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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 1. 483.12 (F600) at J Immediate Jeopardy began on 12/27/18 when Resident #1 verbally told direct care staff that he had stuck his finger up a cognitively impaired resident's (Resident #2) vagina. Staff failed to put into action an effective plan to address and monitor his behaviors resulting in Resident #1 being observed attempting to have sexual intercourse with Resident #3 on 01/04/19. Immediate Jeopardy was removed on 01/14/19 when the facility provided and implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at the lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. An extended survey was completed. Immediate Jeopardy was removed on 01/14/19 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy removal. The facility remains out of compliance at the lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. An amended Statement of Deficiencies was provided to the facility on 4/4/19 because the Informal Dispute Resolution (IDR) process reduced the scope and severity of tag F-607 from a "J" level to a "D" level citation and information in tag F-0000 was changed to reflect the results of the IDR. Event# BPFU11.	F 000		
F 600	Free from Abuse and Neglect	F 600		2/6/19

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

Electronically Signed | 02/04/2019

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600 SS=J	Continued From page 1 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interview, the facility failed to protect 2 of 3 sampled residents (Residents #2 and #3) from sexual abuse from Resident #1. Immediate Jeopardy began on 12/27/18 when Resident #1 verbally told direct care staff that he had stuck his finger up a cognitively impaired resident's (Resident #2) vagina and staff failed to put into action an effective plan to address and monitor his behaviors resulting in Resident #1 being observed attempting to have sexual intercourse with Resident #3 on 01/04/19. Immediate Jeopardy was removed on 01/14/19 when the facility provided and implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at the lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure	F 600	F-600 The facilities corrective actions for those residents sited in F-600 and F-607 are as follows: On 12/27/2019, regarding Resident #2, the corrective action was to place Resident #1 on thirty minute monitoring and to place an alarm stop sign across the door of Resident #2. On 12/28/2019, Resident #1 was relocated to a different unit within the facility. On 1/4/2019, regarding Resident #3, the corrective action was to place Resident #1 on one-to-one monitoring which continued until Resident #1 discharged to the hospital on 1/9/2019. In addition, Resident #1 was evaluated by the facilities Medical Director and visiting Psychiatrist.	

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2 monitoring systems put into place are effective. The findings included: 1. Resident #1 was admitted to the facility on 12/13/18 with diagnoses of disorientation, benign neoplasm of the pituitary gland, unspecified dementia, anxiety disorder and depressive disorder. Admission orders dated 12/13/18 included Quetiapine Fumarate (i.e. Seroquel an antipsychotic medication) 25 milligrams (mg) every day at bedtime for unspecified dementia with behavioral disturbance; Mirtazapine (i.e. Remeron an antidepressant medication) 15mg take one tablet at bedtime for major depressive disorder unspecified; and Donepezil (i.e. Aricept treatment for mild to moderate dementia) 5 mg daily at bedtime for unspecified dementia with behavioral disturbance. Occupational therapy (OT) notes dated 12/18/18 at 4:55 PM stated Resident #1 demonstrated the ability to unlock/lock wheelchair brakes. The OT aide used 12 percent verbal cues for safety awareness and Resident #1 needed stand by assistance during ambulating in room with a rolling walker. Resident #1 was able to manage door and maneuver rolling walker with stand by assistance. Resident #1's admission Minimum Data Set (MDS) dated 12/20/18 coded him with being understood and understanding, having intact cognition, rejecting care 1 to 3 days during the previous 7 days, requiring extensive assistance with bed mobility, transfers, walking, dressing, and toileting, and limited assistance with	F 600	The facility initiated measures to identify other residents who have the potential to be affected by abuse, neglect, or exploitation through the re-education and in-servicing of staff, monitoring tools, and weekly interviews. All nursing staff, administration, and supporting departments received an initial re-education of the facilities policy for neglect, abuse, mistreatment, threatened or alleged abuse of residents beginning on 1/4/2019 and completed on 1/11/2019. Additional in-service trainings regarding the facilities abuse policy, training, and reporting of abuse standards were started on 1/25/2019 completed on 1/30/2019. These trainings included items deemed as immediately reportable to the Administrator and Director of Nursing. The Administrator, Director of Nursing, Social Services Director, and Unit Coordinator received additional training on F-600 items considered to be reportable to DHSR on 1/9/2019 and was completed on 1/14/2019. All Departmental Management were in-serviced on 1/14/2019 for procedural reviews and expectations of abuse reporting. All new employee hires receive Abuse Policy Training during orientation. All staff are annually re-inserviced on the facilities Abuse Policy and as needed to assure compliance with F-600 and F-607. This will be an ongoing measure. Resident interviews are being conducted with five residents on a weekly basis by the Social Services Director. These interviews started on 1/12/2019 and will continue	

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3 locomotion and eating. A care plan was initiated on 12/20/18 for the issue that Resident #1 made inappropriate comments of a sexual nature to female staff. The goal was that Resident #1 would have no increase in making inappropriate comments. Interventions included redirect the resident in a professional manner when he makes inappropriate comments, refer to psychiatric consult as needed and liaison with family as needed. The Care Plan Assessment (CAA) for cognition dated 12/21/18 stated Resident #1 had dementia which affected his cognition. His mood state can also impact cognition. Over the look back period, nursing notes indicated times of disorientation and confusion. The CAA for behaviors dated 12/27/18 stated the resident's cognitive status problems may also contribute to his behavioral symptoms. He has a diagnosis for dementia with behavioral disturbances and is taking medication for this. Although the resident displays behavioral symptoms that may impact himself or others, he is not an immediate threat to himself or others at this time. The OT notes dated 12/26/18 at 10:31 AM stated Resident #1 had improved in standing tolerance allowing for improvements with toileting and lower body dressing. He was able to propel his wheelchair through the facility. Resident #1 was no longer in the facility as he was discharged to the hospital for surgery on 01/09/19. No interview with Resident #1 could be conducted.	F 600	through 3/3/2019. The Social Services Director asks questions regarding being touched or spoken to in a sexual manner, seeing or hearing sexually inappropriate behavior between staff and/or residents, and invasion of privacy. The Assistant Director of Nursing is conducting five observations on non-interviewable residents beginning on 1/11/2019 and ending on 3/1/2019. These observations include looking for signs/symptoms of distress, disarray of clothing or belongings, and assessment of residents baseline. The results of these interviews/observations are used to identify concerns that are to be reported immediately to the Administrator or Director of Nursing. They are also discussed in the morning QI meetings and documented on the QI Abuse Monitoring form. The facilities systemic changes and monitoring tools also aid in identifying residents who have the potential to be affected as those sited in F-600 and F-607. Interviews are being conducted during every care plan meeting with the resident and/or the resident representative. These interviews began on 1/15/2019 and include questions regarding being touched or spoken to in a sexual manner, seeing or hearing sexually inappropriate behavior between staff and/or residents, and invasion of privacy. The same questions are also being asked during Resident Council meetings every month starting with the meeting on	

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4 Resident #3 was admitted to the facility on 04/09/14. Her diagnoses included essential hypertension, heart failure, adjustment disorder with mixed anxiety and transient cerebral ischemic attacks. Her most recent MDS, a quarterly dated 12/20/18 coded her with severely impaired cognitive skills, being nonambulatory and requiring extensive to total assistance with all activities of daily living skills. Review of an occurrence report dated 01/04/19 at 12:08 AM revealed that Resident #1 was in Resident #3's room with socially inappropriate behavior involving resident to resident altercation. This was witnessed by Nurse Aide (NA) #3 with NA #4 and Nurse #5 assigned to resident care. The investigation summary stated Resident #1 was noted lying on top of Resident #3 with his penis out. Resident #3's brief was open on the right side. The residents were separated and a body audit of Resident #3 revealed no redness or blood noted in the vaginal area. The facility immediately began an investigation including written statements and a body audit of Resident #3. A body audit picture signed by Nurse #5 and Nurse #6 on 01/04/19 stated no bleeding no discharge noted at 12:15 AM but also noted on the right side of her labia was "excoriation." A written statement by NA #3 dated 01/03/19 stated that while she was doing her first round, she entered Resident #3's room and saw Resident #1 on top of Resident #3. Resident #3 was crying for help and pushing his head away.	F 600	1/15/2019. On 1/12/2019, a revised 24 hour report was developed to identify any verbal or physical statements of abuse. Unit coordinators and/or licensed unit nursing staff are required to sign and attest to that no allegations of abuse occurred during their shift. These signature pages are collected and reviewed by the Director of Nursing and QI team on a daily basis for any event that could be reported. The weekend nursing management staff have been educated on the revised 24 hour report, with these reports being reviewed every Monday during morning QI meetings. Staff is aware to report any suspected or alleged abuse to the Administrator and/or Director of Nursing immediately. A QI abuse monitoring tool was also developed to assist in trending or finding patterns through reporting of grievances, occurrence reports, the 24 hour report, and resident interviews/observations. The facility has in place a monitoring tool for suspected abuse allegations to assist in documenting any reports to DHSR, regardless of the type of allegation, and to help with identifying trends or patterns. The use of this monitoring tool began on 1/13/2019 and will continue through 3/9/2019. All reported allegations will be completed per regulation timeframe. Any reports made to DHSR will be discussed in the morning QI meetings. After 3/3/2019, the QA committee will continue to monitor on an ongoing basis the results of the plan of care abuse questionnaire weekly, the resident council	

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5 The statement stated "He was trying to (penis in hand) position 'himself' better in her vaginal area." After the incident he continued to make inappropriate sexual remarks and indicated he was looking for more sexual activity. Interview via phone with NA #3 on 01/10/19 at 1:49 AM revealed that she was assigned to Resident #3 beginning 11 PM on 01/03/19 through 7 AM on 01/04/19. She stated that she began her normal rounds around midnight on 01/04/19 with Resident #3. NA #3 stated she entered the resident's room and when she pulled back the curtain she saw Resident #1 on top of Resident #3. Resident #3 was asking for help and pushing Resident #1's head away. NA #3 stated Resident #3's dress was up and her periarea was "very much exposed." Resident #1 was also exposed and he had his penis in his hand positioning himself. NA #3 stated it was obvious to her he was trying to have intercourse with Resident #3. She immediately yelled for the nurse and started to separate the residents. At the time he did not say what he was doing, but afterwards Resident #1 was saying how good it was and how Resident #3 squealed with enjoyment. Resident #3 kept repeating 'Don't let me die this way...I don't want to die this way.' NA #3 stated she had not seen Resident #1 before to this encounter during this shift and was not assigned to care for Resident #1. NA #3 stated that after this incident, Resident #3 was more fidgety and apprehensive during the provision of care than previously. A written statement by Nurse #5 dated 01/04/19 revealed she heard the NA #3 call her name for help. Upon entering Resident #3's room, she observed Resident #1 lying on top of Resident #3.	F 600	abuse questionnaire monthly, and the 24 hour report daily. The QA committee will review this information to identify any patterns and/or trends and develop interventions to assure compliance with F-600. These will be presented to the QA committee by the DON. The date of corrective action completion was 2/6/2019.	

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6	F 600		

Resident #3's brief was open on one side and Resident #1 had his penis out trying to position himself. Resident #1 was removed and a body audit of Resident #3 revealed no redness or bleeding to the vaginal area.

Nurse #5 was interviewed via phone on 01/09/19 at 7:16 PM. Nurse #5 stated she immediately entered Resident #3's room upon the NA calling for help. Resident #1 was observed on top of Resident #3. She stated the right side of Resident #3's brief was open and Resident #1 had his pants partially down exposing his penis. It appeared to Nurse #5 Resident #1 was trying to position himself to have intercourse with Resident #3. Nurse #5 stated she screamed at Resident #1 and screamed for NA #4. Resident #3 was lying there saying 'please don't hurt me, please don't hurt me, please don't let me die like this.' After Resident #1 was removed, Resident #3 continued to just lie there and cry. Nurse #5 stated NA #3 had pulled Resident #1 off of Resident #3. Nurse #5 stated she assisted Nurse #6 with the body audit and noted the brief was open and she was exposed. Nurse #5 stated afterward, Resident #1 was bragging about how he got himself one tonight and she liked it. Upon a follow up phone interview with Nurse #5 on 01/11/19 at 9:33 AM, she stated it was her duty to document the 30 minute checks on Resident #1. She estimated she saw him at the nursing station at approximately 11:45 PM on 01/03/19.

Interview with NA #4 occurred on 01/09/19 at 3:51 PM via phone. NA #4 stated he was assigned to Resident #1 starting 11 PM to 7 AM beginning 01/03/19. NA #4 stated he had seen Resident #1 during initial rounds around 11:15 PM to 11:30 PM. He had been in bed with a brief and pajama

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7	F 600		

bottoms on. He heard a NA call out for help and found NA #3 and Nurse #5 in Resident #3's room. By this time, Resident #1 was observed standing and leaning over the resident. NA #4 then stated Resident #1 was sitting on the edge of the bed with his penis exposed. Resident #1 was placed in a wheelchair and moved to the parlor where he was immediately placed under one on one supervision.

Phone interview with Nurse #6 on 01/09/19 at 7:30 PM revealed he was the supervisor during the night shift beginning 01/03/19. He stated Nurse #5 called him and when he arrived to Resident #3's room, Resident #1 was sitting on the edge of the bed his pants were partially down and Resident #3's brief was open on one side. When he asked Resident #1 what happened, Resident #1 said he was sorry. Nurse #6 immediately reported the incident to the administrator and the Director of Nursing (DON). Resident #3 appeared afraid and was visibly frightened despite her usual lethargy.

A phone interview with Resident #1's physician occurred on 01/09/19 at 3:12 PM. She stated that she saw him initially after admission and twice more, once after each incident relating to sexual behaviors. She described Resident #1 as alert and oriented but delusional with a diagnoses of vascular dementia. Examples of his delusions included that he was able to complete the act of sex with Resident #3. Resident #1 had stated that he can ambulate to Monroe, drive a car and has had 2 children by 2 different women at the same time which the spouse denied. The physician stated she was unaware he could walk until talking with therapy last week. When asked if Resident #1 could have delusions of grandeur,

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

meaning he does something but talks about it in more grandiose detail to make it sound like more occurred and she stated Resident #1 was incompetent.

An attempt to interview Resident #3 was made on 01/09/19 at 9:50 AM with her family member present. Resident #3 was lethargic and would not answer but one question which was do you feel safe here to which she responded yes.

2. Resident #1 was admitted to the facility on 12/13/18 with diagnoses of disorientation, benign neoplasm of the pituitary gland, unspecified dementia, anxiety disorder and depressive disorder.

Admission orders dated 12/13/18 included Quetiapine Fumarate (i.e. Seroquel an antipsychotic medication) 25 milligrams (mg) every day at bedtime for unspecified dementia with behavioral disturbance; Mirtazapine (i.e. Remeron an antidepressant medication) 15mg take one tablet at bedtime for major depressive disorder unspecified; and Donepezil (i.e. Aricept treatment for mild to moderate dementia) 5 mg daily at bedtime for unspecified dementia with behavioral disturbance.

Occupational therapy (OT) notes dated 12/18/18 at 4:55 PM stated Resident #1 demonstrated the ability to unlock/lock wheelchair brakes. The OT aide used 12 percent verbal cues for safety awareness and Resident #1 needed stand by assistance during ambulating in room with a rolling walker. Resident #1 was able to manage door and maneuver rolling walker with stand by assistance.

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9	F 600		

Resident #1's admission Minimum Data Set (MDS) dated 12/20/18 coded him with being understood and understanding, having intact cognition, rejecting care 1 to 3 days during the previous 7 days, requiring extensive assistance with bed mobility, transfers, walking, dressing, and toileting, and limited assistance with locomotion and eating.

A care plan was initiated on 12/20/18 for the issue that Resident #1 made inappropriate comments of a sexual nature to female staff. The goal was that Resident #1 would have no increase in making inappropriate comments. Interventions included redirect the resident in a professional manner when he makes inappropriate comments, refer to psychiatric consult as needed and liaison with family as needed.

The Care Plan Assessment (CAA) for cognition dated 12/21/18 stated Resident #1 had dementia which affected his cognition. His mood state can also impact cognition. Over the look back period, nursing notes indicated times of disorientation and confusion.

The CAA for behaviors dated 12/27/18 stated the resident's cognitive status problems may also contribute to his behavioral symptoms. He has a diagnosis for dementia with behavioral disturbances and is taking medication for this. Although the resident displays behavioral symptoms that may impact himself or others, he is not an immediate threat to himself or others at this time.

The OT notes dated 12/26/18 at 10:31 AM stated Resident #1 had improved in standing tolerance allowing for improvements with toileting and lower

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10	F 600		

body dressing. He was able to propel his wheelchair through the facility.

Review of the nursing notes for Resident #1 revealed on 12/27/18 at 1:11 PM the Director of Nursing wrote that Resident #1 was reported by staff to be saying he had used his fingers on another resident in their private area and that she liked it. Resident #1 had been verbally inappropriate with staff but not with other residents. Family was contacted who reported that prior to admission when Resident #1 was diagnosed with dementia and a pituitary tumor, he became more vocal with his wife regarding sexual matters. The note continued stating "Due to the limitations of the resident's physical body habitus, he would not be able to do anything to another resident. However, he is placed on q (every) 30 minute monitoring by staff. The resident also has delusions that the female resident is his new wife."

The next nursing note dated 12/27/18 at 1:35 PM identified the female resident involved as Resident #2.

Resident #2 was admitted to the facility on 12/31/15 with diagnoses of unspecified dementia and major depressive disorder.

Her cognition Care Area Assessment dated 08/28/18 stated Resident #2 was alert and exhibited impaired ability to communicate. She was nonverbal during the interview with occasional smiles. Her communication was impaired as related to understanding and relating information. She received assistance in all phases of care with her participation involving staff cueing and hands on assistance. She could

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 11	F 600		

stand and ambulate without assistance. She walked on and off the unit with assistance given as needed for redirection and safety.

Her most recent MDS, a quarterly dated 10/30/18 coded her with unclear speech, sometimes understanding, sometimes being understood, not being able to assess her cognition, being ambulatory, and requiring limited assistance with most activities of daily living skills. She was not coded for behavior or mood issues.

In Resident #2's nursing notes, written by the Director of Nursing (DON), was an entry dated 12/27/18 at 2:01 PM that stated a male resident stated he put his fingers in the resident's vagina. A body audit was conducted on the female resident and no signs or symptoms of redness, bruising or discharge were noted. The resident clamped her thighs together when assessed. It appeared that the male resident had fixated on the female resident. The male resident was placed on 30 minute checks. The next nursing note written by the Social Service Director dated 12/28/18 at 12:15 PM identified the male resident as Resident #1.

Review of the facility's investigation of the alleged incident between Resident #1 and Resident #2 included the following written statements and follow up interviews made by the surveyor:

*A hand written statement dated 12/27/18 at 7:06 AM signed by Nurse Aide (NA) #1 stated that at 7 AM he went to check on Resident #1 who stated last night he went into Resident #2's room and "he tried to stick the head in and it wouldn't fit so he just used his finger."
On 01/09/19 at 1:40 PM NA #1 was interviewed.

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12	F 600		

He stated he worked first shift. He stated that when Resident #1 told NA #1 that he had fingered Resident #2, Resident #1 actually used her name. NA #1 stated that Resident #1 tried to put his penis (referring to his head) inside Resident #2 but ended up using his finger. He further stated that he had not seen anything inappropriate between Resident #1 and Resident #2 previous to the allegation. He immediately reported this to his supervisor.

*A hand written statement dated 12/27/18 at 8:30 AM signed by NA #2 stated during breakfast, she noticed Resident #1 was in Resident #2's room. Resident #1 was immediately asked to leave and he said he was feeding Resident #2 "and he said that's not all I did." He then stated to NA #2 in the presence of Nurse #2 that he stuck his finger inside her vagina yesterday and that she wanted him to do it again. Both the NA and Nurse reported this to their supervisor.
NA #2 was interviewed on 01/09/19 at 3:39 PM via phone. NA #2 stated she saw Resident #1 by Resident #2's bed the morning of 12/27/18. Resident #1 referred to Resident #2 as his wife and then stated he stuck his finger inside of her. NA #2 stated that he was bedridden the first couple of days following his admission but after the first few days he could transfer himself and walked by himself. She stated he had called out to female residents before to "come here." NA #2 stated she, NA #1 and Nurse #2 all had to write statements and Resident #1 was placed on 30 minute checks.

*A hand written note dated 12/27/18 at 8:30 AM signed by Nurse #2 stated while at the med cart, NA called her to be a witness to what the resident (#1) was stating in that he stuck his middle finger

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13	F 600		

inside Resident #2 and she liked it.
Nurse #2 was interviewed on 01/09/19 at 1:31 PM. Nurse #2 stated Resident #2 did not verbalize anytime. She stated Resident #2 wandered independently around the halls and they tried to watch her for elopement risk. Resident #1 became more vocal to staff, not residents in a flirtatious manner during his stay at the facility. Nurse #2 stated that on 12/27/18 a nurse aide called to her to witness what Resident #1 was saying, which was that he stuck his finger and motioned to indicate inside the resident. She stated she immediately informed her supervisor. She did not recall Resident #2 acting any differently following this accusation.

*A hand written statement dated 12/27/18 at 9:00 PM signed by Nurse #1 stated she caught Resident #1 trying to go into Resident #2's room and shut the door. Nurse #1 noted she removed Resident #1 and reported the incident to Nurse #3. At first Resident #1 did not answer the nurse's question as to why he tried to shut the door and later stated he wanted to put her to sleep.
Nurse #1 was interviewed via phone on 01/10/19 at 1:50 PM. Nurse #1 stated that she caught Resident #1 going into Resident #2's room and he was trying to shut the door when she caught him. This occurred in the evening on 12/27/18. When she asked him what he was doing, Resident #1 said he was trying to put her to sleep then asked Nurse #1 if he was going to be going to jail and immediately said never mind. She stated she had heard bits and pieces of what Resident #1 had said about Resident #2 and knew he was being watched. She stated she wrote her statement on her own and left it for the next shift after informing her supervisors.

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14	F 600		

Interview on 01/09/19 at 2:59 PM via phone with Nurse #3, the supervisor the evening of 12/27/18, revealed she had been aware of the allegations Resident #1 was saying about what he did to Resident #2 and that he had been placed on 30 minute checks.

*A hand written note dated 12/27/18 at 12:45 PM signed by the DON stated Resident #1's family member stated Resident #2 was sitting on the bed in Resident #1's room his second Sunday at the facility. She reported this on 12/27/18. Resident #1's family member reported this occurred twice. A second note, no date but noted at 10:45 AM, revealed Resident #1's family member called and stated Resident #1 stated he was guilty of the offense of putting his fingers inside of the resident. He stated Resident #2 was fully clothed, had a brief on and was unable to speak. The plans noted included that the social worker discussed concerns with Resident #1's representative, his wife and the physician.; he was placed on 30 minute monitoring for location; he was moved to another unit; and he was placed on Paxil (an antidepressant).
The DON was interviewed on 01/09/19 at 2:00 PM. The DON stated Resident #1 did verbalize to her that he had his fingers inside Resident #2. She stated she talked to the supervisor and staff on the night shift and was unable to obtain proof to the allegations. The DON based this proof off the body audit of Resident #2 having no signs or symptoms of bruising, blood or discharge and staff reports that he was not seen near her prior to his allegations. Once she determined this allegation did not happen she placed him on 30 minute checks for location to be on the safe side.

On 01/09/19 at 1:52 PM Nurse #4 was

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15	F 600		

interviewed. She stated she was the supervisor on 12/27/18 first shift. Once the NA #1 and NA #2 brought Resident #1's allegation to her attention, she notified the DON and got written statements. She did not talk to Resident #1 nor did she hear him make the allegations.

An attempt to interview Resident #2 was made on 01/09/19 at 12:58 PM. She was nonverbal and did not follow directions to shake her head to yes and no questions. She started dancing.

Interview with the Administrator on 01/09/19 at 11:53 AM revealed that she believed that if Resident #1 had tried anything inappropriate with Resident #2, she would have gotten physical with him. She further stated there was nothing to the allegation because Resident #1 was delusional, could not perform marital duties per family interview and that his talk about sexual things occurred because he had a pituitary tumor. The family indicated there was no sexual criminal behaviors they knew of previously. Upon follow up interview on 01/09/19 at 4:09 PM the administrator stated the allegation did not occur because Resident #1 was delusional and Resident #2 had no physical evidence upon a body audit completed 12/27/18.

As a precaution, the Administrator stated they developed a Quality Improvement Plan dated 12/27/18 which was provided. This plan included:
1. review concerns with Resident #1 and Resident #2's families;
2. place resident (#1) on 30 minute monitor for location;
3. male resident (#1) moved to south neighborhood;
4. male resident (#1) placed on Paxil (an

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

antidepressant) for increased sexual behaviors.

Review of Resident #1's medical record revealed on 12/28/18 the physician examined Resident #1 at the request of nursing staff regarding increasing sexual behaviors. The physician noted Resident #1 stated he did not physically touch anyone but admitted to attempting to enter the room of a female resident on more than one occasion and stated he shouldn't have done that. The physical exam noted :motor intact, sensory intact, speech fluent. Alert and oriented x 2 (person and place). "The physician ordered Fluoxetine HCL (an antidepressant) 20 mg daily for sexual behaviors. Review of the computerized physician orders and the Medication Administration Records (MAR) this order had a start date of 12/31/18 and was actually administered beginning 01/01/19.

Review of documentation provided by the facility, 30 minute checks were initiated for Resident #1 and documented beginning 12/27/18 through 01/04/19. Documentation was noted for half hour increments (i.e. 1:00 PM - 1:30 PM, 1:30 PM - 2:00 PM, etc.).

The care plan for Resident #1 was updated on 12/28/18 with a goal that Resident #1 would not have nor vocalize delusions of a sexual nature. Interventions included the physician to evaluate the need of medication to decrease his sexual drive, visit with the resident and allow him to verbalize negative feelings, visit and remind him of the implications of false allegations and ensure he takes his medications.

Review of the nursing notes dated 12/28/18 at 2:29 PM revealed Resident #1 was moved to the

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

south unit on 12/28/18. Nursing notes dated 01/03/19 at 6:53 AM revealed during the shift, Resident #1 exhibited multiple behaviors including wandering in and out of other resident rooms, taking their belongings, removing ornaments from the Christmas tree in the south parlor, getting out of bed and self transferring to his wheelchair and sitting on the foot of his roommates bed using his telephone without permission. After being assisted back to bed, Resident #1 was again noted out of bed trying to give personal care to his roommate. It was noted Resident #1 needed constant redirecting.

Resident #1 was seen by psychiatric services on 01/03/19. The note stated Resident #1's speech was at normal rate and volume although monotone and his affect was restricted but reactive. His thought process was simple at times and he seemed superficially connected. There was no auditory or visual hallucinations recently and no delusions. His insight and judgement were poor. His recent memory and remote memory were intact. Recommendations were to discontinue Seroquel (Quetiapine) and start Depakote 125 mg twice a day.

The Administrator was informed of Immediate Jeopardy on 01/10/19 at 4:40 PM.

The facility provided an acceptable allegation of immediate jeopardy removal on 01/12/19 at 11:23 AM as follows:

White Oak Manor - Charlotte will ensure the safety of residents from abuse.
On 12/27/18, Resident # 1 reported to staff that he 'fingered' Resident # 2, and that Resident # 2

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

approached him and asked him to make love with her in her room. He could not get his penis to work but he indicated he used his finger and they enjoyed each other. Resident # 1 stated they were married and had children together. Resident # 1 was placed on 30-minute location monitoring checks. The 30-minute location monitoring was documented on a spreadsheet. Resident # 2 was immediately assessed by DON, Licensed Nurse and Social Services Director, which included a body audit that took 3 staff members due to the difficulty to examine the resident with her clenching of her thighs. There was no indication that resident was touched or harmed by another resident. Resident # 2 is non-verbal and is unable to say anything about Resident # 1's comments about her. Resident # 1 and # 2's Resident Representatives were notified.

On 1/4/19, Resident # 1 was noted lying in bed of Resident # 3. Resident # 1 was lying on top, toward the left of Resident # 1 with his pants undone and his penis exposed. Resident # 3's brief was noted undone and disheveled on the right side of Resident # 3. Facility staff immediately removed Resident # 1 from Resident # 3's room, and Resident # 3 was assessed by the nursing staff. Police was notified, and reported to the State. Police and Crime Scene Investigator conducted their investigation, and then Resident # 3 was transferred to the hospital for further evaluation. Resident # 1 was immediately placed on one-on-one monitoring with a staff member at all times until his discharge from the facility on 1/9/19 at 5:30AM.

On 12/27/18 and 1/4/19, Social Services Director checked by observation only on other residents that were in the proximity of Resident # 2 and # 3, and those residents were not interviewable due to mental capacity. On 1/10/19 and 1/11/19, Social

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

Services Department conducted interviews with interviewable residents throughout the facility. The interview questions consisted of the following: has anyone touched you an inappropriate manner including sexual, has anyone talked to you in an inappropriate manner, including sexually, has anyone tried to climb in the bed with you, and did you see anything sexually inappropriate to anyone else. All questions were answered with a no.
Non-interviewable residents were assessed by 3 Licensed Nursing staff to determine any distress or clothing disturbances or change from their normal demeanor. No variances were noted during the assessments.
Re-education on the Abuse/Neglect Policy was started on 1/04/19 of all current staff in all departments, and completed on 1/11/19. Newly hired staff will be re-educated during their specific job orientation by the Staff Development Coordinator or Social Services Director. The Abuse/Neglect Policy will be reviewed annually with all staff and as needed throughout the calendar year.
On 1/11/19, the 24-hour report and Quality Improvement (QI) documentation sheets were modified to document and address any observation or verbalization of sexual behavior reported by facility staff.

On 1/11/19, a questionnaire was developed regarding sexual inappropriateness that included physical interaction and verbalizations, and will be implemented during care plan meetings and Resident Council meetings.

The Social Services Department will randomly interview 5 residents per week for 8 weeks. The interview questions will address inappropriate

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

sexual behaviors affecting themselves or that they may have observed. Another 5 random residents that are non-interviewable will be monitored for changes in behavior or demeanor that would possibly indicate any mistreatment or abuse, particularly for sexual interactions whether verbal or physical. The monitoring will identify any allegations of sexual abuse, and assure reporting and the investigation is complete thoroughly. The monitoring will be completed by the Director of Nursing (DON) and/or designee.

All indications or suspicion of sexual abuse will be reported to the Administrator and DON by facility staff, and appropriately reported to the state agency and a thorough investigation will be completed.

The Quality Improvement (QI) committee was informed on 12/27/19 with the situation involving Resident # 2 and on 1/4/19 regarding the incident involving Resident # 3. Results from the monitoring will be discussed Monday through Friday during Quality Improvement (QI) morning meetings and any identified issues or trends will be further discussed at the Quality Assurance meeting with the team and recommendation made as indicated. The QA committee was notified of credible allegation on 1/9/19, 1/10/19, and 1/11/19 respectively throughout the survey process as it was informed to the facility. The QA committee includes the Attending Physician, Administrator, DON, Social Services department, ADON, Nursing Supervisors, Dietary, Activities, SDC, Therapy Department, Restorative Nurse, and MDS Licensed Nurses.

Alleged Compliance Date is 1/12/19

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21 The DON is responsible for ongoing compliance of F600. The facility's credible allegation of IJ removal was verified on 01/14/19 at 6:04 PM and based on verification that Resident #1 was no longer in the building. Interviews with alert and oriented residents were conducted and no one expressed they had been abused and family members were interviewed and voiced no concerns. Administrative and nursing staff verified that training had been provided regarding the abuse policy and need to protect residents, investigate allegations and report to the state agency. This was verified as also being provided to all departments.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure to protect residents from abuse and to investigate and report allegations of abuse for 1 of 2 residents reviewed for sexual abuse	F 607	F-607 The facilities corrective actions for those resident sited in F-600 and F-607 are as follows: On 12/27/2019, regarding	2/6/19

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 22 (Resident #2). Resident #1 informed staff that he put his finger in a cognitively impaired resident's vagina (Resident #2). The facility failed to thoroughly investigate this allegation of abuse or report it to the State agency. The findings included: Review of the facility's Neglect, abuse, Mistreatment, Threatened or Alleged Abuse of Residents policy, which was revised in May of 2017 included the following in part: *under Section V Protection: A. Protection of the resident who has been a victim, the facility will take immediate measures to protect the resident from further harm including measures that might include more frequent monitoring. Under the section of Resident to Resident Abuse the facility was to monitor residents for aggressive/inappropriate behavior toward other residents. * under Section VI Investigation: A. Should an incident or suspected incident of resident abuse be reported, the Administrator, or his designee will investigate the alleged incident. B. The person in charge of the investigation will obtain a completed copy of the Incident report and any supporting documents relative to the allegation. C. The individual conducting the investigation will as a minimum: *Review the completed forms; *Interview the person(s) reporting the incident; *Interview any witnesses to the incident; *Interview staff members on all shifts who have had contact with the resident during the period of the alleged incident;	F 607	Resident #2, the corrective actions was to place Resident #1 on thirty minute monitoring and to place an alarm stop sign across the door of Resident #2. On 12/28/2019, Resident #1 was relocated to a different unit within the facility. On 1/4/2019, regarding Resident #3, the corrective actions was to place Resident #1 on one-to-one monitoring which continued until Resident #1 discharged to the hospital on 1/9/2019. In addition, Resident #1 was evaluated by the facilities Medical Director and visiting Psychiatrist. The facility initiated measures to identify other residents who have the potential to be affected by abuse, neglect, or exploitation through the re-education and in-serving of staff, monitoring tools, and weekly interviews. All nursing staff, administration, and supporting departments received an initial re-education of the facilities policy for neglect, abuse, mistreatment, threatened or alleged abuse of residents beginning on 1/4/2019 and completed on 1/11/2019. Additional in-service trainings regarding the facilities abuse policy, training, and reporting of abuse standards were started on 1/25/2019 and completed on 1/30/2019. These trainings included items deemed immediately reportable to the Administrator and Director of Nursing. All Departmental Management were in-serviced on 1/14/2019 for procedural reviews and expectations of abuse reporting. All new employee hires receive Abuse Policy Training during orientation.	

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 23 *Interview the resident's roommate other residents, visitors as appropriate. E. Statements will be obtained from individuals identified as having potential involvement and/or knowledge of the alleged incident. Statements shall include but not limited to the time frame of contact and or observation of the alleged victim, interaction with the alleged victim and or act ivies at the time of the alleged incident, observation of other person's activities and/or interaction with the alleged victim (including staff, family or others). F. Following a complete and thorough investigation on the alleged abuse a written report will be finalized summarizing the investigation. H. Preliminary reporting requirements will be followed and the results of the final investigation will be reported to appropriate individuals and state agencies as required by law. *Under section VII Reporting and Response in the abuse policy and procedure included in part: B. Upon receipt of an allegation of abuse, The Administrator or designee will notify the State agency(s). C. The report of the initial investigation will be telephoned or faxed to the appropriate State agency. D. The facility will follow the investigation procedure as outlined. E. following the investigation, a five day report will be filed with the appropriate State agency summarizing the investigation, corrective action taken and outcome of the investigation. 1. Resident #1 was admitted to the facility on 12/13/18 with diagnoses of disorientation, benign neoplasm of the pituitary gland, unspecified	F 607	All staff are annually re-inserviced on the facilities Abuse Policy and as needed to assure compliance with F-600 and F-607. This will be an ongoing measure. Resident interviews are being conducted with five residents on a weekly basis by the Social Services Director. These interviews started on 1/12/2019 and will continue through 3/3/2019. The Social Services Director asks questions regarding being touched or spoken to in a sexual manner, seeing or hearing sexually inappropriate behavior between staff and/or residents, and invasion of privacy. The Assistant Director of Nursing is conducting five observations on non-interveiwable residents beginning on 1/11/2019 and ending on 3/1/2019. These observations included looking for signs/symptoms of distress, disarray of clothing or belongings, and assessment residents baseline. The results of these interviews/observations are used to identify concerns that are to be reported immediately to the Administrator or Director of Nursing. They are also discussed in the morning QI meetings and documented on the QI Abuse Monitoring form. The facilities systemic changes and monitoring tools also aid in identifying residents who have the potential to be affected as those sited in F-600 and F-607. Interviews are being conducted during every care plan meeting with the resident and/or resident representative. These interviews began on 1/15/2019 and include questions regarding being touch	

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 24	F 607		

dementia, anxiety disorder and depressive disorder. Admission orders dated 12/13/18 included Quetiapine Fumarate (an antipsychotic medication) 25 milligrams (mg) every day at bedtime for unspecified dementia with behavioral disturbance; Mirtazapine (an antidepressant medication) 15mg take one tablet at bedtime for major depressive disorder unspecified; and Donepezil (a treatment for mild to moderate dementia) 5 mg daily at bedtime for unspecified dementia with behavioral disturbance.

Occupational therapy (OT) notes dated 12/18/18 at 4:55 PM stated Resident #1 carried out activities of daily living skills demonstrating the ability to unlock/lock brakes appropriately. The OT aide used 12 percent verbal cues for safety awareness and proper hand placement and Resident #1 needed stand by assistance during ambulating in room with rolling walker. Resident #1 was able to manage door and maneuver rolling walker with stand by assistance.

Resident #1's admission Minimum Data Set (MDS) dated 12/20/18 coded him with being understood and understanding, having intact cognition, rejecting care 1 to 3 days during the previous 7 days, requiring extensive assistance with bed mobility, transfers, walking, dressing, and toileting, and limited assistance with locomotion and eating.

A care plan was initiated on 12/20/18 in order to address the problem that the resident makes inappropriate comments of a sexual nature to female staff. The goal was that Resident #1 would have no increase in making inappropriate comments. Interventions included redirect the resident in a professional manner when he or spoken to in a sexual manner, seeing or hearing sexually inappropriate behavior between staff and/or residents, and invasion of privacy. The same questions are also being asked during Resident Council meetings every month starting with the meeting on 1/15/2019. On 1/12/2019, a revised 24 hour report was developed to identify any verbal or physical statements of abuse. Unit Coordinators and/or licensed unit nursing staff are required to sign and attest to that no allegations of abuse occurred during their shift. These signature pages are collected and reviewed by the Director of Nursing and QI team on a daily basis for any event that could be reported. The weekend nursing management staff have been educated on the revised 24 hour report, with these reports being reviewed every Monday during morning QI meetings. Staff is aware to report any suspected or alleged abuse to the Administrator and/or Director of Nursing immediately. A QI abuse monitoring tool was also developed to assist in trending or finding patterns through reporting of grievances, occurrence reports, the 24 hour report, and resident interviews/observations. The facility has in place a monitoring rook for suspected abuse allegations to assist in documenting an reports to DHSR, regardless of the type of allegation, and to help with identifying trends or patterns. The use of this monitoring tool began on 1/13/2019 and will continue through 3/9/2019. All reported allegations will be completed per regulation timeframe. Any

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 25 makes inappropriate comments, refer to psychiatric consult at needed and liaison with family as needed. The Care Area Assessment (CAA) for cognition dated 12/21/18 stated Resident #1 had dementia which affected his cognition. His mood state can also impact cognition. Over the look back period, nursing notes indicted times of disorientation and confusion. The OT notes dated 12/26/18 at 10:31 AM stated Resident #1 was improved standing tolerance allowing for improvements with toileting and lower body dressing. He was able to propel through the facility. The CAA for behaviors dated 12/27/18 stated the residents cognitive status problems may also contribute to his behavioral symptoms. He has a diagnosis for dementia with behavioral disturbances and is taken medication for this. Although the resident displays behavioral symptoms that may impact himself or others, he was not an immediate threat to himself or others at this time. Review of the nursing notes for Resident #1 revealed on 12/27/18 at 1:11 PM the Director of Nursing wrote that Resident #1 was reported by staff to be saying he had used his fingers on another resident in their private area and that she liked it. The resident had been verbally inappropriate with staff but not with other residents. Family was contacted who reported that prior to admission when Resident #1 was diagnosed with dementia and a pituitary tumor, he became more vocal with his wife regarding sexual matters. The note continued stating "Due to the	F 607	reports made to DHSR will be discussed in morning QI meetings. After 3/3/2019, the QA committee will continue to monitor on an ongoing basis the results of the plan of care abuse questionnaire weekly, the resident council abuse questionnaire monthly, and the 24 hour report daily. The QA committee will review this information to identify any patterns and/or trends and develop interventions to assure compliance with F-607. These will be presented to the QA committee by the DON. The date of corrective action completion was 2/6/2019.	

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 26	F 607		

limitations of the resident's physical body habitus, he would not be able to do anything to another resident. However, he is placed on q (every) 30 minute monitoring by staff. The resident also had delusions that the female resident is his new wife."

The next nursing note dated 12/27/18 at 1:35 PM identified the female resident involved as Resident #2.

a. Resident #2 was admitted to the facility on 12/31/15 with diagnoses of unspecified dementia and major depressive disorder. Her cognition CAA dated 08/28/18 stated Resident #2 was alert and exhibited impaired ability to communicate. She was nonverbal during the interview with occasional smiles. Her communication was impaired as related to understanding and relating information. She received assistance in all phases of care with her participation involving staff cueing and hands on assistance. She could stand and ambulate with and without assistance and walked on and off the unit with assistance given as needed for redirection and safety.

Her most recent MDS, a quarterly dated 10/30/18 coded her with unclear speech, sometimes understanding, sometimes being understood, not being able to assess her cognition, being ambulatory, and requiring limited assistance with most activities of daily living skills.

In Resident #2's nursing notes was an entry dated 12/27/18 at 2:01 PM written by the Director of Nursing stated a male resident made statements that he had inappropriate physical contact with a female resident. The male resident stated he put his fingers in the resident's

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 27	F 607		

vagina. A body audit was conducted on the female resident and no signs or symptoms of redness, bruising or discharge were noted. The resident clamped her thighs together when assessed. It appeared that the male resident had fixated on the female resident. The male resident was placed on 30 minute checks. The next nursing note written by the Social Service Director dated 12/28/18 at 12:15 PM identified the male resident as Resident #1.

Review of the facility's investigation of the alleged incident between Resident #1 and Resident #2, provided by the Director of Nursing on 01/09/19, did not include an occurrence report/incident report, did not include evidence of the state agency notification of the allegation or the report summary and findings. The facility provided their evidence of the investigation which included the following written statements and follow up interviews made by the surveyor:

*A hand written statement dated 12/27/18 at 7:06 AM signed by Nurse Aide (NA) # 1 stated that at 7 AM he went to check on Resident #1 who stated last night he went into Resident #2's room and "he tried to stick the head in and it wouldn't fit so he just used his finger."

On 01/09/19 at 1:40 PM NA #1 was interviewed to confirm his written statement. He stated that when Resident #1 told the NA that he had fingered Resident #2, Resident 1 actually used her name. NA #1 stated that Resident #1 told him he tried to put his penis (referring to his head) inside Resident #2 but ended up using his finger. He further stated that he had not seen anything inappropriate between Resident #1 and Resident #2 previous to the allegation. He reported it to his

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 28	F 607		

supervisor.

*A hand written statement dated 12/27/18 at 8:30 AM signed by NA #2 stated during breakfast, she noticed Resident #1 was in Resident #2's room. Resident #1 was immediately asked to leave and he said he was feeding Resident #2 "and he said that's not all I did." He then stated to NA #2 in front of the nurse (Nurse #2) that he stuck his finger inside her vagina yesterday and that she wanted him to do it again.

NA #2 was interviewed on 01/09/19 at 3:39 PM via phone to confirm the written statement. NA #2 stated she saw Resident #1 by Resident#2's bed the morning of 12/27/18. Resident #1 referred to Resident #2 as his wife and then stated he stuck his finger inside of her. NA #2 stated that he was bedridden the first couple of days following his admission but after the first few days he could transfer himself and walked by himself. She stated he had called out to female residents before to "come here." She stated she, NA #1 and Nurse #2 all wrote statements.

*A hand written note dated 12/27/18 at 8:30 AM signed by Nurse #2 stated while at the med cart NA called her to be a witness to what the resident was stating in that he stuck his middle finger inside Resident #2 and she liked it.

Nurse #2 was interviewed on 01/09/19 at 1:31 PM to confirm the written statement. Nurse #2 stated Resident 2 did not verbalize anytime. She stated Resident #2 wandered independently around the halls and they try to watch her for elopement risk. Resident #1 became more vocal to staff, not residents in a flirtatious manner. Nurse #2 stated that on 12/27/18 a nurse aide called to her to

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 29	F 607		

witness what Resident #1 was saying which was that he stuck his finger and motioned to indicate inside the resident. She does not recall Resident #2 acting any differently following this accusation.

*A hand written statement dated 12/27/18 at 9:00 PM by Nurse #1 who stated she caught Resident #1 trying to go into Resident #2's room and shut the door. Nurse #1 noted she removed Resident #1 and reported the incident to Nurse #3. At first Resident #1 did not answer the nurse's question as to why he tried to shut the door and later stated he wanted to put her to sleep.

Nurse #1 was interviewed via phone on 01/10/19 at 1:50 PM to confirm her written statement. Nurse #1 stated that she caught Resident #1 going into Resident #2's room and he was trying to shut the door when he caught him. This occurred in the evening on 12/27/18. When she asked him what he was doing, Resident #1 said he was trying to put her to sleep then asked Nurse #1 if he was going to be going to jail and immediately said never mind. She stated she wrote her statement on her own and left it for the next shift after informing her supervisors.

*A hand written note dated 12/27/18 at 12:45 PM signed by the Director of Nursing (DON) stated Resident #1's daughter stated Resident #2 was sitting on the bed in Resident #1's room his second Sunday at the facility. She reported this on 12/27/18. Resident #1's daughter reported this occurred twice. A second note, no date but noted at 10:45 AM, revealed Resident #1's daughter called and stated Resident #1 stated he was guilty of the offense of putting his fingers inside of the resident. He stated she was fully clothed, had a brief on and was unable to speak.

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 30	F 607		

The plans noted included that the social worker discussed concerns with Resident #1's representative, his wife and the physician; he was placed on 30 minute monitoring for location; he was moved to another unit; and he was placed on Paxil (an antidepressant).

*A hand written note, dated 12/27/18 at 12:45 PM by the DON, indicated a skin assessment was completed on Resident #2 by the DON, social Service Director and East supervisor noting her periarea/rectal area showed no bruising, bleeding or discharge was noted.

The DON was interviewed on 01/09/19 at 2:00 PM. The DON stated Resident #1 did verbalize to her that he had his fingers inside Resident #2. She stated she talked to the supervisor and staff on the night shift and was unable to obtain proof to the allegations. She stated to be on the safe side, she placed him on 30 minute checks for location. She stated that there was no way this could have occurred so she did not report the allegation or follow the abuse policy because the event did not happen based on no physical evidence from Resident #2's body audit.

The facility provided their developed quality improvement plan dated 12/27/18 which included discussing concerns with Resident #1 and Resident #2's family; placing Resident #1 on 30 minute monitoring for his location; moving Resident #1 to another unit; and placing Resident #1 on an antidepressant for increased sexual behaviors.

An attempt to interview Resident #2 was made on 01/09/19 at 12:58 PM. She was nonverbal and did not follow directions to shake her head to yes

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 31	F 607		

and no questions. She started dancing.

Resident #1 was no longer in the facility as he was discharged to the hospital for surgery on 01/09/19. No interview with Resident #1 could be conducted.

On 01/09/19 at 1:52 PM Nurse #4 was interviewed. She stated she was the supervisor on 12/27/18 first shift on the East side. Once the nurse aide brought the allegations Resident #1 was making to her attention, she notified the DON and got written statements. She did not talk to Resident #1 nor did she hear him make the allegations. A follow up interview with Nurse #4 on 01/10/19 at 8:45 AM revealed she was not asked about interactions between Residents #1 and #2 previous to the morning of 12/27/18.

On 01/09/19 at 4:09 PM the Administrator stated that Resident #1 was delusional and confused and she knew nothing occurred between Resident #1 and Resident #2 because Resident #2's body audit showed no trauma. She further stated that she placed Resident #1 on 30 minute monitoring on 12/27/18 (at 10:00 AM per the documentation) as a precaution and she felt this monitoring was effective.

The DON was interviewed again on 01/10/19 at 12:30 PM and provided the names of the staff she interviewed that proved to her there was no way Resident #1 assaulted Resident #2. She named Nurse #6 and Nurse #4. Additionally she named NA #1 and Resident #1.

Additional interviews were conducted with these staff as follows:
*NA #1, who worked first shift, was interviewed on

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 32	F 607		

01/10/19 at 8:37 AM. NA #1 stated no one questioned him about any interactions known to him regarding interactions between Residents #1 and #2 previous to Resident #1 reporting his sexual behavior the morning of 12/27/18.
*Nurse #4, who worked first shift, was interviewed on 01/10/19 at 8:45 AM. She stated that no administrative staff had asked her about interactions between Resident #1 and Resident #2 over the previous day of 12/26/18.
*Nurse #6, who worked third shift, was interviewed via phone on 01/10/19 at 11:49 PM. Nurse #6 denied that the DON questioned him about any interaction he knew of between Residents #1 and #2. He further stated he learned of the allegation 2 to 3 days later during supervisory report.

An interview was conducted with the Social Service Director (SSD) on 01/10/19 at 12:31 PM. She stated that she heard that Resident #1 was bragging about what he allegedly did to Resident #2. She assisted in the body audit of Resident #2 and stated she would have checked with the residents who were cared for by the aide who had the same assignment as Resident #2. SSD stated during follow up interview on 01/10/19 at 3:53 PM that she "eye balled" those residents directly around Resident #2's room. She stated no resident was interviewable so she did not attempt to interview any other resident. She stated she knew her residents well and would have been able to tell if they were traumatized by observing them. She was unable to say how many or who she eye balled. She stated she did not eyeball or try to interview any resident surrounding Resident #1's room. She further stated she did not do any body audits on the residents surrounding either residents' rooms.

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 33	F 607		

Interview with the Administrator on 01/09/19 at 11:53 AM revealed that she did not believe that Resident #1 was capable of assaulting Resident #2 and that Resident #2 would have fought back if Resident #1 tried anything inappropriate. She stated abuse did not occur and there was no need to launch a formal investigation and report the incident to the health care personnel investigations per their policy based on Resident #2 having no signs or symptoms of sexual abuse.

A phone interview with Resident #1's physician occurred on 01/09/19 at 3:12 PM. She stated that she saw him initially after admission and twice more, once after each incident relating to sexual behaviors. She described Resident #1 as alert and oriented but delusional with a diagnoses of vascular dementia. Examples of his delusions included that he was able to complete the act of sex with Resident #3. Resident #1 had stated that he can ambulate to Monroe, drive a car and has had 2 children by 2 different women at the same time which the spouse denied. The physician stated she was unaware he could walk until talking with therapy last week. When asked if Resident #1 could have delusions of grandeur, meaning he does something but talks about it in more grandiose detail to make it sound like more occurred and she stated Resident #1 was incompetent.

Interviews were conducted with staff who worked with Resident #1 and #2 on 12/26/18 on all three shifts as follows:
*On 01/10/19 at 8:35 AM, NA #5 stated she worked day shift on 12/26/18 and stated no administrative staff asked her about any interaction between Resident #1 and Resident #2

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 34	F 607		

during her shift on 12/26/18.
*On 01/10/19 at 8:55 AM, NA #6 stated she worked 12/26/18 first shift and that she had known nothing about the accusations Resident #1 made about assaulting Resident #2 and that no one asked her questions about known interactions between the two residents.
*On 01/10/19 at 9:06 AM a phone call was made to NA #7 who stated she worked second shift on 12/26/18. She stated no administrative staff asked her about known interactions between Residents #1 and #2 on 12/26/18.
*On 01/10/19 at 9:43 AM a phone interview with NA #9 was conducted. NA #9 stated she worked the evening of 12/26/18 and that no administrative staff questioned her about any interaction observed between Residents #1 and #2 during her shift on 12/26/18.
*On 1/10/19 at 9:46 AM, NA #10 stated she worked the day shift on 12/26/18 and recalled staff asking about behaviors of Resident #1.
*On 01/10/19 at 1:27 PM Nurse #7 was interviewed via phone. She stated she was the charge nurse the night of 12/26/18 and stated that no administrative staff had asked her about any interactions she may have witnessed between Resident #1 and Resident #2 during her shift.
*On 01/10/19 at 2:30 PM a phone interview with NA #11 revealed she worked with Resident #2 on 12/26/18 during the evening shift. She stated she was never asked by administration about any interaction observed between Residents #1 and #2 on 12/26/18.
*On 01/10/19 at 7:00 PM, a phone interview with NA #12 revealed she worked the night of 12/26/18 and stated that no one had asked her about any interaction she observed between Resident #1 and Resident #2 that night. She

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 35	F 607		

further stated she knew no details about the allegation.
*On 01/10/19 at 11:49 PM a phone interview with Nurse #6 revealed he worked the night shift of 12/26/18. He stated no one asked him questions about any observations he made of Resident #1 or Resident #2.
*On 01/10/19 at 11:57 PM NA #14 stated during a phone interview that she worked the night of 12/26/18. She further stated no administrative staff asked her about any observations she saw between Residents #1 and #2 that night.

b. Review of an occurrence report dated 01/04/19 at 12:08 AM revealed that Resident #1 was in cognitively impaired Resident #3's room with socially inappropriate behavior involving resident to resident altercation. This was witnessed by Nurse Aide (NA) #3 with NA #4 and Nurse #5 assigned to resident care. The investigation summary stated Resident #1 was noted lying on top of Resident #3 with his penis out. Resident #3's brief was open on the right side. The residents were separated and a body audit of Resident #3 revealed no redness or blood noted in the vaginal area.

Interview with Nurse #5 on 01/09/19 at 7:15 PM revealed she was the charge nurse on south unit during the third shift beginning on 01/03/19 at 11:00 PM and ending on 01/04/19 at 7:00 AM. Nurse #5 stated that she was called to Resident #3's room on 01/04/19 at 12:08 AM where she saw Resident #1 lying on top of Resident #3 with his pants partially down and his penis in his hand as if he was trying to reposition himself to have intercourse. Resident #3's brief was open on one side.

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 36	F 607		

Interview with NA #4 on 01/09/19 at 3:51 PM revealed he had put resident #1 in bed wearing pajama pants and a brief between 11:15 PM and 11:30 PM on 01/03/19. Then he was called to Resident #3's room where he saw Resident #1 sitting on the edge of Resident #3's bed leaning over Resident #3, with his penis exposed.

On a follow up phone interview on 01/11/19 at 9:33 AM, Nurse #5 stated she thought she had last seen Resident #1 for his 30 minute location check around 11:45 PM sitting at the nursing station. It was the nurse's responsibility to conduct the 30 minute checks on Resident #1.

Interview via phone with NA #3 on 01/10/19 at 1:49 AM revealed that she was assigned to Resident #3 beginning 11:00 PM on 01/03/19 through 7:00 AM on 01/04/19. She stated that she began her normal rounds around midnight on 01/04/19 with Resident #3. NA #3 stated she entered the resident's room and when she pulled back the curtain she saw Resident #1 on top of Resident #3. Resident #3 was asking for help and pushing Resident #1's head away. NA #3 stated Resident #3's dress was up and her periarea was "very much exposed." Resident #1 was also exposed and he had his penis in his hand positioning himself. NA #3 stated it was obvious to her he was trying to have intercourse with Resident #3. She immediately yelled for the nurse and started to separate the residents. At the time he did not say what he was doing, but afterwards Resident #1 was saying how good it was and how Resident #3 squealed with enjoyment. Resident #3 kept repeating 'Don't let me die this way...I don't want to die this way.' NA #3 stated she had not seen Resident #1 before this encounter during this shift and was not

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 37 assigned to care for Resident #1. NA #3 stated that after this incident, Resident #3 was more fidgety and apprehensive during the provision of care than previously. Review of the facility's investigation revealed the Resident #1 was removed immediately, Resident #3 was checked for injuries, the police were called and health care personnel investigations was conducted. Resident #3 was then sent to the hospital for evaluation which revealed no evidence of sexual contact.	F 607		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		2/6/19

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 38	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 39 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document observed inappropriate sexual behavior in the medical record for 1 of 3 sampled residents reviewed for medical record accuracy. (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/13/18 with diagnoses of disorientation, benign neoplasm of the pituitary gland, unspecified dementia, anxiety disorder and depressive disorder. Resident #1's admission Minimum Data Set (MDS) dated 12/20/18 coded him with being understood and understanding, having intact cognition, rejecting care 1 to 3 days during the previous 7 days, requiring extensive assistance with bed mobility. transfers, walking, dressing, and toileting, and limited assistance with locomotion and eating. Review of an occurrence report dated 01/04/19 at 12:08 AM revealed that Resident #1 was in Resident #3's room with socially inappropriate behavior involving resident to resident altercation. This was witnessed by Nurse Aide (NA) #3 with NA #4 and Nurse #5 assigned to resident care. The investigation summary stated Resident #1 was noted lying on top of Resident #3 with his penis out. Resident #3's brief was open on the right side. The residents were separated and a body audit of Resident #3 revealed no redness, or blood noted in the vaginal area.	F 842	White Oak of Charlotte ensures medical records are complete and accurate. The facility ensures an occurrence involving a resident will be documented in the resident's medical record. On 1/16/2019, the DON made an entry for the 1/4/2019 occurrence involving Resident #3. All other residents, including current and newly admitted residents, who have an occurrence will have documentation in their medical record regarding the occurrence. Clinical staff, including Physician's, Physician Extenders, Licensed Nurses, Social Workers, Dietician, Activity Professionals, and Therapists were re-educated on documenting occurrences in the resident's medical record by the SDC on 1/30/2019, 1/31/2019, 2/1/2019, 2/3/2019, 2/4/2019, and 2/5/2019. Newly hired clinical staff will receive this education during their job specific orientation with the SDC and annually thereafter. The DON and/or ADON will monitor progress in the medical record of 5 residents daily starting on 1/22/2019 and ending on 3/22/2019 and as needed thereafter. The DON and/or ADON choose records based on information on	

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 _____	C 01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 40 The facility immediately began an investigation including written statements and a body audit of Resident #3. A body audit picture signed by Nurse #5 and Nurse #6 on 01/04/19 stated no bleeding no discharge noted at 12:15 AM but also noted on the right side of her labia was "excoriation". Review of Resident #1's medical record revealed no nursing notes from between 01/03/19 at 5:30 PM which stated he was disruptive and must be watched at all times through 01/04/19 at 7:53 AM. The nursing notes for 01/04/19 at 7:53 AM described Resident #1 being in the parlor, removing Christmas decorations from the tree and mantel which resulted in him losing his balance and falling. Review of ongoing nursing notes from 01/04/19 at 7:53 AM through 01/09/19 at 7:13 AM did not mention any contact with Resident #3 or other residents but occasionally indicated he had a one to one sitter with him. On 01/10/19 at 3:42 PM, the Director of Nursing reviewed Resident #1's nursing notes and stated there was nothing written in the notes indicating any behaviors by Resident #1 towards Resident #3. She stated there should have been some documentation and that it was most likely only written in the occurrence report. The Director of Nursing verified that the occurrence reports for Resident #1 and Resident #3 were not part of the residents' medical records.	F 842	the 24 hour report, including weekday and weekend reports. This is to ensure documentation of occurrences involving residents are documented in the resident's medical record. Results from the monitoring will be discussed Monday through Friday in morning QI meeting and any identified issues or trends will be further discussed at the Quality Assurance meeting with the team and recommendations made as indicated. The DON will present findings to the QA committee quarterly and as needed. Duration of inclusion in the QA process will be through 3/22/2019 and randomly thereafter. After 3/22/2019, the QA committee will continue on an ongoing basis to review five occurrences weekly to assure notes are made in the resident's medical record. The DON or designee will chose the occurrences as stated above. The results of the reviews will be discussed in the daily Monday through Friday morning QI meetings. The QI team will evaluate any trends, patterns, or concerns and make changes to assure compliance with F-842. The DON is responsible for ongoing compliance of F-842	