STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilora Lake Healthcare	6001 Wilora Lake Road Charlotte, NC 28212

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interviews, the facility failed to protect a resident from misappropriation of personal funds when the former Business Office Manager used a resident's debit card to pay the former Business Office Manager's personal bills. This deficient practice affected 1 of 3 residents reviewed for prevent misappropriation of resident property (Resident #14). The findings included:Resident #14 was admitted to the facility on [DATE]. Resident #14 was her own Responsible Party.A quarterly Minimum Data Set assessment dated [DATE] indicated that Resident #14 was cognitively intact.A review of the Initial Allegation Report dated 3/6/2026 indicated the facility became aware of the misappropriation of Resident #14's funds by the former Business Office Manager on 3/6/2026 when the Travel Business Office Manager assumed the former Business Office Manager's duties of assisting Resident #14 with an ongoing Medicaid application. The former Business Office Manager had resigned her position as of 2/20/2026. The Travel Business Office Manager noted charges listed on Resident #14's bank statements that were for personal expenses for the former Business Office Manager. The misappropriation occurred between 9/30/2025 and 12/22/2025 and the total amount stolen was $4,945.62. Resident's 14's debit card was immediately cancelled and a new one was ordered on 3/6/2026. The Travel Business Office Manager notified the former facility Administrator of the misappropriation. The Administrator notified and interviewed Resident #14 who confirmed the charges were not authorized. The former Administrator filed reports with local law enforcement, Adult Protective Services (APS) and the State Agency. Resident #14's family was notified and an investigation was initiated immediately. The Initial Report was signed by the former Administrator.A review of the 5-Day Investigation Report revealed the facility had contacted local law enforcement and was waiting for a detective to be assigned to the case. APS had been notified but screened out the report and forwarded the information to the State Agency. The facility attempted numerous times to reach the former Business Office Manager for a statement but the former Business Office Manager did not respond to any of the attempted contacts. The Administrator and Regional Business Office Manager contacted the current residents, the resident representatives and the discharged residents from 3/1/2025 to 3/1/2026 to inquire if any unauthorized charges had been noted in their accounts. No concerns were noted. The former Business Office Manager was employed at the facility from 3/13/2025 to 2/20/2026. The facility held a Resident Council Meeting on 3/9/2026 to discuss misappropriation and that staff should not be using resident funds or receiving gifts. All staff members including contracted staff received education regarding abuse, neglect, and misappropriation on 3/9/2026. The facility requested a check from their corporate office in the amount of $4,945.62 to reimburse Resident #14. The 5-Day Investigation Report was signed by the former Administrator. A review of Resident #14's bank statements revealed that the former Business Office Manager had used Resident #14's debit card on 9/30/2025 for a credit card payment in the amount of $386.87; on 10/3/2025 for a credit card payment in the amount of $184.00; on 10/31/2025 for a natural gas payment in the amount of $567.88; on 11/5/2025 for a credit card payment in the amount of $544.04; on 11/25/2025 for a credit card payment in the amount of $334.71; on 11/25/2025 for a credit payment in the amount of $504.33; on 12/9/2025 for a credit card (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	payment in the amount of $309.16; on 12/9/2025 for a credit card payment in the amount of $521.48; on 12/16/2025 for a credit card payment in the amount of $316.53; on 12/16/2025 for a credit card payment in the amount of $349.04; on 12/18/2025 for a credit card payment in the amount of $386.91; on 12/18/2025 for a credit card payment in the amount of $490.33 and on 12/22/2025 for an internet service fee in the amount of $50.34.A review of a report filed by local law enforcement on 3/6/2026 at 6:59 PM indicated that local law enforcement had been advised of credit card fraud as the suspected individual had used the victim's credit card to make unauthorized charges at multiple online locations.An interview was conducted with Resident #14 on 4/19/2026 at 3:13 PM. Resident #14 reported the former Business Office Manager used her debit card for the former Business Office Manager's own personal bills. Resident #14 stated she did not give the former Business Office Manager permission to use her card. Resident #14 went on to say she was disappointed in the former Business Office Manager as she had trusted her but that these things happened. Resident #14 stated she would not have known any money was missing from her account if the Travel Business Office Manager had not been reviewing past bank statements for the Medicaid application. Resident #14 handled her own financial affairs. Resident #14 indicated she initially was not going to press charges but decided that theft was theft and that was wrong. Resident #14 spoke with local law enforcement but had not heard anything further. Resident #14 thought the matter was in the hands of the police now. Resident #14 stated that the money taken had been reimbursed to her and had been put in her facility trust account per her preference. Resident #14 was satisfied with the resolution.An interview with the Director of Nursing (DON) was held on 4/22/2026 at 8:35 AM. The DON stated that once the misappropriation was identified that the former Business Office Manager had used the Resident 14's funds for her own personal use, the State Agency, APS and local law enforcement were notified. Resident #14 was notified by the former Administrator that the misappropriation had occurred and an investigation began immediately. The DON stated the former Business Office Manager had already left the position when the misappropriation was discovered. The facility had attempted to contact the former Business Office Manager but had been unsuccessful. The DON reported that no other issues with misappropriation of resident funds were identified during the investigation. The DON stated Resident #14 had been reimbursed for the amount of money misappropriated. A telephone interview with the former Business Office Manager was attempted on 4/22/2026 at 10:36 AM. The former Business Office Manager endorsed that she had worked at the facility a very short time but she would have to call back as was in a meeting and could not talk at that time. The former Business Office Manager disconnected the call and did not respond to future attempts to contact her by text message on 4/22/2026 at 1:51 PM and voice mail on 4/23/2026 at 8:35 AM.A telephone interview with the former Administrator was conducted on 4/22/2026 at 10:45 AM. The former Administrator indicated she had been advised on 3/6/2026 by the Travel Business Office Manager that unauthorized charges had been made on Resident #14's debit card by the former Business Office Manager for personal expenses. The Travel Business Office Manager had taken over assisting Resident #14 with her Medicaid application as the former Business Office Manager had resigned. When Resident #14's bank statements were reviewed by the Travel Business Office Manager, the misappropriation of funds was discovered. The former Administrator stated she contacted the State Agency, APS, and local law enforcement. An investigation began immediately. The former Administrator stated she was never able to contact the former Business Office Manager to obtain a statement. Resident accounts were reviewed and no other residents (both current and residents present (but now discharged) during the time the former Business Office Manager worked in the facility) were identified as having funds misused. The former Administrator stated she had no idea why Resident #14 was targeted. The former Administrator stated there had been no employment issues with the former Business Office Manager and she had worked a notice and resigned under good standing. The former Administrator stated she never had any idea that the former Business Office Manager would have misappropriated any resident's funds and thought she was a good employee.An interview was conducted with the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Travel Business Office Manager on 4/22/2026 at 11:10 AM. The Travel Business Office Manager stated that she identified the misuse of Resident #14's funds while reviewing Resident #14's bank statements. The Travel Business Office Manager indicated she had taken over the former Business Office Manager's duties after she had left the position. The Travel Business Office Manager reported she was assisting Resident #14 with her ongoing Medicaid application. The Medicaid office had asked for the past 3 years of bank statements to confirm the pension amounts Resident #14 received on a monthly basis. Resident #14's bank records from 5/2023 to 12/2025 were received and when the Travel Business Office Manager began to review these on 3/6/2026, she stated she noted transactions made in the name of the former Business Office Manager beginning 9/30/2025 and ending 12/22/2025. The Travel Business Office Manager immediately reported the misappropriation to the former Administrator, the Business Office Supervisor at corporate and an investigation began immediately. The Travel Business Office Manager stated she had no idea why Resident #14 had been targeted. Reviews of all resident accounts during the time the former Business Office Manager worked in the facility were conducted and no other unauthorized transactions were identified. The Travel Business Office Manager stated it was a rare occasion when there was a resident filing a Medicaid application and needed the facility's assistance with the application process. The Travel Business Office Manager stated usually a resident's Responsible Party, Financial Power of Attorney or Guardian handled the application process. Resident #14 handled her own finances and did not have involved family to assist her with the Medicaid application process. An interview with the Regional President of Operations was conducted on 4/22/2026 at 12:10 PM. The Regional President of Operations reported she was involved in the investigation and had contacted Resident 14's bank fraud unit. The Regional President of Operations was told the charges were over 90 days old so the bank fraud unit could not assist Resident #14 and this was a matter for local law enforcement. The Regional President of Operations stated the facility audited all resident accounts that were active when the former Business Office Manager was employed at the facility and no other issues were noted with those accounts. The Regional President of Operations did not know why Resident #14 was targeted for misappropriation by the former Business Office Manager.An interview with the Administrator was conducted on 4/22/2026 at 11:45 AM. The Administrator indicated the misappropriation had just been identified as she was taking over the position of facility Administrator. Reports to the State Agency, APS, and local law enforcement had been made. Resident #14 had received a letter from local law enforcement dated 3/31/2026 that the case had been assigned but law enforcement had not yet contacted the facility or Resident #14. The Administrator stated a reimbursement check for the total amount of the misappropriated funds had been deposited into Resident #14's facility trust account on 4/13/2026.On 4/23/2026 at 10:44 AM the assigned local law enforcement officer investigating the misappropriation responded via email. The Officer stated he was following up with the reporting person and the investigation was ongoing. The Officer stated he had advised his contact at the Medicaid Department of the Department of Justice regarding the status of the case.The facility provided a corrective action plan that was not accepted by the State Agency as it did not contain evidence that addressed prevention of misappropriation of resident funds.

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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 observation, record review, and staff interviews, the facility failed to provide toileting hygiene after a bowel movement and prior to placing a new and clean pull up on a resident dependent on staff for assistance with activities of daily living (ADL) for 1 of 4 residents (Resident #24).The findings included:Resident #24 was admitted to the facility on [DATE] with diagnoses which included type II diabetes mellitus, neurogenic bladder with suprapubic urinary catheter, muscles weakness and lymphedema.Resident #24's care plan dated 02/26/26 revealed a focus area for impaired physical mobility with goal for resident to be able to perform activity within physical limits. The interventions included:Consult physical therapy per order.Determine level of assistance needed based on activities of daily living (ADL) evaluation.Encourage resident to increase activity as indicated.Evaluate resident's ability to perform ADL.Monitor for environment barriers to mobility.Observe resident's posture and gait.Observe range of motion in all joints.Resident #24's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and required substantial to maximal assistance of one staff member with toileting hygiene, bed mobility and sitting to standing with her walker. The assessment also revealed the resident was occasionally incontinent of her bladder and frequently incontinent of her bowels.An observation on 04/20/26 at 2:29 PM of suprapubic catheter care revealed Nurse Aide (NA) #1 providing care and the Assistant Director of Nursing (ADON) observing care as well.NA #1 began by removing Resident #24's pull up which had visible brown substance on the pull up and an odor of stool. The NA removed the pull up from the resident and without cleaning the resident from the bowel movement began care of her suprapubic catheter. After completing the care of the catheter and without cleaning the resident he placed a new pull up on the resident and placed her covers over her in the bed. NA #1 gathered his supplies and trash and left the resident's room.An interview on 04/20/26 at 2:40 PM with Resident #24 revealed she was not aware earlier that day that she had a bowel movement because she could not always tell but said if she had a bowel movement she would have wanted to be cleaned prior to having another pull up placed on her. Resident #24 stated she was a large resident and knew that it was sometimes difficult to clean her up but said she preferred to be clean and not have the smell of stool.An interview on 04/20/26 at 2:46 PM with NA #1 revealed he was aware Resident #24's pull up had a brown liquid substance on it earlier that day and said he didn't know why he had not cleaned her but said he was nervous about being observed providing suprapubic catheter care and had just forgotten to clean her. NA #1 stated he had seen the brown liquid substance on Resident #24's pull up and had smelled it when he removed it and said he should have cleaned her up prior to proceeding with her suprapubic catheter care. NA #2 further stated he would go back and clean her and place a clean pull up on her.An interview on 04/20/26 at 2:51 PM with ADON, who is also the Staff Development Coordinator and Infection Preventionist, revealed she had not seen the pull up was soiled with a brown liquid substance but stated she had smelled it and did not know why NA #1 had not cleaned the resident before putting on a clean pull up. She stated she should have stopped him and made him clean her but was not positioned where she could see what was on the pull up. The ADON stated she would have expected NA #1 to have cleaned the resident when he saw the brown liquid substance on her pull up.A telephone interview on 04/23/24 at 11:19 AM with the Director of Nursing (DON) revealed she expected the staff to clean all residents after a bowel movement before placing clean pull ups or briefs on them.

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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 Hand Hygiene when Nurse Aide (NA) #1 failed to sanitize his hands in between changing his gloves while providing suprapubic urinary catheter care to Resident #24. The facility also failed to follow their Enhanced Barrier Precautions (EPB) policy and procedure when NA #1 failed to wear a gown while providing incontinence care and while transferring Resident #24 and then NA #1 and NA #2 adjusted the same resident up in the bed after placing a turn sheet under her without wearing a gown. The deficient practice occurred for 2 of 8 staff observed for infection control practices (NA #1 and NA #2).The findings included:1. a. Review of the facility's Hand Hygiene policy and procedure which is part of the Infection Control policies and procedures last revised on 11/13/25 revealed the following:Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.Policy Explanation and Compliance Guidelines:1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.3. Alcohol-based hand rub (ABHR) with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Hand Hygiene Table:Alcohol based hand rub is preferred:After handling contaminated objects.Before applying and after removing personal protective equipment (PPE), including gloves.When during resident care, moving from a contaminated body site to a clean body site.When in doubt.An observation of suprapubic urinary catheter care on 04/20/26 at 2:29 PM with NA #1 on Resident #24 who was on Enhanced Barrier Precautions (EBP) with a sign on her door and a caddie of personal protective equipment attached to her door was completed. The observation revealed NA #1 washing his hands with soap and water and donning a gown, face shield and gloves. NA #1 proceeded to prepare 2 basins of water one with soap and water and one with just water. He placed the basins on the overbed table on top of a towel. NA #1 began by removing Resident #24's soiled brief and tossed it in the trash. NA #1 then removed his gloves and without sanitizing his hands, donned a clean pair of gloves and began cleaning the suprapubic catheter with soaped washcloths. After cleaning the catheter, he removed his gloves and without sanitizing his hands donned a clean pair of gloves and rinsed the catheter with a wet washcloth and then proceeded to apply a new pull up on the resident. After applying the pull up, he emptied the basins and doffed his face shield, gown, and gloves, washed his hands with soap and water and removed the dirty linen and trash from the resident's room and left the room.An interview on 04/20/26 at 2:46 PM with NA #1 revealed he realized after providing care that he had not followed appropriate hand hygiene when he didn't sanitize his hands after removing his gloves and before applying clean gloves. He stated he was nervous about being watched and said he just forgot to sanitize his hands and said he even kept hand sanitizer in his pocket.An interview on 04/20/26 at 2:51 PM with the Assistant Director of Nursing (ADON), who was the Infection Preventionist (IP) revealed NA #1 should have sanitized his hands each time he removed his gloves before putting on clean gloves. The IP stated she had done education with all the staff about hand hygiene and doffing and donning personal protective equipment (PPE).A telephone interview with the Director of Nursing (DON) on 04/23/26 at 11:19 AM revealed she would have expected NA #1 to have sanitized his hands each time he removed his gloves and before putting on clean gloves.b. Review of the Enhanced Barrier Precautions policy and procedure which is part of the Infection Control policies and procedures last revised on 11/13/25 revealed the following:Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Policy Explanation and Compliance Guidelines:Implementation of Enhanced Barrier Precautions (EBP): a. Make gowns and gloves available immediately near or outside of the resident'sroom. Note: face protection may also be needed if performing activity with risk of splash or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spray.b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. c. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room).High-contact resident care activities include: c. Transferring f. Changing briefs or assisting with toileting.An observation of incontinence care on 04/20/26 at 2:58 PM revealed a sign on the door indicating Resident #24 was on EBP with a caddie on her door containing PPE. The observation revealed NA #1 walking into Resident #24's room and donning gloves, obtaining a clean pull up and wipes and without donning a gown proceeding to remove the resident's pull up. NA #1 removed the pull up and began cleaning the resident in the front and then cleaned her behind. NA #1 was having difficulty getting the resident clean in bed and assisted her to stand with her walker so he could finish cleaning her behind and ensure her pull up was pulled up in the back. NA #1 then assisted the resident back on her bed, removed his gloves, sanitized his hands and left the room to get another staff member to assist in getting her pulled up and adjusted in the bed. NA #2 and NA #1 returned to Resident #24's room and donned clean gloves and without putting on a gown proceeded to assist the resident in moving side to side in the bed to place her turn sheet under her. After adjusting the turn sheet, NA #1 and NA #2 pulled the resident up in bed with the turn sheet and placed her covers over her. NA #1 and NA #2 removed their gloves; NA #1 removed the trash from the room and they both sanitized their hands after leaving the room.An interview with NA #1 and NA #2 on 04/20/26 at 3:04 PM revealed they were not aware they were supposed to wear a gown when providing incontinence care, transferring a resident, and adjusting a resident up in the bed. NA #1 and NA #2 stated they saw the sign and the caddie when going into the room but did not realize they had to wear PPE when adjusting a resident up in the bed. The EBP sign on the resident's door was reviewed with NA #1 and NA #2 and they both agreed they should have worn a gown while providing care to Resident #24.An interview on 04/20/26 at 3:15 PM with the IP revealed she would have expected NA #1 and NA #2 to have worn a gown while providing incontinence care, transferring the resident and adjusting the resident up in the bed. A telephone interview with the Director of Nursing (DON) on 04/23/26 at 11:19 AM revealed Resident #24 was on EBP due to her suprapubic urinary catheter and she would have expected NA #1 and NA #2 to have worn a gown during high-contact resident care activities.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Regional Ombudsman and staff, the facility failed to provide a written discharge notice to the resident and send a copy of the notice to the Regional Ombudsman for a resident discharged home for 1 of 1 resident reviewed for discharge (Resident #83). The findings included: Resident #83 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. The resident's overall goal was for discharge to the community and active discharge planning was already occurring with referrals made to the local contact agency. A nursing note dated 3/31/26 at 7:21 PM stated Resident #83 was discharged home. She was alert and oriented and medication administration was explained and Resident #83 verbalized understanding by repeating the process.A review of Resident #83's electronic medical record (EMR) revealed no transfer or discharge notice was issued to Resident #83. A telephone interview with Resident #83 was attempted but was unsuccessful as the phone number had been disconnected. A telephone interview on 4/22/26 at 4:25 PM with the Regional Ombudsman revealed she had not received any notices of transfer or discharge, to include Resident #83's discharge, since December 2025 when the Former Social Worker left the facility. A telephone interview occurred with the Former Administrator on 4/22/26 at 4:12 PM. She stated she left the facility at the beginning of March 2026, did not recall Resident #83 and did not recall if a written transfer or discharge notice was given to Resident #83. She indicated the Former Social Worker (SW) would send transfer and discharge notices to the Regional Ombudsman. The Former Administrator stated when the Former SW left the facility in December 2025, the Former Medical Records Coordinator oversaw sending the notices to the Regional Ombudsman. The Former Administrator stated she did not personally send a transfer or discharge notice for Resident #83 to the Regional Ombudsman. An interview with the SW on 4/22/26 at 4:23 PM revealed she came to the facility at the beginning of April 2026 and was not familiar with Resident #83. She stated she had taken over the responsibility of sending the transfer and discharge notices to the Regional Ombudsman. A telephone interview with the Former Medical Records Coordinator occurred on 4/23/26 at 12:38 PM. She stated she was employed at the facility from November 2024 to the end of February 2026. The Former Medical Records Coordinator stated the Former Administrator had a background in social work and handled all the tasks of the SW's role after the Former SW left in December 2025. The Former Medical Records Coordinator stated she did not recall Resident #83 or if she had received a transfer or discharge notice from the facility. The Former Medical Records Coordinator indicated she did not have access to any transfer and discharge notices to send to the Regional Ombudsman. A telephone interview with the Administrator on 4/24/26 at 8:59 AM revealed she came to the facility in the middle of March 2026. She had the expectation that a designated staff member would have provided Resident #83's discharge notice and would have sent copies of all written transfer and discharge notices to the Regional Ombudsman.