

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/01/2025
NAME OF PROVIDER OR SUPPLIER  White Oak Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1926 Ridge Avenue Warren, OH 44484	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/01/2025
NAME OF PROVIDER OR SUPPLIER  White Oak Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1926 Ridge Avenue Warren, OH 44484	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, review of a facility self-reported incident (SRI) investigation, review of police reports, review of the Emergency Medical Services (EMS) run report, review of hospital documentation, review of facility policy, and interviews, the facility failed to provide adequate supervision to prevent Resident #16, who was cognitively impaired, aphasic and at risk for elopement (with use of a WanderGuard device) from eloping. This resulted in Immediate Jeopardy and the potential for Actual Harm, serious physical injury or death on [DATE] when 911 dispatch for the local police department received a 911 call from a passerby in the community with concerns for an unattended individual. The individual, identified to be Resident #16 was found by the police, coming out of the woods and falling into a ditch in a residential area that was 0.6 miles from the facility. The resident was noted to be confused and wearing a monitor device on his ankle which prompted the police to check with the facility to see if they had a missing resident, as the resident could give no details and had no identification on him. Resident #16 was subsequently transferred from the scene to a local hospital for treatment of hypotension (low blood pressure) and was stabilized after resuscitation with intravenous fluids. Resident #16 returned to the facility on [DATE] and his WanderGuard remained in place. On [DATE] during the onsite investigation it was identified the facility WanderGaurd system was not functioning properly because an unknown person was entering a master override code into the system that was disarming the WanderGaurd system which placed Resident #16 and other residents at risk of accidents/hazards pertaining to elopement. The facility identified five residents (#4, #13, #16, #22, and #26) as at risk for elopement. The facility census was 32. On [DATE] at 3:34 P.M. the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #349 were notified Immediate Jeopardy began on [DATE] when Resident #16, exited the facility without staff knowledge and was found 0.6 miles away from the facility in a ditch by the police department. The facility was not aware Resident #16 was missing from the building until the police arrived at the facility for identification of Resident #16. Resident #16 was subsequently transported to the emergency room by Emergency Medical Services (EMS) who arrived at the scene, received testing and treatment with intravenous (IV) fluid and then returned to the facility. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective action. On [DATE] at approximately 5:50 P.M. Regional Director of Clinical Services (RDCS) #349 completed an elopement assessment on Resident #16 and reviewed the resident's elopement risk care plan. On [DATE] Resident #16 returned to the facility from the hospital. Pain assessment, skin assessment, neurological checks through [DATE] were initiated and charted in the resident record. On [DATE] the ADON and SSD reviewed elopement assessments on 32/32 residents to ensure all current residents had elopement assessments in the last quarter. One new Resident (#13) identified at risk for elopement and wander guard placed and resident added to elopement binder. On [DATE] an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Administrator, Nurse Practitioner (NP) #351 and the DON to discuss the elopement incident, interventions initiated and plan of care. On [DATE] the Administrator and Maintenance Director completed an elopement drill on first shift. On [DATE] the Ohio Department of Health surveyor and Maintenance Director identified the wander guard system was not functioning as designed. At 4:15 P.M. the DON was notified and placed staff for door supervision. Secure Care company was notified at 5:00 P.M. by the Administrator. On [DATE] at approximately 10:00 A.M. Secure Care company arrived to inspect the wander guard system and determined a universal code, which was a separate code from the new code was being entered by unidentified staff that was overriding the system which caused the wander guard system to not alarm. On [DATE] the Administrator and RDCS #349 determined the root cause of the elopement was a universal over-ride code was being used by staff instead of the new door code that was changed on [DATE]. The universal override code, when entered into the keypad to open the secured doors, would disable the wander guard system. On [DATE] all facility door codes were changed including a change of the master override code by Administrator. The master override code would be privy to only the Administrator and Maintenance Director. On [DATE] facility staff completed a headcount to ensure all 32/32 residents were accounted for. On [DATE] 42/43 staff (2/2 Activities Staff, 14/15 Certified Nursing Assistants (CNAs), 8/8 Dietary Staff, 6/6 Housekeeping Staff, 3/3 Licensed Practical Nurses (LPNs), 2 Registered Nurses (RNs), and 7 administrative staff including the DON, ADON, Administrator, Human Resources, Social Services and Medical Records) were educated on the new facility door code, the elopement policy, and the</p>		