fahrenheit with no precipitation and south-southwest winds at a speed of 6 miles per hour (mph) and on 6/29/25 at 2:00 AM the temperature was 74 degrees Fahrenheit with no precipitation and southwest winds at a speed of 3 mph.During an interview with the Director of Nursing (DON) on 4/08/26 at 3:24 PM she revealed she was notified by the Former Administrator on 6/29/25 at approximately 7:00 AM that Resident #89 exited the building at approximately 2:00 AM and was immediately redirected back into the facility. She indicated the emergency exit door on the west hall was unlocked and did not alarm and there was a concern the door malfunctioned. She stated one to one supervision for Resident #89 was initiated immediately following the incident. She stated the emergency exit door was also inspected by the Maintenance Director and was working properly and they were unsure why the door was unlocked and did not alarm. The DON indicated she was not aware prior to today that Resident #89 exited the facility unsupervised on 6/28/25. She stated she reviewed Resident #89's record and per a nurse's note written by Nurse #2, 30-minute checks were initiated on 6/28/25 and documented on paper. The DON indicated she was unable to locate the 30-minute checks documented on paper however they were documented on the TAR beginning 6/29/25 and continued in addition to the one-to-one supervision which was added to the staffing schedule. She stated due to Resident #89's cognitive impairment and risk for falls it was very unsafe for him to exit the facility unsupervised due to the potential of getting lost or falling which could result in injury. The DON revealed she should have been notified of the incident on 6/28/25 and one to one supervision for Resident #89 should have been initiated immediately. A phone interview was conducted with the Former Administrator on 4/08/26 at 2:41 PM. Nursing Supervisor #1 called her on 6/29/25 at approximately 2:30 AM and notified her that Resident #89 exited the facility through an emergency exit door that was unlocked and did not alarm. She revealed she instructed Nursing Supervisor #1 to initiate 1 on 1 supervision for Resident #89 immediately and to have a staff member assigned to monitor the emergency exit door on the west hall until it was inspected by the Maintenance Director. The Former Administrator indicated that the Maintenance Director inspected the door and it was in good working order and they were unsure why the door was unlocked and did not alarm. The Former Administrator stated the wander alarm bracelets only activated the locks and alarms on the main entrance door and the employee entrance door. The Former Administrator revealed she was not aware of the incident involving Resident #89 on 6/28/25 prior to this interview. The Former Administrator stated she should have been notified of the incident on 6/28/25 and one to one supervision should have been implemented immediately for Resident #89. She stated that a cognitively impaired resident that was at risk for falls exiting the facility unsupervised was unsafe and could result in the resident being seriously injured. The Administrator was notified of immediate jeopardy on 4/09/26 at 12:15 PM. The facility provided the following credible allegation for immediate jeopardy removal:Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #89 had an order for a wander bracelet dated 3/3/25 which was applied to his right wrist. According to Nurse #1's progress note dated 6/28/25 at 7:06am, Resident #89 was noted walking around the facility and exited through the emergency exit door on the west hallway near room W4. Resident #89's wander alarm bracelet was in place. Nurse #1 pursued Resident #89 and they re-entered the facility through the main entrance and walked back to Resident #89's room. There was no acute distress or injury to Resident #89 noted in the progress note. Resident #89 has a diagnosis of insomnia and has scheduled melatonin 3 milligrams (mg) and trazodone 50 mg at bedtime. Resident #89's medications were documented as given but he was still awake and wandering throughout the facility at night. An order was initiated on 6/29/25 for 30-minute checks of Resident #1's whereabouts. The Licensed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurses indicated on the Medication Administration Record that staff were completing 30-minute checks during the shift they worked. On 6/29/25 at 4:21am, Re[TRUNCATED]

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to label and date leftover food items stored for use, keep a food preparation area clean and orderly and store a scoop without the potential for cross-contamination. These practices occurred in 1 of 2 walk-in coolers, 1 of 1 food preparation areas, and 3 of 3 Nourishment rooms (Nourishment room [ROOM NUMBER], Nourishment room [ROOM NUMBER], Nourishment room [ROOM NUMBER]). These practices had the potential to affect food served to residents. The findings included:a. An initial tour of the main kitchen occurred on 4/6/26 at 10:05 AM with the Dietary Manager. The following concerns were identified:- Visible dirt and grime build up present on the three water spigots above the cooking range.- A plastic scoop was left in the rice bin with the handle and bottom touching the rice in the food preparation area. - A cardboard flat of 9 croissants was cut open with no open or use by date was found in walk-in cooler #2. Seven croissants had been used from the container and not resealed. An interview with the Dietary Manager on 4/6/26 at 10:10 AM the vent hood had been cleaned by an outside vendor a few months prior. She stated she would have water spigots included in the next cleaning. The Dietary Manager also stated the open croissants were missed by kitchen staff and the rice scoop should be stored in the appropriate holder on the bin.b. Items found in the refrigerator in Nourishment room [ROOM NUMBER] on 4/6/26 at 10:18 AM that were open and not labeled with an open or use by date included: - One half-eaten creme pie with three used plastic forks in the pan,- One small reusable container of ranch dressing.c. Items found in the refrigerator in Nourishment room [ROOM NUMBER] on 4/6/26 at 10:20 AM that were open with an open date, but no use by date included: -One vanilla pudding cup dated 4/6,-One wrapped fast-food sandwich dated 3/9. d. One fast food milkshake was found in the refrigerator in Nourishment room [ROOM NUMBER] on 4/6/26 at 10:22 AM with no open or use by date. A second interview with the Dietary Manager occurred on 4/6/26 at 10:20 AM and revealed all food in the nourishment rooms needed to be labeled with an open date and a use by date which should be seven days after the open date. The Dietary Manager stated the pudding cup should have been thrown away by nursing staff after it was opened. A third interview with the Dietary Manager on 4/9/26 at 3:02 PM revealed she had a few new staff members who were not labelling the opened items correctly in the coolers by forgetting to add the appropriate dates. The Dietary Manager stated the nourishment rooms were inspected by kitchen staff each morning and had not yet been completed on the morning of 4/6/26. She stated nursing staff often left items in the nourishment room refrigerators and did not label them appropriately.An interview with the Administrator on 4/9/26 at 4:40 PM revealed he had the expectation for the kitchen staff to properly store food served in the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to maintain a resident's dignity when Nurse Aide (NA) #6 quickly pulled Resident #67 backward down the hall approximately 30 feet from the day room to her room while reclined in a geriatric chair for 1 of 3 sampled residents reviewed for dignity (Resident #67). A reasonable person would have expected to be treated with dignity and would have wanted to be wheeled forward in their geriatric chair.Findings included:Resident #67 was readmitted to the facility on [DATE]. A review of the quarterly MDS dated [DATE] revealed Resident #67 was assessed as having clear speech and severe cognitive impairment. The assessment indicated Resident #67 required the use of a wheelchair for mobility. During a continuous observation on 4/6/26 at 2:45 PM in the South Hall, NA#6 was observed quickly pulling Resident #67 backward down the hall approximately 30 feet from the day room to her room while she was reclined in a geriatric chair.During an interview on 4/9/26 at 2:39 PM, NA #6 indicated the Resident #67 used a reclining geriatric chair. He stated when he took Resident #67 from the day room to her room, he felt it was better to pull her backward down the hall because it was harder to push her chair moving forward even when she was reclined. NA #6 stated he was not aware of any problems with the reclining geriatric chair.An interview and observation with Social Worker #1 were completed on 4/9/26 at 3:36 PM. While Resident #67 was resting in bed, SW #1 pushed Resident #67's reclining geriatric chair forwards and backwards in the South Hallway. There were no noted concerns with the chair not functioning properly. SW #1 stated Resident #67's reclining geriatric chair was working fine and needed no repairs.A telephone interview with the Staff Development Director on 4/13/26 at 12:06 PM revealed all staff were educated during orientation and received ongoing education on residents' rights and dignity. He also stated staff were frequently educated on resident wheelchair use, including caution with speed and when or if footrests should be used. The Staff Development Director stated Resident #67 should not have been pulled backwards in her geriatric chair and he would make a note to include the term geriatric chair along with wheelchairs for future staff education.An interview with the Director of Nursing on 4/9/26 at 3:58 PM revealed she expected staff to push residents in their wheelchairs forward and not at a fast pace. An interview with the Administrator on 4/9/26 at 4:34 PM revealed he expected staff to push residents in wheelchairs and geriatric chairs forward in a dignified manner and at a normal pace.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, resident and staff interviews, the facility failed to provide hair washing services for 1 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #144). The findings included:Resident #144 was admitted to the facility on [DATE] with diagnoses which included senile degeneration of the brain, chronic obstructive pulmonary disease, and heart failure.Resident #144's care plan, last revised 3/23/26, had a focus area for ADL deficits due to generalized weakness Interventions included set up for hair and oral hygiene daily and assist with bathing and dressing, encouraging Resident #144 to do as much as possible. Resident #144's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired and extensive assistance from staff for ADL. The MDS further revealed Resident #144 had no behaviors, and there was no rejection of care noted. A review of the facility shower schedule revealed Resident #144 was to be showered on Tuesday and Friday mornings on first shift.An observation of Resident #144 on 4/6/26 at 11:30 AM revealed Resident #144 lying in her bed watching television. Her hair was long, stringy and visibly greasy.A second observation of Resident #144 on 4/7/26 (Tuesday) at 10:00 AM revealed Resident #144 sleeping in her bed and her hair was visibly greasy and dirty and stuck flat against her head.A third observation of Resident #144 on 4/9/26 at 10:40 AM revealed Resident #144 watching television in her bed. Her hair was stringy, visibly dirty and stuck against her head.A review of Resident #144's Electronic Medical Record (EMR) indicated she received a shower on the morning of 4/7/26 by Nurse Aide (NA) #5.An interview with NA #5 on 4/9/26 at 2:33 PM revealed she was assigned to Resident #144 on 4/7/26 and gave her a bed bath. NA #5 stated she did not give Resident #144 a full shower but always gave her a bed bath on her shower days. She stated she would typically wet down Resident #144's hair during the bed bath but stated her hair was becoming all tangled up, especially in the back. NA #5 also stated a bathing team from Hospice services came a couple of times a week for additional bath visits but was unsure what they did when they visited Resident #144. NA #5 stated Resident #144 used to go to the beauty shop to have her hair washed and trimmed, but she believed it had been over two months since Resident #144 had gone, and she was not sure why her hair was not being done in the beauty shop. A telephone interview with the Hospice Nurse occurred on 4/9/26 at 4:09 PM. She stated the Hospice team visited Resident #144 a couple of times a week for bath visits and they would provide bed baths and use a no-rinse shampoo product for her hair. She was not sure when Resident #144's last bath visit was during the week of 4/6/26. The Hospice Nurse stated Resident #144 was able to get up out of bed, but she found Resident #144 to be in her bed on most of her visits. The Hospice Nurse stated she was not sure what type of showers or baths the facility provided Resident #144 regularly. A telephone interview with the Beauty Shop Operator occurred on 4/13/26 at 12:16 PM. She indicated she had seen Resident #144 before in her shop, but she had not seen her recently. The Beauty Shop Operator stated she was in another facility and did not have her full schedule with her to verify Resident #144's appointments but stated the Unit Secretary at the facility kept track of a monthly beauty shop list for the residents who received Medicaid. She stated if a resident missed an appointment for whatever reason, they were added to the next month's schedule. The Beauty Shop Operator stated she would add Resident #144 to her list to be seen the following week.A telephone interview with the Unit Secretary on 4/13/26 at 12:22 PM revealed it had been a while since Resident #144 was in the beauty shop. She indicated she kept a book with a beauty shop list for the Beauty Shop Operator for the last two months but had just cleaned out some of the previous lists. The Unit Secretary stated she believed it had been longer than two months since Resident #144 had visited the beauty shop and her name had been left off the list by mistake.An interview with the Director of Nursing (DON) on 4/9/25 at 4:02 PM revealed Resident #144 received additional bath visits from the Hospice team two to three times a week. She indicated that any NA assigned to Resident #144 was expected to bathe her twice a week and she knew they (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performed a thorough wash down of each resident. The DON stated she did not know when Resident #144's hair had been washed last and indicated the NAs assigned to her would know. An interview with the Administrator on 4/9/25 at 4:35 PM was conducted. He expected when Resident #144 was scheduled for a shower, her hair would be properly washed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and staff interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions (EBP) when Nurse #5 did not wear a gown while providing catheter care for Resident #132 and Nurse Aide (NA) #3 and NA #4 failed to wear a gown while conducting a mechanical lift transfer of Resident #161 who had a feeding tube. The deficient practice occurred for 3 of 10 staff members observed for infection control practices (Nurse #5, NA #3, and NA #4).The findings included: A review of the facility's policy titled Enhanced Barrier Precautions, revised on 7/26/2022, indicated: Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities. High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, Peripherally Inserted Central Catheter (PICC) lines, midline catheters, and wound care if deemed chronic by a medical provider or if MDRO was present. An observation of catheter care for Resident #132 provided by Nurse #5 was made on 4/08/2026 at 1:47 PM. Resident #132's room had an enhanced barrier precautions sign posted outside the door with personal protective equipment (PPE) stored in a plastic bin on the door including gowns. The signage on the door instructed staff to apply a gown and glove during high contact resident care activities. Nurse #5 entered the room without wearing a gown. She washed her hands and put gloves on. She then removed the residents brief and proceeded to provide catheter care for Resident #132. Nurse #5 then discarded any unused supplies and her gloves and proceeded to wash her hands with soap and water at the sink. An interview with Nurse #5 on 4/08/2026 at 1:55 PM revealed she was aware that Resident #132 was on enhanced barrier precautions. Nurse #5 stated that she only needed to wear a gown if she were changing the catheter, not while providing catheter care. She explained she had received the infection control training on EBP but must have just misunderstood the instructions. An interview with the Infection Preventionist was completed on 4/09/26 at 9:43AM. The Infection Preventionist stated he completed rounds daily to ensure that all residents had the appropriate infection precaution signs posted and staff had available PPE. The Infection Preventionist reported that all staff were trained during orientation on proper use of PPE and proper PPE use was reviewed in monthly staff meetings on all shifts by the Infection Preventionist and shift supervisors. The facility most recently had an Infection Control in-service covering EBP two weeks prior. The Infection Preventionist stated that the staff should wear the appropriate PPE according to the infection precaution signs posted for each resident and that included wearing PPE (gown and gloves) while providing catheter care for residents on EBP. An interview with the Director of Nursing (DON) was completed on 4/08/2026 at 2:55 PM. The DON stated she expected all staff members to use the appropriate PPE according to the infection precaution sign posted for each resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An observation was conducted with Resident #161 on 4/6/2026 at 12:36 PM. Resident #161's room had an Enhanced Barrier Precautions (EBP) sign posted on the door with a hanging plastic holder containing Personal Protective Equipment (PPE) on the door. A partially filled container of tube feeding formula was hanging by the bedside. Resident #161 was returning from an outside appointment and was seated in his wheelchair. Nurse Aide #3 (NA) and NA #4 were observed entering the room with the mechanical lift to assist Resident #161 into bed. NA #3 and NA #4 were not wearing gowns. Both were wearing gloves. NA #3 and NA #4 completed the mechanical lift transfer. An interview with NA #3 was conducted on 4/6/2026 at 12:56 PM as he exited Resident #161's room. NA #3 was shown the Enhanced Barrier Precautions sign and asked what it meant. NA #3 stated he was aware Resident #161 was on Enhanced Barrier Precautions due to having a gastrostomy tube for tube feeding. NA #3 stated a gown was only required when performing some type of care not when transferring a resident. When shown the portion of the sign that indicated both a gown and gloves were required for transferring a resident, NA #3 stated again that transferring was not performing care and he did not consider a transfer to be a high-contact resident care activity. An interview with NA #4 was conducted on 4/6/2026 at 1:05 PM. NA #4 indicated she usually worked on the [NAME] unit and was unsure what was required on the East unit. NA #4 stated that 4/6/2026 was the first time she had worked with Resident #161. When asked how NA #4 knew who was on EBP on the [NAME] unit, NA #4 stated she followed the EBP signage. When asked if the EBP sign on Resident #161's door was different than the signs used on the [NAME] unit, NA #4 stated, No. NA #4 stated she sometimes used a gown when transferring residents on EBP but not all of the time. An interview was conducted on 4/9/2026 at 11:00 AM with the Infection Preventionist. The Infection Preventionist stated that NA #3 and NA #4 should have worn a gown when entering the room to provide a mechanical lift transfer for Resident #161 as that was considered a high-contact resident care activity. The Infection Preventionist indicated that the EBP sign was posted on the door along with the hanging plastic holder containing PPE as he rounded daily to make sure the signage was accurate and PPE was available. The Infection Preventionist further stated that he had completed an all staff Infection Control in-service approximately 2 weeks ago which included training on EBP and PPE use. NA #3 and NA #4 had received this recent training as well as EBP training during orientation when hired, monthly EBP/PPE use reviews during staff meetings and yearly through online training modules. An interview was conducted on 4/9/2026 at 4:10 PM with the Director of Nursing (DON). The DON stated all staff members should utilize the appropriate PPE according to the infection control signage posted for each resident. The DON stated NA #3 and NA #4 should have worn a gown when conducting the mechanical lift transfer for Resident #161. An interview was conducted on 4/9/2026 at 4:28 PM with the Administrator. The Administrator stated he expected staff to wear the required PPE when providing care to residents on EBP. The Administrator stated NA #3 and NA #4 should have worn gowns when transferring Resident #161.