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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	**716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/04/25 through 08/08/25, the credible allegation was validated on 08/12/25, therefore the exit date was changed to 08/12/25. Event ID #1D27FC-H1. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness.	E0000		
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 08/04/25 through 08/08/25, the credible allegation was validated on 08/12/25 therefore the exit date was changed to 08/12/25. Event ID #1D27FC-H1. The following intakes were investigated: 841134, 841137, 841140, 841141, 841144, and 2567919. 5 of the 9 allegations resulted in deficiency. Immediate jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of J. Tag F600 constituted substandard quality of care. Immediate jeopardy began on 05/09/25 and was removed on 08/10/25. An extended survey was conducted.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a	F0550		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0550 SS = D	Continued from page 1 manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to maintain a resident's dignity when incontinence care was not provided as needed for 1 of 3 residents reviewed for dignity (Resident #139). Findings included: Resident #139 was admitted on 12/22/20 with diagnoses which included cerebrovascular accident (stroke) and hypertension (high blood pressure). A quarterly Minimum Data Set (MDS) dated 06/27/25 revealed Resident #139 was cognitively intact, received a diuretic (a drug that causes the kidneys to make more urine) daily, was always incontinent of bowel and bladder, and was dependent with incontinence care and toileting.	F0550		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0550 SS = D	Continued from page 2 An interview with Resident #139 was conducted on 08/05/25 at 11:32 AM. Resident #139 stated that a few weeks ago she had an incontinent episode early in the morning. She asked to be changed, and no one came back to change her. She reported that she laid in wet briefs all day until her daughter arrived sometime after lunch. Resident reported she couldn't remember who the aide was on the shift. Resident stated, "I can't do anything for myself, and I don't like laying in my own filth." "I couldn't even eat my lunch the smell was so bad." Resident #139 reported this made her feel angry and upset. A telephone interview with Nursing Assistant (NA) #6 was conducted on 08/08/25 at 2:00 PM. NA #6 was familiar with Resident #139 and the incident that occurred on 07/20/25. She reported she was out in the hall with NA #7, when Resident #139's daughter stepped into the hall and asked them who her mother's NA was. NA #6 reported she told the daughter it was NA #5 and asked if one of us could get her to come to the room. NA #6 reported she told her NA #5 was out with another resident and asked if we could help her with something. NA #6 indicated the daughter took her and NA #7 into the room and pulled back Resident #139's blankets and Resident #139's clothes, under pad and sheets were wet. NA #6 indicated she apologized and told the daughter she was unsure of what had happened as Resident #139 was not on her assignment and she had just started her shift. NA #6 reported she told the daughter she would go get some clean linens and would bathe Resident #139. NA #6 reported she told NA #7 to let her get the Unit Manager before she began cleaning up Resident #139. NA #6 stated she could tell Resident #139 had been laying in soiled clothes and sheets for a while as there was a ring where the urine had started to dry. NA #6 indicated she could tell it was urine because of the smell. NA #6 stated she made the Unit Manager aware of the situation on her way to get clean linens and the Unit Manager went to the room to assess the resident. NA #6 reported she had never been aware of Resident #139 refusing care A telephone interview with NA #7 was conducted on 08/08/25 at 2:50 PM. NA #7 was familiar with Resident #139 and the incident that occurred on 07/20/25. She reported she was out in the hall with NA #6, when Resident #139's daughter stepped into the hall and asked them who her mother's NA was. NA #6 told her it was NA #5. NA #7 indicated the daughter asked if one of us could get NA #5 to come to the room. NA #6 told the daughter she was out with another resident and asked if they could help her with something. The daughter them	F0550		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0550 SS = D	Continued from page 3 into the room and pulled Resident #139's blankets back and she observed wet clothes, under pad and sheets. She (NA #7) and NA #6 apologized and told her we were unsure of what had happened as Resident #139 was not on either of our assignments and they both had just started our shifts. NA #6 told the daughter she would go get some clean linens and bathe Resident #139. NA #7 explained while NA #6 was gone she removed the pillow from under Resident #139's knees and found a soiled brief. NA #6 notified the Unit Manager of the situation, and she came in to assess the Resident. The interview further revealed they all worked together to get Resident #139 cleaned up and in dry clothes and linens. Resident #139 has never refused care when she was on my assignment. Three attempts were made to contact NA #5 and there was no ability to leave a voicemail, and no return call or text was received. An interview with the Nurse/Unit Manager #7 was conducted on 08/08/25 at 3:00 PM. Nurse #7 stated Resident #139 was always incontinent of bowel and bladder. Nurse #7 reported, that several weeks ago around 3:00 PM, NA #6 told her, Resident #139 was laying in urine. She reported she went to the room and Resident #139's daughter was quite angry because her mother was soaking wet with urine. Nurse #7 reported that upon entering the room, she noticed a strong urine smell and observed Resident #139 lying in bed with wet clothes, under pad and sheets and a soiled brief lying at the foot of her bed. There were rings around her body on the sheets and under pad where the urine had begun to dry. Nurse #7 recalled Resident #139's daughter asked her had Resident #139 been changed at all today. Nurse #7 reported she told Resident #139's daughter she had to assume Resident #139 had not from the looks of her bed. Nurse #7 stated no one had reported to her that Resident #139 had refused care during the shift. Nurse #7 reported that Resident #139 would refuse care sometimes. An interview with the Director of Nursing (DON) was conducted on 08/08/25 at 3:45 PM. The DON stated Resident #139 was incontinent of bowel and bladder. The DON indicated Resident #139's daughter made her aware of the incident the day it happened. A grievance was filed and an investigation done which resulted in the termination of NA #5. DON reported that NA #5 reported to her during the investigation that Resident #139 had refused care all day. NA #5 did not report this to any unit manager or supervisor. An interview with the Administrator was conducted on	F0550		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0550 SS = D	Continued from page 4 08/08/25 at 4:00 PM. The Administrator stated she expected staff to provide care to all residents and if care was being refused then to report that to the Unit Manager or the DON. The Administrator stated she was made aware of the situation during the investigation process and was in agreement with the decision to terminate NA #5 due to her not making anyone aware of Resident #139 refusing care and allowing her to remain wet all day.	F0550		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by:	F0583		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0583 SS = D	Continued from page 5 Based on record reviews, staff, and family interviews, the facility failed to protect private health information for residents when they provided Resident #153's medical records and a list of resident names, room numbers, medical record numbers, and allergies to Resident #43's Representative at a medical appointment. This deficient practice affected 1 of 2 residents reviewed for privacy (Resident #153). The findings included: Resident #153 was admitted to the facility on 06/03/24 and was discharged on 03/23/25. Resident #43 was admitted to the facility on 07/20/23. A review of Resident 43's neurology consultation form dated 08/15/24 revealed that the provider documented "sent wrong medical records on Resident #153, as well as allergies for every resident" in the facility. A telephone interview was conducted with Resident #43's Representative on 08/07/25 at 8:41 AM. Resident #43's Representative reported he attended a medical appointment for Resident #43 on 08/15/24. The Representative stated that the facility transport staff handed the Representative an envelope prior to the appointment in the waiting room. When Resident #43 was taken to the exam room, the provider asked questions that did not pertain to Resident #43. The Resident Representative reported he and the physician looked at the paperwork in the envelope and it was not Resident #43's information. The Resident Representative indicated the medical office called the facility to get the medical records for Resident #43 and waited almost an hour for the correct forms to be faxed over to the provider. During the telephone interview, the surveyor asked what information was in the envelope, and Resident Representative stated, "hold on, I'll tell you" and began rustling papers. Resident Representative stated that the papers listed of all the facility resident names, their medical record numbers, their room numbers, and their allergies. The Resident Representative stated the physician order printout which included diagnosis list for Resident #153's was also in the envelope. The Resident Representative confirmed he was still in possession of the information. When asked if the doctor's office had given the information back to him to keep, the Resident Representative said he could not recall and stated he needed to get off of the phone. A telephone interview was conducted with the Neurology Office Supervisor on 08/07/25 at 10:02 AM. Neurology	F0583		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0583 SS = D	Continued from page 6 Office Supervisor stated that the provider who had seen Resident #43 on 08/15/24 had retired. The Neurology Office Supervisor indicated that when residents attend medical appointments, the transportation staff bring the relevant health information to the appointment but do not enter the exam room with the residents. The Neurology Office Supervisor stated the provider documented incorrect records were brought to the appointment on the consultation form. A written statement dated 08/15/24 at 9:30 AM written by the Transporter stated, “I took some papers off the printer, looked at the first few pages and they were for resident (Resident #43) who I was transporting”. An interview with the Transporter was conducted on 08/07/25 at 10:59 AM. The Transporter stated that prior to the appointment for Resident #43, he grabbed the papers off the printer. The Transporter reviewed the papers, and the first few pages belonged to Resident #43. At the appointment, Resident #43’s Representative was present, and the Transporter handed the envelope to Resident #43’s Representative. The Transporter overheard the receptionist and representative discuss the paperwork, but they did not ask the Transporter any questions. The Transporter stated no files were received back from the resident representative after the appointment and was unsure where the paperwork went. Nurse #4 completed a written statement dated 08/15/24. Nurse #4 “attempted to print out the face sheet and order report for Resident #43. Another resident’s information was also printed. The transporter agreed to pick up copies from the printer”. According to the statement, Nurse #4 received a phone call that AM from the neurology office that the incorrect medical records were sent to the appointment. Information for Resident #43’s appointment was faxed to the neurology office. A telephone interview was attempted with Nurse #4 on 08/07/25 at 11:42 AM. Nurse #4 was not available for interview. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the day of Resident #43's appointment, Resident #153’s health information was inadvertently sent to the appointment. The health information sent incorrectly included a diagnosis list and physician orders for Resident #153, and a list of all facility residents' names, medical record numbers, room numbers, and the residents' allergies. The Administrator stated that a breach report was filed with the Department of Health and	F0583		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0583 SS = D	Continued from page 7 Human Services. The Administrator stated that all facility resident representatives were notified of the information breach. Resident #153's representative was notified of the specific breach of health information. The Administrator stated that Resident #43's Representative retained the medical records. The Administrator reported that the Resident Representative was contacted repeatedly by the Administrator and by Corporate to return the medical records but refused and stated he wanted "to prove a point" and had not been returned.	F0583		
F0600 SS = SQC-J	Free from Abuse and Neglect 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 reviews, resident, staff, resident representative, and Nurse Practitioner (NP) interviews, the facility failed to protect the resident's right to be free from abuse for 4 of 30 residents reviewed for abuse (Resident #32, Resident #59, Resident #86, and Resident #125). On 05/09/25, Resident #32 was heard yelling for help when Resident #154 entered Resident #32's room and grabbed her by the neck and pinned her against the wall. Resident #32 was noted to be swatting at Resident #154 to free herself. Resident #154 sustained scratches to left ear. On 04/20/25, Resident #154 balled up his fist and hit Resident #86 in the mouth. Resident #86 sustained a cut to her upper lip with bleeding. On 04/17/25, Resident #32 was heard yelling for help when Resident #154 entered Resident #32's room and grabbed her arm and pulled it. When staff arrived, Resident #32 was noted to be swatting at Resident #154 in an attempt to free herself. Resident	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 8 #154 sustained scratches to left eye and left lip. On 08/16/24, Resident #156 hit Resident #125 on the left shoulder and placed his hands around her neck causing a 2-centimeter by 2-centimeter (cm) reddened area to Resident #125's left shoulder. The facility also failed to protect the resident's right to be free from sexual abuse for 1 of 30 residents reviewed for abuse (Resident #59). On 08/29/24, Resident #156 and Resident #59 were observed in the hallway. Resident #156 had one hand down the front of Resident #59's brief, and one hand down the back of Resident #59's brief. A reasonable person would expect to be protected from abuse in their own home and would expect to experience mental anguish with feelings such as fear, humiliation, anxiety, anger, and depressed mood after experiencing physical or sexual abuse. This deficient practice was for 4 of 30 residents reviewed for abuse (Resident #32, Resident #59, Resident #86, and Resident #125). Immediate jeopardy began on 05/09/25 when Resident #32 was in her bedroom when Resident #154 entered her room, grabbed her by the neck, and had her pinned against the wall in the corner. The immediate jeopardy was removed on 08/10/25 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the following examples: 1b (Resident #86), 1c (Resident #32), 2a (Resident #59), and 2b (Resident #125) to ensure education and monitoring systems put into place are effective. Findings included: 1a. Resident #32 was admitted to facility on 09/24/24 and resided in a locked memory care unit. Resident #32's diagnoses included Alzheimer's disease, dementia in other diseases with behavioral disturbance, generalized anxiety disorder, and depression. A review of Resident #32's quarterly Minimum Data Set (MDS) dated 04/01/25 revealed Resident #32 was severely cognitively impaired, required supervision for all activities of daily living (ADLs), and used a walker for ambulation. Resident #32 received antipsychotics and antidepressants daily. Resident #32 was coded for having adequate hearing and vision, usually able to make herself understood, and able to understand others. A review of Resident #32's care plan initiated 10/14/24 revealed plan for diagnosis of anxiety. Stated goal was Resident #32 would show decreased signs of anxiety. Interventions included allow Resident #32 to verbalize	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 9 her feelings, monitor for changes in mood, and monitor for adverse reactions to anxiety medications. Hospital discharge instructions prior to admission to facility dated 09/20/24 revealed Resident #154 was admitted to the hospital on 09/03/24 for evaluation of increased confusion and hallucinations. Resident #154's hospital discharge note indicated a sitter was required during hospital stay but was discontinued 48 hours prior to discharge. Resident #154 required medication for agitation up to 24 hours prior to discharge from the hospital. Behavioral disturbances noted in the hospital discharge note included agitation. Discharge instructions were to continue current medications as ordered after discharge. Resident #154 initially admitted to the facility on 09/23/24 and readmitted on 04/26/25. Resident #154 discharged from facility to hospital on 05/09/25. Resident #154's diagnoses included unspecified dementia with other behavioral disturbances, depression, generalized anxiety disorder, and insomnia due to other mental disorders. A review of Resident #154's care plans revealed a plan initiated 10/14/24 which noted Resident #154 was verbally and physically aggressive with others (cursing and yelling at staff and other residents, threatening staff, combative with staff). The stated goal was Resident #154 would have little to no episodes of behavior during the next review period. Interventions included: allow resident time to calm down in a safe and quiet place when agitation occurred, redirect Resident #154 when behaviors occurred, notify the provider of mood or behavioral changes, document behaviors, monitor Resident #154 for medication side effects, and notify the psychiatric provider as needed. Another care plan was initiated on 03/24/25 for Resident #154's psychotropic drug use related to the diagnosis of dementia with behavioral disturbance. The stated goal was Resident #154 will have no negative events associated with psychotropic medications. Interventions included monitor Resident #154 for adverse reactions such as sedation and notify the provider of adverse reactions. Another care plan initiated 04/18/25 stated Resident #154 was the aggressor in a resident-to-resident altercation. The stated goal was Resident #154 would exhibit no symptoms of agitation resulting in altercations. Interventions included notify the provider for changes in mood or increased agitation, monitor behaviors during activities and while around other residents, redirect Resident #154, and provide 1:1 support as needed.	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 10 Physician orders for Resident #154 revealed Resident #154 received the following medications: · An order written 09/23/24 for mirtazapine (an antidepressant) 7.5 milligrams by mouth daily at bedtime. · An order written 11/11/24 for escitalopram (an antidepressant) 20 milligrams by mouth daily. · An order written 04/21/25 for valproic acid delayed release tablet (an anticonvulsant used as a mood stabilizer) 250 milligrams by daily at 12:00 PM and 500 milligrams by mouth daily at bedtime. · An order written 04/25/25 for quetiapine (an antipsychotic) 75 milligrams by mouth daily in the AM and 100 milligrams by mouth daily in the PM. · An order written 04/30/25 for haloperidol (an antipsychotic) solution 5 milligrams per milliliter. Administer 1 milliliter (equals 5 milligrams) injection intramuscularly (in the muscle) daily as needed for increased anxiety, behaviors causing danger to self or others, or aggressiveness for 14 days. A Psychiatric Nurse Practitioner consultation note dated 02/11/25 for Resident #154 was reviewed. The consultation note stated Resident #154 had been assessed due to increased anxiety and agitation on 02/11/25. Assessment of Resident #154 revealed he appeared anxious and restless. Staff reported Resident #154 was agitated, exit seeking, yelled and cursed at staff, was combative with staff, and had attempted to aggress on other residents. The note revealed Resident #154's agitation was ongoing from 02/07/25 through the Psychiatric Nurse Practitioner's assessment date of 02/11/25. The Psychiatric Nurse Practitioner's recommendations from assessment were to increase Resident #154's daily dose of quetiapine (an antipsychotic medication). A review of Resident #154's quarterly MDS dated 04/03/25 revealed Resident #154 was severely cognitively impaired. Resident #154 coded for having behaviors 1 to 3 days in the 7-day look-back period. These behaviors included: Physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others Resident #154 was not coded for refusal of care or wandering. Resident #154 received antipsychotic medications daily, antidepressant medications daily, and anticonvulsant (used as a mood stabilizer) medications daily. Resident	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 11 #154 required partial assistance with ADL and walked independently. Resident #154 coded as having impaired vision (required large print), no hearing deficits, and clear speech. A facility incident report dated 05/09/25 at 4:50 PM was completed for Resident #32. Nurse #2 completed the incident report because of the resident-to-resident altercation involving Resident #154. The incident report revealed Resident #32 was in her room when Resident #154 entered Resident #32's room and cornered Resident #32 with hands around her neck. The incident report noted Resident #32 exhibited fear after the incident. Interventions used for Resident #32 after the altercation included redirection and simplifying the environment. A progress note dated 05/09/25 at 4:39 PM written by the Infection Preventionist revealed Resident #32's Representative was notified of altercation of Resident #154 in Resident #32's room with hands around Resident #32's neck. A review of skin assessment completed by the Infection Preventionist, dated 05/09/25 for Resident #32 revealed no bruising or injury noted after 05/09/25 incident. A progress note dated 05/10/25 at 12:50 PM written by Director of Nursing (DON) revealed daily body audits were added for 3 days because of altercation with Resident #154. A progress note dated 05/10/25 at 4:34 PM written by Nurse #2 stated a body audit was performed and no injury was noted. Resident #32 noted to be in a pleasant mood in facility dayroom at time of assessment. No other notes related to the incident or further body audits were documented in Resident #32's progress notes. An interview with Resident #32 was conducted on 08/06/25 at 2:24 PM. The surveyor asked Resident #32 if she recalled the incident involving Resident #154. Resident #32 stated "Oh yes, I remember". Resident #32 (who was 84-years-old) then verbalized, "I don't know why an older man would want to do to a little girl, I was so young, and he touched me all over". Resident #32 then verbalized "to this day, I am still scared of older men". A telephone interview was attempted on 08/08/25 at 1:13 PM with Resident #32's Representative. Resident Representative was unwilling to be interviewed.	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 12 A facility incident report dated 05/09/25 at 4:31 PM was completed by Nurse #2 for Resident #154. The incident report revealed Resident #154 entered Resident #32's room, grabbed Resident #32's by the neck, and pinned Resident #32 in the corner of the room with her back against the wall. Resident #32 was noted to be hitting Resident #154 in an attempt to free herself. Resident #154 sustained scratches to left ear. Resident #154 noted to be wandering unit prior to the incident. Wandering recorded as occurred daily for Resident #154 and intruded on the privacy or activity of others. Resident #154 noted entering another resident's room immediately after the incident. Interventions included redirection and a simplified environment. The incident report noted Resident #154 was transferred to the hospital on 05/09/25 related to multiple resident altercations. A handwritten untimed statement dated 05/09/25 written by Nurse Aide (NA) #1 revealed NA #1 heard Resident #32 yelling "help me" from Resident #32's room. NA #1 entered Resident #32's room and observed Resident #154 had Resident #32 "by the neck". NA #1 reported Resident #32 and Resident #154 were separated, and nurse notified. A telephone interview was attempted with NA #1 on 08/08/25 at 9:22 AM. NA #1 was not available for interview. A progress note dated 05/09/25 at 4:31 PM written by the Infection Preventionist revealed Resident #154 had an altercation with another resident in the other resident's room. Resident #154 was noted with his hands around Resident #32's neck. Resident #154 entered another resident's room after staff redirected him out of Resident #32's room. The Administrator and Resident #154's Representative notified. A progress note dated 05/09/25 at 6:07 PM written by the Infection Preventionist noted the on-call provider was notified of the altercation and Resident #154 exited the building at 6:01 PM via Emergency Medical Services for the hospital. An interview with Nurse #2 was conducted on 08/08/25 at 11:43 AM. Nurse #2 was assigned to Resident #32 and Resident #154 on 05/09/25. Nurse #2 stated on 05/09/25, Resident #32 was heard calling for help from her bedroom. Nurse #2 reported NA #1 responded to Resident #32's room and witnessed Resident #154 in front of Resident #32 who was pinned with back against the wall in the inner corner of the room. NA #1 reported to Nurse #2 he observed both of Resident #154's hands	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 13 around her neck. Nurse #2 stated Resident #32 and Resident #154 were separated when staff arrived at room. The Infection Preventionist was also on the unit at the time and responded to the incident. Nurse #2 stated Resident #32 was assessed for injury and none were noted. Resident #154 assessed for injury and superficial scratches to the left ear noted. The scratches to Resident #154's ear did not require treatment. Nurse #2 reported Resident #32 was not crying but was shaking after the altercation. Nurse #2 recalled Resident #32 was in the dayroom after the altercation and appeared "distraught" but could not indicate what distraught meant. Nurse #2 could not recall if Resident #32 verbalized anything to her at the time of the incident. Nurse #2 stated Resident #154 continued to be agitated after the incident. Nurse #2 verbalized Resident #154 had a history of aggression to other residents. When Resident #154 continued to be agitated, the on-call provider was notified and a 1-time order for medication was administered to Resident #154. Nurse #2 could not recall what medication was administered. Resident #154 transferred to the hospital due to continued agitation for an involuntary psychiatric hold. Nurse #2 stated Resident #32 and Resident #154's responsible parties were notified of the altercation. An interview with the facility Nurse Practitioner (NP) was conducted on 08/07/25 at 1:18 PM. The NP stated if a resident had increased agitation, they were evaluated to rule-out physical cause of agitation. The NP indicated labs such as urinalysis would be collected to rule out infection. If a resident would not calm down, the on-call or on-duty NP would order a 1-time dose of medication, then would reassess effectiveness. The NP recalled Resident #154 and stated the Psychiatric Nurse Practitioner took over Resident #154's care because of his ongoing behaviors. The NP reported that the Psychiatric Nurse Practitioner would discuss any medication changes with the NP. The NP knew several medication changes had occurred for Resident #154, and he continued to have periods of agitation even with medication changes. The NP reported that Resident #154 had a long history of violent behaviors and family had reported to the facility that he had been aggressive at home prior to his first hospitalization. The NP was off duty on the date 05/09/25 but was notified of the altercation between Resident #32 and Resident #154 the next day. A telephone interview with the Psychiatric Nurse Practitioner was conducted on 08/07/25 at 1:17 PM. The Psychiatric Nurse Practitioner recalled Resident #154 well. The Psychiatric Nurse Practitioner verbalized	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 14 Resident #154 had severe aggressive behaviors and was “a lot” to manage. The Psychiatric Nurse Practitioner stated Resident #154 was not appropriate for the facility, but Resident #154 was a family member of a facility staff member, so they kept him. The Psychiatric Nurse Practitioner had discussed with administrative staff it was unsafe to leave Resident #154 in the facility because of his behavior and verbalized it placed others at risk for significant harm. On 05/09/25 when Resident #154 was transferred to the hospital, the Psychiatric Nurse Practitioner spoke with hospital staff prior to Resident #154 being discharged back to the facility. The Psychiatric Nurse Practitioner reported during a team discussion on 05/09/25 that Resident #154 would be accepted back to the facility, but they would have to manage him "aggressively" with medication such as haloperidol (an antipsychotic medication), which they would not normally order because of his severe behaviors. However, Resident #154 did not return to the facility. A statement written by Social Worker dated 04/23/25 at 11:30 AM revealed that Social Worker was notified on that date that Resident #154’s family had disclosed to provider that Resident #154 had a history of physical aggression. This physical aggression was reported by family to “the point of almost murdering his first wife and being put in prison”. Resident #154 was hospitalized and family “expressed that hospital staff met with family and told family that resident needed to be in a geriatric psychiatric inpatient” unit. Statement also revealed family was not in agreement with that placement due to concern family could not visit Resident #154. Family also reported that prior to Resident #154 being hospitalized on 09/03/24, Resident #154 was “aggressive at home”. An interview with the Social Worker was conducted on 08/08/25 at 11:55 AM. The Social Worker stated that after any resident-to-resident altercation, staff assessed residents involved for injury, nursing staff would perform body audits for 3 days, head trauma protocol if indicated, and notify the provider. The Social Worker performed monitoring for Resident #32 after the altercation for several days and Resident #32 did not recall the altercation. The Social Worker was not aware of any trauma in Resident #32’s past. The Social Worker verbalized because of Resident #32’s inability to recall the incident, it was determined there were no adverse effects from the altercation. The Social Worker did not produce any documentation of Resident #32’s assessment after the incident. The Social Worker verbalized that she became aware from family on 04/23/25 that Resident #154 had a history of	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 15 violent behavior and had reportedly almost murdered his first wife. The Social Worker stated they were not aware of any history of aggression when Resident #154 was admitted. The Social Worker reported Resident #154 transferred to the hospital on 05/09/25 due to continued agitation and was involuntarily committed. An interview with the DON was conducted on 08/08/25 at 12:05 PM. The DON indicated the staff reported the altercation between Resident #32 and Resident #154 at the time it occurred. The DON indicated the incident was investigated thoroughly, neither Resident #32 nor Resident #154 had any significant injuries. The DON verbalized when resident-to-resident altercations occurred, staff would separate the residents involved, move them to a safe location, assess each resident for injury, place a resident 1:1 for safety, and notify the DON and the Administrator. The DON stated that Resident #154 was placed 1:1 for safety after the incident until he transferred to the hospital about an hour later. The DON stated if the residents involved sustained significant injury, the medical provider would also be notified. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operating Manual for abuse allegation investigation. The Administrator verbalized due to both Resident #32 and Resident #154 being severely cognitively impaired, it was determined there was no willful intent from Resident #154 to harm Resident #32 therefore it would not constitute abuse. The Administrator stated the Social Worker assessed Resident #32 for several days after the incident and Resident #32 could not recall the altercation. The Administrator stated that Resident #154 had ongoing behaviors and would have location tracking (30-minute checks) initiated if agitated until calm. Resident #154 was placed 1:1 for safety after the incident until he transferred to the hospital two hours later and was involuntarily committed due to his aggressive behaviors. The Administrator reiterated that without willful intent, she felt no abuse had occurred. The Administrator was notified of immediate jeopardy on 08/08/25 at 5:59 PM. The facility provided the following IJ removal plan: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The identification of the residents is the following:	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 16 Resident #154 was discharged from the facility on 05/09/25 for involuntary commitment to the hospital and did not return to the facility. On 05/09/25 at 4:30 PM it was observed by a NA #1 Resident #154 had walked into Resident #32's room where an altercation occurred. Resident #154 had grabbed resident #32 by the neck. At the time of the altercation staff immediately separated the residents and assisted Resident #154 back to his room. Incident on 05/09/25 with Resident #154 and Resident #32. Resident #32 had no injury noted on her body according to the incident report. Resident #32 was assessed by Nurse #2 at the time of the altercation and was noted to be fearful. NA #1 provided 1:1, and redirection until Resident #32 was calm and displayed no further signs of fear. Resident #32 currently does not recall incident due to having severely impaired cognition and is at baseline with her psychosocial wellbeing. Incident on 04/20/25 with Resident #154 and Resident #86. Resident #86 stated Resident #154 hit her due to no one witnessing the incident. Resident #86 sustained a cut to her upper lip. Resident #86 was and is currently at baseline for her psychosocial well-being. Incident on 04/17/25 with Resident #154 and Resident #32. Resident #32's arm was pulled by Resident #154. No injury was noted to Resident #32 who was assessed to be at baseline with her psychosocial wellbeing. Resident #154 was noted with small scratch under left eye and small reddened area to lower left side of lip. No other injuries were noted. Both residents were immediately separated, provided a calm environment, and monitored for any distress. On 08/29/24 Resident #156 was observed by nurse placing both his hands in Resident #59's brief. Residents were separated immediately, and skin audit was performed and no injuries noted to Resident #59. One-on-one caregiver assigned to monitor Resident #156. Resident #59 had no distress noted and accepted a snack during one-on-one visit with her. Resident #59 was placed on hourly checks to ensure no emotional distress and there was no distress noted. Resident #59 is currently at baseline with her psychosocial wellbeing. On 08/16/24 Resident #156 was observed hitting Resident #125 on the left shoulder and then placed his hands around Resident #125's neck. Resident #156 was assisted back to his room, provided a calm environment, and was administered his bedtime medications to calm him. Resident #125 sustained a reddened area to left	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 17 shoulder which measured 2 centimeters by 2 centimeters. There were no visible injuries noted around the resident's neck and was noted to be at baseline for her psychosocial well-being and currently is as well. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. White Oak Manor – Kings Mountain will ensure to protect severely cognitively impaired residents from resident-to-resident abuse. Corrective Actions: Current residents in the memory care unit (rooms 313-326) were potentially at risk for adverse outcome from resident-to-resident abuse. An audit of current resident care plans was completed on 08/08/25 by the Administrator and Social Services Director to identify potential residents who could present with aggressive behaviors. Beginning 08/08/25 at 11:00 PM the identified residents were placed on location and behavioral mood status monitoring every 30 minutes. On 08/08/25 the DON educated nurses and NAs working on the memory care unit on how to complete the new location and behavior tracking for the identified high-risk residents who had potential for aggressive behaviors. The nurses and NAs were also educated about steps to take if a resident exhibited anxious or aggressive behavior. 30-minute monitoring will be completed by either an NA or nurse assigned to the memory care unit. Monitoring will be reviewed by the management nurse Monday through Friday, and the charge nurse on duty for 7:00 AM to 3:00 PM shift on Saturday and Sunday. Beginning on 08/08/25 at 3:00 PM, the facility increased staff numbers in the memory unit by 2 NAs on 1st shift (7:00 AM to 3:00 PM) and 2nd shift (3:00 PM to 11:00 PM) and 1 NA on 3rd shift (11:00 PM to 7:00 AM), bringing the total staff to 5 NAs on 1st and 2nd shifts and 2 NAs on 3rd shift. On 08/08/25 the Staffing Coordinator was notified by the DON and Administrator that additional staffing would be implemented in the memory care unit. This staffing ratio would continue indefinitely. On 08/08/25 the DON educated NAs and nurses on the memory care unit that staffing numbers would be increased. This provided additional monitoring for residents on the memory care unit who had the potential for aggressive behaviors, to prevent further resident-to-resident altercations. Until additional activity personnel are hired, the Activities Director will be assigned to the memory care	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 18 unit Monday through Friday 8:00 AM to 4:00 PM to provide activities and one-on-one interactions as needed. Beginning on 08/09/25 the facility will assign 1 additional nurse from Monday through Friday, which would total 2 nurses assigned to the memory care unit on the weekdays. During the weekend, a minimum of 1 nurse and 1 medication aide would be assigned to the memory care unit during the weekends. On 08/08/25 the Administrator notified the staffing coordinator to schedule the additional nurses. On 08/08/25, the DON educated the additional nurses assigned to the memory care unit on ensuring the 30-minute checks were completed. Nurses who worked in the memory care unit were notified staffing numbers were increased to provide additional monitoring for residents who had potential for aggressive behaviors to prevent further resident-to-resident altercations. All current staff members were re-educated on the abuse protocol which included the identification of resident-to-resident abuse, reporting abuse, and investigating the abuse thoroughly to prevent further abuse. The re-education also included behavioral training to deescalate aggressive behaviors. Nurses and NAs assigned to the memory care unit were educated on performing 30-minute checks for the high-risk residents with the potential for aggressive behaviors. Staff were also educated how to deescalate behaviors, to provide 1:1 care for any resident demonstrating anxious or aggressive behaviors, and to report the behavior to the provider if interventions were unsuccessful. The reeducation was completed by Nursing Administration, department directors for Nursing, Social Services, Therapy, Activities, Maintenance, Dietary, and Housekeeping. The reeducation was completed on 08/08/25 in person and by telephone. Newly hired staff would receive this training during their job specific orientation with the Staff Development Coordinator or Social Services Director. Nursing Administration and Social Services Directors would monitor by checking the 24-hour reports to ensure no resident-to-resident altercations or abuse occurred, and the location/behavioral mood monitoring had been completed. All corrective actions were implemented by 08/10/25. Alleged date of immediate jeopardy removal: 08/10/25. The facility's IJ removal plan was validated on 08/12/25 by the following: A review of staff inservices	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 19 from 08/08/25 related to reporting of abuse and neglect. Inservices reviewed were for all staff from every department. The inservice included a description of types of abuse, identifying signs of abuse, and what is considered reportable. Interviews with facility staff from each department revealed they had received education on abuse and neglect and reporting physical and sexual abuse and neglect on 08/08/25. Staff interviewed discussed different scenarios and were able to describe types of abuse, and what steps they would take in the event of resident-to-resident altercation, abuse, or neglect. Staff stated if abuse or neglect had been witnessed, suspected, or reported, they would immediately separate the residents, call additional staff for help, and would not leave the residents alone to verify their safety from further abuse. Staff verbalized a nurse would be notified immediately to complete assessment of the residents involved. Staff interviewed described the process for notification of administrative staff of incidents of abuse or neglect. Staff stated all high-risk residents for aggressive behaviors had been identified, and every 30-minute location tracking was performed by one assigned staff every shift. If a resident aggressed toward a peer, resident would be placed 1:1 staffing for safety. Facility staff stated no further resident-to-resident altercations had occurred. A review of facility orientation education for new hires included education on facility abuse and neglect policy and reporting abuse and neglect. A review of staff assignment sheets revealed the staff had been increased on the memory care unit. An assigned staff was noted each shift to complete the 30-minute location tracking for each high-risk resident. A review of high-risk resident location tracking data sheets revealed every 30-minute tracking for each high-risk resident had begun on 08/08/25 at 11:00 PM and remained ongoing through 08/12/25. Staff verbalized 30-minute tracking would continue indefinitely. Interview with the Administrator and DON revealed they had received training from their corporate staff regarding abuse and neglect, sexual behaviors, and protocols for reporting abuse and neglect to the appropriate agencies. Staff had been educated in person or via telephone, and all staff were able to demonstrate their understanding of the education they had received. The facility's immediate jeopardy removal date was validated as 08/10/25. The following examples were cited at a lower scope and severity of E: b. Resident #86 was admitted to facility on 11/08/2024	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 20 and resided on a locked memory care unit. Resident #86's diagnoses included unspecified dementia with other behavioral disturbance, generalized anxiety disorder, and depression. A review of Resident #86's quarterly MDS dated 02/15/25 revealed Resident #86 was severely cognitively impaired, required supervision for all activities of daily living (ADL), and used a walker for ambulation. Resident #86 received antianxiety and antidepressants daily. Resident #86 was coded for having adequate hearing and vision, usually able to make herself understood, and able to understand others. Resident #86's care plan initiated 11/26/24 revealed a plan for the diagnosis of anxiety. The stated goal was Resident #86 would show decreased signs of anxiety. Interventions included allow Resident #86 to verbalize her feelings, monitor for changes in mood, and monitor for adverse reactions to anxiety medications. Resident #86 also had a plan for diagnosis of depression dated 11/26/24 and revised 07/28/25. The stated goal was Resident #86 would show decreased signs of depression. Interventions included allow Resident #86 to verbalize her feelings, monitor for changes in mood, and monitor for adverse reactions to antidepressant medications. A facility incident report dated 04/20/25 at 9:02 PM for Resident #86 was completed by Nurse #2 because of a resident-to-resident altercation with Resident #154. The incident report revealed Resident #86 was in her room when Resident #154 entered Resident #86's room and had fist balled up "making contact" with Resident #86's face. Incident report described the injury to Resident #86 as "small area to upper lip with small amount of blood. Bleeding stopped. No swelling noted. No complaints of pain or discomfort". The incident report noted Resident #86 exhibited anger during the incident. Interventions for Resident #86 included redirection, location tracking, and simplifying the environment. A progress note dated 04/20/25 at 11:06 PM written by Nurse #8 revealed Resident #86 was heard yelling loudly from her room. Staff arrived and observed Resident #154 standing in front of Resident #86 with his hand balled up into a fist. Resident #86 stated "he hit me" and Resident #154 was removed from Resident #86's room. Resident #86 was assessed, and top lip was noted with a small amount of blood, but no swelling. Resident #86 stated to staff "I am not hurt" and was noted to be very angry repeating "why did he do that"? Resident #86 was given a snack and calmed down. Resident #86's Representative was notified of the altercation.	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 21 A progress note dated 04/21/25 at 6:28 PM written by Nurse #1 revealed Resident #86 had no complaints of mouth pain and no change in eating habits and was in a pleasant mood. A progress note dated 04/22/25 at 10:48 PM written by Nurse #1 noted Resident #86 had location tracking, had no complaints of pain or discomfort related to cut to upper lip. Resident #86 was not interviewable due to dementia. A telephone interview was attempted with Resident #86's Representative on 08/08/25 at 2:12 PM. Resident #86's Representative was unavailable for interview. A physician order dated 04/23/25 revealed Resident #154 was transferred to the hospital via Emergency Medical Services for a psychiatric evaluation on 04/23/25 because of ongoing agitation and aggression. A facility incident report dated 04/20/25 at 9:02 PM for Resident #154 was completed by Nurse #2 due to a resident-to-resident altercation. The incident report revealed Resident #154 was exhibiting increased agitation. Resident #154 entered Resident #86's room, balled up his hand into a fist and hit Resident #86 in the mouth. Report documented Resident #154 sustained no injury. Resident #154 was noted to have aggression toward others for 1 to 3 of the previous 7 days. The incident report stated Resident 154's behavior placed others at risk for injury. Interventions included redirection and simplified environment. Note for follow-up with NP for medication review due to increased behaviors and 2 resident altercations. A progress note dated 04/20/25 at 10:49 PM written by Nurse #6 revealed Resident #154 was agitated prior to the altercation. Resident #154 was noted "yelling loudly, throwing notebooks off the desk, and attempting to shove staff". Resident #154 was redirected and had a snack and appeared calm. Staff then heard Resident #86 yelling and entered the room to find Resident #154 with his hand balled into a fist. Resident #86 stated to staff "he hit me" and was assessed with a cut with a small amount of blood on her upper lip. Resident #154 was removed from Resident #86's room and when calm told staff "I am so sorry, I should not have done that". A handwritten statement dated 04/20/25 at 7:10 PM written by NA #2 revealed NA #2 heard Resident #86 shouting coming from Resident #86's room. NA #2 entered Resident #86's room and observed Resident #154 and Resident #86 standing in doorway. NA #2 observed	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 22 Resident #154 had “fist balled up to Resident #86’s face making contact”. Resident #154 and Resident #86 were immediately separated, and NA #2 notified the nurse. A telephone interview was attempted with NA #2 on 08/08/25 at 10:12 AM. NA #2 was not available for interview. An interview with Nurse #2 was conducted on 08/08/25 at 11:43 AM. Nurse #2 was assigned to Resident #86 and Resident #154 on 04/20/25. Nurse #2 stated on 04/20/25, Resident #86 was heard calling for help in her bedroom. Nurse #2 reported NA #2 responded to Resident #86’s room and witnessed Resident #154 in front of Resident #86 with fist balled up hitting Resident #86 in the face. Nurse #2 stated Resident #86 and Resident #154 were separated when staff arrived at room. Nurse #2 stated Resident #86 was assessed for injury and had a small cut to her upper lip. Resident #154 was assessed for injury and had none. Nurse #2 reported Resident #86 was upset after the incident. Nurse #2 could not recall if Resident #86 verbalized anything to her at the time of the incident. Nurse #2 stated Resident #154 continued to be agitated after the incident. Nurse #2 verbalized Resident #154 had a history of aggression to other residents. Resident #154 placed on location tracking with every 15-minute checks for safety until he went to bed. A hospital psychiatry consultation dated 04/24/25 revealed Resident #154 was assessed in the Emergency Department on 04/23/25 for chief complaint of “aggressive and violent behaviors”. Resident #154 had “been violent, hitting other clients, and throwing items”. The hospital psychiatric provider documented a discussion with the facility Psychiatric Nurse Practitioner, who reported Resident #154 had physical altercations with 2 other residents that week. The Facility Psychiatric Nurse Practitioner reported concern related to Resident#154’s unpredictable behaviors. Recommendations from hospital psychiatry provider were to continue Resident #154's current medications. The psychiatry consult report stated Resident #154 was not appropriate for psychiatric facility because of calm behavior during his assessment. An interview with the Social Worker was conducted on 08/08/25 at 11:55 AM. The Social Worker performed monitoring for Resident #86 after the altercation for several days and Resident #86 did not recall the altercation. The Social Worker verbalized because of Resident #86’s inability to recall the incident, it was	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 23 determined there were no adverse effects from the altercation. The Social Worker did not produce any documentation of Resident #86's assessment after the incident. An interview with the DON was conducted on 08/08/25 at 12:05 PM. The DON stated that Resident #154 was placed on location tracking with every 15-minute checks for safety after the altercation. The DON stated if the residents involved sustained significant injury, the medical provider would also be notified. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operating Manual for abuse allegation investigation. The Administrator stated the Social Worker assessed Resident #86 for several days after the incident. The Administrator stated that Resident #154 had ongoing behaviors and was placed on location tracking (15-minute checks) after the altercation until calm. The Administrator reiterated that without willful intent, she felt no abuse had occurred. c. A facility incident report dated 04/17/25 at 12:30 PM for Resident #32's was completed by Nurse #6 because of a resident-to-resident altercation with Resident #154. The incident report revealed Resident #32 was in her bedroom lying in bed when Resident #154 entered Resident #32's room. Resident #32 was heard yelling "get out!!!" and "help". Staff discovered Resident #154 with hands on Resident #32's arms. Resident #32 was observed "swatting" at Resident #154 to free herself. The incident report noted Resident #32 exhibited anger after the incident. Interventions for Resident #32 included simplified environment. A progress note dated 04/17/25 at 12:24 PM written by Nurse #6 revealed Resident #32 was heard yelling due to Resident #154 in her room. Resident #32 was noted yelling "get out!!!" and "help". Staff discovered Resident #154 with his hands on Resident #32's arms. Resident #32 was observed "swatting and trying to get male residents hands released". Resident #32 was assessed and no injuries noted. Resident #32's Representative was notified. A facility incident report for Resident #154 dated 04/17/25 at 12:30 PM was completed by Nurse #6 due to a resident-to-resident altercation with Resident #32. The incident report revealed Resident #154 entered Resident #32's room. Resident #32 heard by staff screaming "get out" and "help". Resident #154 became agitated and grabbed Resident #32 and began pulling on her arms.	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 24 Resident #154 sustained scratches to left eye and small red area to lower lip. Resident #154 was noted to be wandering unit prior to the incident. Wandering was recorded as occurred daily for Resident #154 and intruded on the privacy or activity of others. Interventions included redirection and simplified environment. A progress note dated 04/17/25 at 12:21 PM written by Nurse #6 revealed Resident #154 walked into Resident #32's room. Resident #32 was heard screaming "get out" and "help". Resident #154 became agitated and grabbed Resident #32 and began pulling her arms. Staff separated Resident #32 and Resident #154. Resident #154 sustained a small scratch under left eye and small red area to lower side of left lip. A progress note dated 04/18/25 at 10:51 AM written by Nurse #2 revealed Resident #154 was calm and in a pleasant mood. Location tracking (every 30-minute checks) initiated this shift. No staff statements were available for review. A telephone interview was attempted with Nurse #6 on 08/08/25 at 10:22 AM. Nurse #6 was not available for interview. An interview with the DON was conducted on 08/08/25 at 12:05 PM. The DON indicated the incident was investigated thoroughly, neither Resident #32 nor Resident #154 had any significant injuries. The DON stated if the residents involved sustained significant injury, the medical provider would also be notified. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operating Manual for abuse allegation investigation. The Administrator verbalized due to both Resident #32 and Resident #154 being severely cognitively impaired, it was determined there was no willful intent from Resident #154 to harm Resident #32. The Administrator stated the Social Worker assessed Resident #32 for several days after the incident and Resident #32 could not recall the altercation. 2a. Resident #156 was initially admitted to the facility on 08/07/2024 and was discharged to Hospice House on 11/18/2024. Resident #156's diagnoses included senile degeneration of brain (a brain disease resulting in dementia), unspecified dementia with other behavioral disturbance, major depressive disorder, and	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 25 generalized anxiety disorder. A review of Resident #156's admission MDS dated 08/13/24 revealed Resident #156 was severely cognitively impaired. Resident #156 was coded as having behaviors 1 to 3 days in the 7-day look-back period. These behaviors included: other behavioral symptoms not directed toward others. Resident #156 was not coded for refusal of care or wandering. Resident #156 received antipsychotic medications daily, antidepressant medications daily, and anticonvulsant medications daily. Resident #156 required minimal assistance with ADL and walked independently. Resident #156 was coded for having impaired vision (required large print), no hearing deficits, and clear speech. A care plan dated 08/15/24 noted Resident #156 yelled out, paced, wandered/intruded on the privacy of others, opened other residents' doors, and put himself on the floor. The stated goal for this care plan was Resident #156 would have no episodes of behavior during the next review period. Interventions included document behaviors as noted, redirect resident when behaviors occurred, and provide diversional activities as needed. Another care plan dated 08/19/24 stated Resident #156 was at risk for resident-to-resident altercations. The goal for the care plan was Resident #156 would show no signs of agitation resulting in altercations and would not cause injury or harm to himself or others. Interventions included allow Resident #156 to verbalize emotions, express any negative feelings, and provide 1:1 emotional support as needed, notify provider of any mood or behavioral concerns, initiate location/behavior tracking as needed, monitor for any signs of agitation and redirect resident to a safe and quiet place to allow resident time to calm down when agitation occurs. Another care plan dated 08/22/24 stated Resident #156 had been "noted trying to pull TV off wall, trying to flip table and cabinets over in day room, being aggressive with others (shaking fists at others), and spitting out medication. Stated goal for this care plan was Resident #156 would have little to no episodes of behavior during the next review period with staff intervention. Interventions for Resident #156 included document behaviors as noted, redirect resident when behaviors occurred, provide diversion activities as needed, and psychiatric services as needed. Resident #156's care plan revealed a plan initiated 08/30/24 Resident #156 had been noted "sticking his hands in female resident's brief". The stated goal of this care plan was Resident #156 would "not display any inappropriate sexual behaviors towards others with redirection". Interventions for Resident #156 included "engage resident in activities for increased	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 26 socialization with others so resident can be monitored and has fewer opportunities to be alone with other residents, monitor and document behaviors, and redirect resident as needed". Resident #59 was admitted to facility on 10/20/23 and resided on a locked memory care unit. Resident #59's diagnoses included unspecified dementia with mood disturbance, unspecified psychosis not due to a known substance or physiological condition (a physical condition in the body), generalized anxiety disorder, and depression. A review of Resident #59's annual MDS dated 08/01/24 revealed Resident #59 was severely cognitively impaired, required supervision for all ADL, and was independent with ambulation. Resident #59 received antipsychotics and antianxiety medications daily. A care plan initiated 08/18/23 for Resident #59's diagnosis of anxiety. Stated goal was Resident #59 would have decreased signs of anxiety. Interventions included allow Resident #59 to verbalize her feelings, monitor for changes in mood, and monitor for adverse reactions to medications. A care plan dated 08/30/24 revealed a care plan for Resident #59 "sticking sensory items in brief". The stated goal was Resident #59 would "have little to no episodes of behavior during the next review period and residents' dignity will be maintained with staff intervention". Interventions included immediately address indecency to regain resident's dignity, document behaviors as noted, redirect Resident #59 when behaviors occurred. A facility incident report for Resident #59 dated 08/29/24 at 10:35 PM was completed by Nurse #3 because of a resident-to-resident altercation with Resident #156. The incident report revealed Resident #154 had touched Resident #59 inappropriately. Skin assessment of Resident #59 performed which noted no injury. Resident #59 was placed on hourly checks for evaluation of emotional distress. Resident #156 was placed 1:1 staffing for monitoring. Incident report reflected provider, resident representative, DON, and the social worker were notified. A progress note dated 08/29/24 at 10:35 PM written by Nurse #3 revealed Resident #59 was observed by staff in the hallway of memory care unit standing with a "male resident touching her inappropriately". Resident #59 and Resident #156 were separated. 1:1 staff was assigned to Resident #156. Staff initiated every 1-hour checks on Resident #59 for emotional distress. An assessment was performed on Resident #59 with no injury	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 27 noted. The on-call provider was notified. Resident representative, DON, and the social worker were notified. Resident #59 was not interviewable due to dementia. Telephone interview attempted with Resident #59's Representative on 08/08/25 at 2:12 PM. Resident Representative was unavailable for interview. A facility incident report dated 04/20/25 at 10:35 PM for Resident #156 completed by Nurse #3 due to a resident-to-resident altercation with Resident #59. The incident report revealed Resident #156 was had touched female resident (Resident #59) inappropriately. Resident #156 and Resident #59 were separated. 1:1 staff assigned to Resident #156. Provider, resident representative, DON, and social worker were notified A progress note dated 08/29/24 at 10:35 PM written by Nurse #3 revealed Resident #156 was in the hallway of memory care unit standing with Resident #59 "touching her inappropriately". Resident #59 and Resident #156 were separated. 1:1 staff was assigned to Resident #156. Staff initiated every 1-hour checks on Resident #59 for emotional distress. A skin assessment was performed on Resident #59 with no injury noted. The on-call provider was notified. Resident representative, DON, and the social worker were notified. Nurse #3's handwritten statement dated 08/29/24 at 10:35 PM revealed Resident #156 was observed in the hallway with Resident #59. Resident #156 had "both of his hands into her brief". Resident #156 and Resident #59 were immediately separated. 1:1 staff was assigned to Resident #156, and his roommate was moved to another room. Every 1-hour checks on Resident #59 to monitor for emotional distress were initiated. Nurse performed assessment of Resident #59 with no issues noted. An interview with Nurse #3 was conducted on 08/08/25 at 07:12 AM. Nurse #3 was present when Resident #156 was observed with his hands down Resident #59's pants. Nurse #3 reported Resident #156 had one hand down the front and his other hand was down the backside of Resident #59's pants. Nurse #3 could not recall if Resident #156 was moving his hands or rubbing Resident #59's genitals. Nurse #3 could not recall if Resident #59 was yelling out or had verbalized anything during the altercation. Nurse #3 could not recall if Resident #59 had struggled or was agitated during or after the incident. Nurse #3 could not recall if other residents were present. Nurse #3 stated Resident #156 was placed 1:1 for safety until he went to bed. Nurse #3 stated	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 28 Resident #156 was the grandfather of the facility Restorative Nurse who investigated the incident. The Restorative Nurse approached Nurse #3 the next day and stated Resident #156 would not have stuck his hands down Resident #59's pants in a sexual way. Nurse #3 stated the incident was reported to the interim DON at the time it occurred. Nurse #3 stated she was unaware how the Administrator and interim DON followed up with the incident. Nurse #3 verbalized feeling "like they were making it less of a deal than it really was". A typed unsigned statement by NA #3 dated 08/08/25 at 10:25 AM revealed the statement was obtained by the Administrator due to not being able to locate original handwritten statement by NA #2 from 08/29/24. The statement revealed NA #3 observed Resident #59 and Resident #156 in the middle of the hallway on the memory care unit. NA #3 heard Resident #59 say "stop" and realized Resident #156's hands were down Resident #59's pants. NA #3 separated Resident #59 and Resident #156 who "appeared agitated". NA #3 reported Resident #59 was given a snack and was "unable to recall the event and didn't seem distressed or agitated". A telephone interview with NA #3 was attempted on 08/08/25 at 10:37 AM. NA #3 was unavailable for interview. An interview with facility NP conducted on 08/07/25 at 1:18 PM. The NP remembered Resident #156. The NP indicated that Resident #156 had periods of agitation and was seen by the Psychiatric Nurse Practitioner, but NP could not recall if they followed him or just evaluated him as needed. The NP was notified of the altercation between Resident #59 and Resident #156 the next day. A telephone interview with the Psychiatric Nurse Practitioner was conducted on 08/07/25 at 1:17 PM. The Psychiatric Nurse Practitioner could not recall Resident #156 and had no access to his records at the time of interview. An interview with the Social Worker was conducted on 08/08/25 at 11:55 AM. The Social Worker verbalized because Resident #156 was severely cognitively impaired, it was determined there was no willful intent, and Resident #59 had no adverse effects from the altercation. The Social Worker did not produce any documentation of resident assessment after the incident. The Administrator reported that since Resident #59 had been known to put toys down her pants, they determined that Resident #156 must have attempted to grab some sort of toy from her brief, and they felt	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 29 it was not sexually motivated. An interview with the DON was conducted on 08/08/25 at 12:05 PM. The DON stated that at the time of the incident, the facility had an interim DON. An interview with the Interim DON was conducted on 08/08/25 at 12:39 PM. The Interim DON stated staff had reported the incident when it occurred on 08/29/24. The Interim DON stated Resident #59 and Resident #156 were in the hallway of the memory care unit, and Resident #156 had both his hands down Resident #59's pants. The Interim DON stated one of Resident #156's hands was in the front of Resident #59's brief, and the other hand was down the backside of Resident #59's brief. The Interim DON was unsure if Resident #156 contacted Resident #59's skin. The Interim DON reported Resident #156 was placed 1:1 staffing for safety but could not recall for how long. Resident #59 underwent every 1-hour monitoring to rule out emotional distress. The Interim DON assisted Nurse #3 with assessment of Resident #59 and there were no injuries noted. Resident #59 was mumbling at the time of assessment but that was baseline behavior. The Interim DON reported the altercation to the Administrator. The Interim DON indicated because Resident #59 and Resident #156 had dementia, it was not a willful act from Resident #156. The Interim DON stated Resident #59 was known to put fidget toys down her pants and when they investigated, the Administrator and Social Worker thought possibly Resident #59 placed a toy down brief and Resident #156 had attempted to grab it. A care plan was initiated for Resident #59 and Resident #156 after the incident. The Interim DON could not recall if Resident #156 had aggression or sexual behaviors to any other residents. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator verbalized due to both Resident #59 and Resident #156 being severely cognitively impaired, it was determined there was no willful intent from Resident #156 to harm Resident #59. The Administrator stated the Social Worker assessed Resident #59 for several days after the incident and Resident #59 could not recall the altercation. The Administrator stated that she was surprised to hear that Nurse #3 felt they were making the situation less of a deal than it was. The Administrator verbalized it may be viewed as a conflict of interest to have Resident #156's granddaughter complete the investigation, but the Administrator stated that it was appropriate. The Administrator reported that since Resident #59 had been known to put toys in her pants, they determined that Resident #156 must have attempted to grab some sort of toy from her brief and felt it was	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 30 not sexually motivated. b. Resident #125 was initially admitted to facility on 06/09/23 and was readmitted on 11/11/24 and resided in a locked memory care unit. Resident #125's diagnoses included Alzheimer's disease, dementia with behavioral disturbance, unspecified psychosis not due to a known substance or physiological condition (a physical condition in the body), generalized anxiety disorder, and depression. A review of Resident #125's annual MDS dated 06/06/24 revealed Resident #125 was severely cognitively impaired, required partial assistance for all activities of daily living (ADL), and required supervision with ambulation. A review of Resident #125's care plan with an initial start date 06/15/23 and revised 07/14/25. The care plan for Resident #125 included depression. Stated goal was Resident #125 would have decreased signs of depression. Interventions included allow Resident #125 to verbalize her feelings, monitor changes in mood, and monitor adverse reactions to medications. No facility incident report was completed for Resident #125. A facility incident report dated 08/16/24 at 7:02 PM for Resident #156 was completed by Nurse #2 because of a resident-to-resident altercation with Resident #125. The incident report revealed Resident #156 became physically aggressive with Resident #125. Resident #156 "hit and placed hands on other resident's (Resident #125's) neck". The incident report noted Resident #156 exhibited anger, anxiety, and desire to harm others during the incident. Interventions for Resident #156 included redirection, simplified environment, and location monitoring. Resident #125 was noted to have a reddened area which measured 2 centimeters by 2 centimeters on left upper arm. No injuries to Resident #125's neck were observed. Resident #156's behaviors were noted to present danger to self or others. A progress note dated 08/16/24 at 6:50 PM written by Nurse #2 revealed Resident #156 was in the dayroom of the memory care unit and hit Resident #125 in the left shoulder and placed his hands around Resident #125's neck. Resident #125 and Resident #156 were separated. Resident #156 continued to be agitated paced in hallway, yelled, and attempted to place himself on the floor. 15-minute location tracking initiated. A progress note dated 08/16/24 at 6:50 PM written by	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 31 Nurse #2 revealed Resident #125 was seated in dayroom when Resident #156 “hit her on the left shoulder and placed hands on her neck”. Resident #125 and Resident #156 were separated. Resident #125 had a reddened area to left shoulder which measured 2 centimeters by 2 centimeters. No injury was noted to Resident #125’s neck area when a skin assessment was performed. The progress note indicated Resident #125 was in a pleasant mood and voiced no complaints. 15-minute location tracking was initiated for Resident #125. The provider and Resident #125’s Representative were notified of the altercation. An interview with Nurse #2 was conducted on 08/08/25 at 11:43 AM. Nurse #2 was present for this altercation but could not recall what happened because it had been so long. Nurse #2 could not state why an incident report was not completed for Resident #125 for the altercation. Resident #125 was not interviewable due to dementia. Telephone interview with Resident #125’s Representative was conducted on 08/08/25 at 1:59 PM. Resident #125’s Representative stated the facility notified her of the altercation on 08/16/24 but did not reveal who was involved. Resident Representative stated Resident #125 had a reddened area to her left shoulder and had been choked. After the incident, the facility made no follow-up contact with Resident #125’s Representative. Resident Representative stated “it was upsetting. She (Resident #125) had always been small, but she would fight back and not take any crap”. Resident Representative also stated Resident #125 had been mugged in the past, so being attacked by a stranger would have been very upsetting to her. A progress note dated 08/16/24 at 11:36 PM written by Nurse #8 revealed Resident #156 continued to be agitated and paced in hallway and yelled out loudly. 1:1 staff was initiated at that time. Resident #156 calmed down with 1:1 staff and went to bed with no further behaviors. An interview with the Social Worker was conducted on 08/08/25 at 11:55 AM. The Social Worker stated that after any resident-to-resident altercation, nursing staff assessed residents involved for injury. Nursing staff would perform body audits for 3 days, head trauma protocol if indicated, and notify the provider, and administration. The Social Worker verbalized because Resident #156 was severely cognitively impaired, it was determined there was no willful intent behind his actions, and Resident #125 had no adverse effects from	F0600		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0600 SS = SQC-J	Continued from page 32 the altercation. The Social Worker did not produce any documentation of resident assessment after the incident. An interview with the DON was conducted on 08/08/25 at 12:05 PM. The DON indicated at the time of the incident; an interim DON was in that role. An interview with the Interim DON was conducted on 08/08/25 at 12:39 PM. The Interim DON was aware of the incident of Resident #156 choking Resident #125 on 08/17/24 but could not recall details. The Interim DON could not recall if Resident #156 had aggression or sexual behaviors to any other residents prior to altercation. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator verbalized due to both Resident #125 and Resident #156 being severely cognitively impaired, it was determined there was no willful intent from Resident #156 to harm Resident #125. The Administrator stated the Social Worker assessed Resident #125 for several days after the incident and Resident #125 could not recall the altercation.	F0600		
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated	F0609		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0609 SS = E	Continued from page 33 representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to identify abuse and ensure staff implemented facility's abuse policy and procedures for reporting abuse. This occurred when the facility failed to report allegations of resident-to-resident abuse to the State Survey Agency within the specified time frames. The facility also failed to notify the county Adult Protective Services (APS) of allegations of abuse. This deficient practice affected 4 of 30 residents reviewed for abuse (Resident #32, Resident #59, Resident #86, and Resident #125). The findings included: A review of undated facility policy titled "Protocol for Reporting Abuse" revealed if a reasonable person suspected that abuse had occurred, staff would immediately notify the administrator or designee, person in charge, and officials including the State Survey Agency and APS no later than 2 hours after the allegation was made if the events of allegation involved abuse or resulted in serious bodily injury. 1. Resident #154 was initially admitted to the facility on 09/23/24, readmitted on 04/26/25, and discharged from facility to hospital on 05/09/25. Resident #154's diagnoses included unspecified dementia with other behavioral disturbances, depression, generalized anxiety disorder, and insomnia due to other mental disorders. A review of Resident #154's quarterly Minimum Data Set (MDS) dated 04/03/25 revealed Resident #154 was severely cognitively impaired. a. Resident #32 was admitted to facility on 09/24/24. Resident #32's diagnoses included Alzheimer's disease, dementia in other diseases, generalized anxiety disorder, and depression. A review of Resident #32's quarterly MDS dated 04/01/25 revealed Resident #32 was severely cognitively impaired. A facility incident report dated 05/09/25 at 4:31 PM was completed for Resident #154. The incident report	F0609		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0609 SS = E	Continued from page 34 revealed Resident #154 entered Resident #32's room and placed hands around Resident #32's neck and pinned Resident #32 in the corner of the room with her back against the wall. Resident #32 noted to be hitting Resident #154 to free herself. Resident #154 sustained scratches to left ear. A facility incident report dated 05/09/25 at 4:50 PM was completed for Resident #32. The incident report revealed Resident #32 was in her room when Resident #154 entered Resident #32's room and cornered Resident #32 against the wall with hands around her neck. A review of facility reported incidents revealed no facility initial investigation or 5-day investigation reports were submitted to the North Carolina Division of Health Service Regulation (DHSR). An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator verbalized due to both Resident #32 and Resident #154 being severely cognitively impaired, it was determined there had been no willful intent from Resident #154 to harm Resident #32 therefore it would not constitute abuse. The Administrator stated after a thorough investigation, and discussion with corporate, it was determined the altercation did not need to be reported to the State Survey Agency or APS. The Administrator verbalized "If I felt it needed to be reported, I would have". The Administrator reiterated that without willful intent, no abuse occurred. b. Resident #86 was admitted to facility on 11/08/24. Resident #86's diagnoses included unspecified dementia with other behavioral disturbance, generalized anxiety disorder, and depression. A review of Resident #86's quarterly MDS dated 02/15/25 revealed Resident #86 was severely cognitively impaired. A facility incident report dated 04/20/25 at 9:02 PM was completed for Resident #86. The incident report revealed Resident #86 was in bedroom when Resident #154 entered Resident #86's room and had fist balled up "making contact" with Resident #86's face. Incident report described injury to Resident #86 as "small area to upper lip with small amount of blood". A facility incident report dated 04/20/25 at 9:02 PM was completed for Resident #154. The incident report revealed Resident #154 had increased agitation. Resident #154 entered Resident #86's room, balled up	F0609		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0609 SS = E	Continued from page 35 fist and hit Resident #86 in the mouth. Resident #154 sustained no injury. A review of facility reported incidents revealed no facility initial investigation or 5-day investigation reports were submitted to the DHSR. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator verbalized due to both Resident #86 and Resident #154 being severely cognitively impaired, it was determined there was no willful intent from Resident #154 to harm Resident #86 therefore it would not constitute abuse. The Administrator stated after a thorough investigation, and discussion with corporate, it was determined the altercation did not need to be reported to the State Survey Agency or APS. The Administrator verbalized “If I felt it needed to be reported, I would have”. The Administrator reiterated that without willful intent, no abuse occurred. c. Resident #32 was admitted to facility on 09/24/24. Resident #32’s diagnoses included Alzheimer's disease, dementia in other diseases, generalized anxiety disorder, and depression. A review of Resident #32’s quarterly MDS dated 04/01/25 revealed Resident #32 was severely cognitively impaired. A facility incident report dated 04/17/25 at 12:30 PM was completed for Resident #32. The incident report revealed Resident #32 was in her bedroom in bed when Resident #154 entered Resident #32’s room. Resident #32 was heard yelling “get out!!!” and “help”. Staff discovered Resident #154 with hands on Resident #32’s arms. Resident #32 was observed “swatting” at Resident #154 to free herself. A facility incident report dated 04/17/25 at 12:30 PM was completed for Resident #154. The incident report revealed Resident #154 entered Resident #32’s room. Resident #32 was heard by staff screaming “get out” and “help”. Resident #154 became agitated and grabbed Resident #32 and began pulling on her arms. A review of facility reported incidents revealed no facility initial investigation or 5-day investigation reports were submitted to the DHSR. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the	F0609		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0609 SS = E	Continued from page 36 facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator verbalized due to both Resident #32 and Resident #154 being severely cognitively impaired, it was determined there was no willful intent from Resident #154 to harm Resident #32 therefore it would not constitute abuse. The Administrator stated after a thorough investigation, and discussion with corporate, it was determined the altercation did not need to be reported to the State Survey Agency or APS. The Administrator verbalized “If I felt it needed to be reported, I would have”. The Administrator reiterated that without willful intent, no abuse occurred. 2. Resident #156 was admitted to the facility on 08/07/24 and was discharged on 11/18/24. Resident #156’s diagnoses included senile degeneration of the brain (a brain disease resulting in dementia), unspecified dementia with other behavioral disturbance, major depressive disorder, and generalized anxiety disorder. A review of Resident #156’s admission MDS dated 08/13/24 revealed Resident #156 was severely cognitively impaired. a. Resident #59 was admitted to facility on 10/20/23. Resident #59’s diagnoses included unspecified dementia with mood disturbance, unspecified psychosis not due to a known substance or physiological condition (a physical condition in the body), generalized anxiety disorder, and depression. A review of Resident #59’s annual MDS dated 08/01/24 revealed Resident #59 was severely cognitively impaired. A facility incident report dated 08/29/24 at 10:35 PM was completed for Resident #59. The incident report revealed Resident #156 had touched Resident #59 inappropriately. Skin assessment of Resident #59 noted no injury. A facility incident report dated 08/29/24 at 10:35 PM was completed for Resident #156. The incident report revealed Resident #156 had touched Resident #59 inappropriately. A review of Nurse #3’s handwritten statement dated 08/29/24 at 10:35 PM revealed Resident #156 was observed in the hallway with Resident #59 with “both of his hands into her brief”. An interview with Nurse #3 was conducted on 08/08/25 at	F0609		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0609 SS = E	Continued from page 37 07:12 AM. Nurse #3 was present when Resident #156 was observed with his hands down Resident #59's pants. Nurse #3 reported Resident #156 had one hand down the pants in the front side and his other hand was down the backside of Resident #59's pants. A review of facility reported incidents revealed no facility initial investigation or 5-day investigation reports were submitted to the DHSR. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator verbalized due to both Resident #59 and Resident #156 being severely cognitively impaired, it was determined there was no willful intent from Resident #156 to harm Resident #59 therefore it would not constitute abuse. The Administrator stated after a thorough investigation, and discussion with corporate, it was determined the altercation did not need to be reported to the State Survey Agency or APS. The Administrator verbalized "If I felt it needed to be reported, I would have". The Administrator reiterated that without willful intent, no abuse occurred. b. Resident #125 was admitted to facility on 06/09/23. Resident #125's diagnoses included Alzheimer's disease, dementia with behavioral disturbance, unspecified psychosis not due to a known substance or physiological condition (a physical condition in the body), generalized anxiety disorder, and depression. A review of Resident #125's annual MDS dated 06/06/24 revealed Resident #125 was severely cognitively impaired. A review of facility reported incidents revealed no facility incident report was completed for Resident #125. A progress note for Resident #125 dated 08/16/24 at 6:50 PM revealed Resident #125 was seated in dayroom when Resident #156 "hit her on the left shoulder and placed hands on her neck". Resident #125 and Resident #156 were separated. Resident #125 had a reddened area to left shoulder which measured 2 centimeters by 2 centimeters. No injury was noted to Resident #125's neck area. A facility incident report dated 08/16/24 at 7:02 PM was completed for Resident #156. The incident report revealed Resident #156 became physically aggressive with Resident #125. Resident #156 "hit and placed hands	F0609		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0609 SS = E	Continued from page 38 on other resident's (Resident #125's) neck". The event form noted Resident #156 exhibited anger, anxiety, and desire to harm others during the incident. Resident #125 was noted to have a reddened area which measured 2 centimeters by 2 centimeters on left upper arm. No injuries to Resident #125's neck were observed. A review of facility reported incidents revealed no facility initial investigation or 5-day investigation reports were submitted to the DHSR. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator verbalized due to both Resident #125 and Resident #156 being severely cognitively impaired, it was determined there was no willful intent from Resident #156 to harm Resident #125 therefore it would not constitute abuse. The Administrator stated after a thorough investigation, and discussion with corporate, it was determined the altercation did not need to be reported to the State Survey Agency or APS. The Administrator verbalized "If I felt it needed to be reported, I would have". The Administrator reiterated that without willful intent, no abuse occurred.	F0609		
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0610		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	**716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086**

(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
F0610 SS = E	Continued from page 39 Based on record review and staff interviews, the facility failed to complete a thorough investigation after allegations of resident-to-resident abuse occurred. This deficient practice affected 4 of 30 residents reviewed for abuse (Resident #32, Resident #59, Resident #86, and Resident #125). Findings included: The undated facility abuse policy titled “White Oak Management, Inc. Plan for the Prevention of Elder Abuse” was reviewed. A section of policy titled “Resident to Resident Abuse” stated “all forms of abuse, including resident-to-resident abuse, must be reported immediately to the Director of Nursing and the facility administrator”. Section 6 titled “Investigation” stated “all reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management”. The administrator or designee shall investigate the allegation by completing the following: · Review the completed documentation forms or any other pertinent documentation related to the allegation. · Review the resident’s medical record to determine events leading up to the allegation. · Interview the person reporting the incident. · Interview witnesses to the incident. · Interview the resident (if appropriate). · Review the medical record to obtain the resident’s orientation and decision-making capacity. · Interview staff members (on all shifts) who had contact with the resident during the period of alleged incident. · Interview other residents, the resident’s roommate, family members, and visitors as appropriate. Statements would be obtained from all individuals with potential involvement or knowledge of the incident. Statements should be timed and dated. Following a complete and thorough investigation, a summarized investigation report should be completed by the administrator. Corrective action should be taken pending final summary of the investigation. 1. Resident #154 was initially admitted to the facility	F0610		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0610 SS = E	Continued from page 40 on 09/23/24, readmitted on 04/26/25, and discharged from facility to hospital on 05/09/25. Resident #154's diagnoses included unspecified dementia with other behavioral disturbances, depression, generalized anxiety disorder, and insomnia due to other mental disorders. A review of Resident #154's quarterly Minimum Data Set (MDS) dated 04/03/25 revealed Resident #154 was severely cognitively impaired. a. Resident #32 was admitted to facility on 09/24/24. Resident #32's diagnoses included Alzheimer's disease, dementia in other diseases, generalized anxiety disorder, and depression. A review of Resident #32's quarterly MDS dated 04/01/25 revealed Resident #32 was severely cognitively impaired. A facility incident report dated 05/09/25 at 4:50 PM was completed for Resident #32. The incident report revealed Resident #32 was in her room when Resident #154 entered Resident #32's room and cornered Resident #32 against the wall with hands around her neck. The event form noted Resident #32 exhibited fear after the incident. A facility incident report dated 05/09/25 at 4:31 PM was completed for Resident #154. The incident report revealed Resident #154 entered Resident #32's room and placed hands around Resident #32's neck and pinned Resident #32 in the corner of the room with her back against the wall. Resident #32 noted to be hitting Resident #154 to free herself. Resident #154 sustained scratches to left ear. A review of skin assessment form dated 05/09/25 for Resident #32 revealed no bruising or injury noted after the 05/09/25 incident. There was no skin assessment form available for review for Resident #154 after the altercation. No skin assessment forms for other cognitively impaired residents residing on the memory care unit were available for review. No resident interviews were available for review. A handwritten untimed statement dated 05/09/25 written by Nurse Aide (NA) #1 revealed NA #1 heard Resident #32 yelling "help me" from Resident #32's room. NA #1 entered Resident #32's room and observed Resident #154 had Resident #32 "by the neck".	F0610		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0610 SS = E	Continued from page 41 An untimed written statement dated 05/09/25 from the Infection Preventionist revealed Resident #154 had been in Resident #32's room "with his hands around her neck". The Infection Preventionist wrote Resident #154 and Resident #32 were separated, and Resident #154 immediately entered another resident's room. Staff redirected Resident #154 to his room. No investigation summary by the Administrator or designee was available for review. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator stated there were no concerns about how the investigation was conducted and confirmed no other investigation materials were available. b. Resident #86 was admitted to facility on 11/08/24. Resident #86's diagnoses included unspecified dementia with other behavioral disturbance, generalized anxiety disorder, and depression. A review of Resident #86's quarterly MDS dated 02/15/25 revealed Resident #86 was severely cognitively impaired. A facility incident report dated 04/20/25 at 9:02 PM was completed for Resident #86. The incident report revealed Resident #86 was in the bedroom when Resident #154 entered Resident #86's room and had fist balled up "making contact" with Resident #86's face. Incident report described injury to Resident #86 as "small area to upper lip with small amount of blood". A facility incident report dated 04/20/25 at 9:02 PM was completed for Resident #154. The incident report revealed Resident #154 had increased agitation. Resident #154 entered Resident #86's room, balled up fist and hit Resident #86 in the mouth. Resident #154 sustained no injury. No skin assessment forms were available for review for Resident #86 or Resident #154. No skin assessment forms for other cognitively impaired residents residing in the memory care unit were available for review. A handwritten statement dated 04/20/25 at 7:10 PM written by NA #2 revealed NA #2 heard shouting coming from Resident #86's room. NA #2 entered Resident #86's room and observed Resident #154 and Resident #86 standing in doorway. NA #2 observed Resident #154 had	F0610		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0610 SS = E	Continued from page 42 “fist balled to Resident #86’s face making contact”. No investigation summary by the Administrator or designee was available for review. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator stated there were no concerns about how the investigation was conducted and confirmed no other investigation materials were available. c. Resident #32 was admitted to facility on 09/24/24. Resident #32’s diagnoses included Alzheimer's disease, dementia in other diseases, generalized anxiety disorder, and depression. A review of Resident #32’s quarterly MDS dated 04/01/25 revealed Resident #32 was severely cognitively impaired. A facility incident report dated 04/17/25 at 12:30 PM was completed for Resident #32. The incident report revealed Resident #32 was in her bedroom in bed when Resident #154 entered Resident #32’s room. Resident #32 was heard yelling “get out!!!” and “help”. Staff discovered Resident #154 with hands on Resident #32’s arms. Resident #32 was observed “swatting” at Resident #154 to free herself. A facility incident report dated 04/17/25 at 12:30 PM was completed for Resident #154. The incident report revealed Resident #154 entered Resident #32’s room. Resident #32 was heard by staff screaming “get out” and “help”. Resident #154 became agitated and grabbed Resident #32 and began pulling on her arms. There were no skin assessment forms available for review for Resident #32 or Resident #154 after this incident. No skin assessment forms for other cognitively impaired residents residing on the memory care unit were available for review. No staff witness statements were available for review. No resident interviews were available for review. No investigation summary by the Administrator or designee was available for review. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse	F0610		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0610 SS = E	Continued from page 43 allegation reporting and investigation. The Administrator stated there were no concerns about how the investigation was conducted and confirmed no other investigation materials were available. 2. Resident #156 was admitted to the facility on 08/07/24 and was discharged on 11/18/24. Resident #156's diagnoses included senile degeneration of the brain (a brain disease resulting in dementia), unspecified dementia with other behavioral disturbance, major depressive disorder, and generalized anxiety disorder. A review of Resident #156's admission MDS dated 08/13/24 revealed Resident #156 was severely cognitively impaired. a. Resident #59 was admitted to facility on 10/20/23. Resident #59's diagnoses included unspecified dementia with mood disturbance, unspecified psychosis not due to a known substance or physiological condition (a physical condition in the body), generalized anxiety disorder, and depression. A review of Resident #59's annual MDS dated 08/01/24 revealed Resident #59 was severely cognitively impaired. A facility incident report dated 08/29/24 at 10:35 PM was completed for Resident #59. The incident report revealed Resident #156 had touched Resident #59 inappropriately. Skin assessment of Resident #59 noted no injury. A facility incident report dated 08/29/24 at 10:35 PM was completed for Resident #156. The incident report revealed Resident #156 had touched Resident #59 inappropriately. No skin assessment forms were available for review for Resident #59 or Resident #156. No skin assessment forms for other cognitively impaired residents residing on the memory care unit were available for review. No resident interviews were available for review. A review of typed unsigned statement of NA #3 dated 08/08/25 at 10:25 AM was completed. Statement was obtained by the Administrator due to "not being able to locate original handwritten statement from 08/29/24". The statement revealed NA #3 observed Resident #59 and Resident #156 in the middle of the hallway on the memory care unit. NA #3 heard Resident #59 say "stop" and realized Resident #156's hands were down Resident	F0610		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0610 SS = E	Continued from page 44 #59's pants. NA #3 separated Resident #59 and Resident #156 who "appeared agitated". A review of Nurse #3's handwritten statement dated 08/29/24 at 10:35 PM revealed Resident #156 was observed in the hallway with Resident #59 with "both of his hands into her brief". No investigation summary by the Administrator or designee was available for review. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator stated there were no concerns about how the investigation was conducted and confirmed no other investigation materials were available for review. b. Resident #125 was admitted to facility on 06/09/23. Resident #125's diagnoses included Alzheimer's disease, dementia with behavioral disturbance, unspecified psychosis not due to a known substance or physiological condition (a physical condition in the body), generalized anxiety disorder, and depression. A review of Resident #125's annual MDS dated 06/06/24 revealed Resident #125 was severely cognitively impaired. No facility incident report was available for review for Resident #125. A facility incident report dated 08/16/24 at 7:02 PM was completed for Resident #156. The incident report revealed Resident #156 became physically aggressive with Resident #125. Resident #156 "hit and placed hands on other resident's (Resident #125's) neck". Resident #125 was noted to have a reddened area which measured 2 centimeters by 2 centimeters on left upper arm. No injuries to Resident #125's neck were observed. No skin assessment forms were available for review for Resident #59 or Resident #156. No skin assessment forms for other cognitively impaired residents residing on the memory care unit were available for review. No resident interviews were available for review. No investigation summary by the Administrator or designee was available for review. No other investigation materials were available for review related to this resident-to-resident	F0610		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0610 SS = E	Continued from page 45 altercation. An interview with the Administrator was conducted on 08/08/25 at 12:10 PM. The Administrator stated the facility followed the State Operations Manual for abuse allegation reporting and investigation. The Administrator stated there were no concerns about how the investigation was conducted and confirmed no other investigation materials were available.	F0610		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate.	F0627		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0627 SS = D	Continued from page 46 §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.	F0627		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0627 SS = D	Continued from page 47 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.	F0627		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0627 SS = D	Continued from page 48 (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record,	F0627		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0627 SS = D	Continued from page 49 the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Hospital Case Manager, Resident's Representative, and staff interviews, the facility failed to allow a resident to return to the first available bed at the facility after being sent to the hospital for a medical and psychiatric (psych) evaluation. The resident remained in the hospital despite being medically cleared to return to the nursing home after 5 days. This deficient practice was evidenced for 1 of 3 residents reviewed for transfer and discharge (Resident #154). Findings included: Resident #154 was admitted to the facility on 9/23/2024 and discharged to the hospital on 5/9/2025. Resident #154 was admitted with diagnoses that included spinal stenosis, muscle weakness, dementia with other behavioral disturbance, depression, generalized anxiety disorder, unspecified glaucoma and resided in the locked unit. Review of Resident #154's face sheet indicated a family member was Resident #154's emergency contact, Resident Representative (RR), and responsible party. A review of progress notes for Resident #154 revealed a	F0627		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0627 SS = D	Continued from page 50 note dated 05/09/25 at 4:31 PM Resident #154 had an altercation with Resident #32 in Resident #132's room. Resident #154 noted with his hands around Resident #32's neck. Resident #154 entered another resident's room after staff redirected him out of Resident #32's room. The Administrator and Resident #154's Representative notified. One-on-one staff assigned to Resident #154. A progress note dated 05/09/25 at 6:07 PM noted the on-call provider was notified of incident and Resident #154 exited the building at 6:01 PM via Emergency Medical Services for the hospital. A progress note dated 05/09/25 at 6:41 PM revealed Resident #154 discharged out via involuntary commitment. Resident #154 discharged due to "change of condition and endanger to resident and others" related to incident with Resident #32. A review of facility incident report for Resident #32's dated 05/09/25 at 4:50 PM completed by Nurse #2 because of a resident-to-resident altercation with Resident #154. The incident report revealed Resident #32 was in her room when Resident #154 entered Resident #32's room and cornered Resident #32 with hands around her neck. The event form noted Resident #32 exhibited fear after the incident. Interventions for Resident #32 included redirection and simplifying the environment. Review of Resident #154's discharge Minimum Data Set (MDS) dated 5/9/2025 revealed Resident #154 was severely cognitively impaired and indicated physical behavioral symptoms directed toward others, wandering behavior, coded as unplanned discharge with return anticipated. Review of Resident #154's Hospital Records and Hospital Case Manager notes dated 5/9/2025 to 6/2/2025 revealed the following: 5/10/2025: Hospital Case Management met with daughter outside resident room. Resident is a Long-Term Care (LTC) resident at a local facility and if possible, the family wishes for resident to return there. Hospital Case Manager called and spoke to the Corporate Regional Coordinator for the local facility, and she will check with the facility to see if resident can return to the facility. Hospital Case Manager called and spoke to the Admissions Nurse from the local facility concerning the ability of resident returning to the facility. The Admissions Nurse states that she did not know, and it would be up to administration, and they have not made a decision. Hospital Case Management will follow up for a	F0627		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0627 SS = D	Continued from page 51 decision. Resident was not medically ready for discharge. 5/13/2025: Sitter at bedside. Hospital Case Manager spoke to Corporate Regional Coordinator regarding resident returning for LTC/locked unit at discharge. Per Corporate Regional Coordinator, management is discussing the resident returning at a corporate level due to his behavior at the facility and she will notify Hospital Case Management once a decision has been made. Hospital Case Management following. 5/13/2025: Administrator at local facility contacted Hospital Case Management to discuss resident. Administrator informed Hospital Case Management of resident behaviors at the facility and is unable to accept this resident at this time. Administrator has requested a psych eval stating that unless psych sees him and a major condition change is made with the resident, they cannot take him back. Hospital Case Management informed MD of above and psych has been consulted. Psych plans to see resident later today. Hospital Case Management will follow. 5/14/2025: Medically ready for discharge 5/15/2025: Sitter remains in place and psych is making medication adjustments. RR is aware that resident may not be able to return to local facility unless improvement has been made with the medication adjustments and resident no longer exhibits aggressive behaviors. Per staff resident has not been aggressive or combative since this admission. Hospital Case Management will allow time for resident to improve and will fax out for placement and follow up with local facility on Monday. Hospital Case Management informed family that locked units are limited and recommended they discuss alternate plans for the resident such as private sitters and/or staying with family. 5/19/2025- Virtual sitter in place. Hospital Case Management spoke to Corporate Regional Coordinator regarding resident returning and the facility is unable to accept him back; RR updated. Hospital Case Management spoke to resident RR regarding discharge plans and placement being difficult due to needing a locked unit. RR states that the resident's wife is hesitant for him to return home due to being unable to care for him. RR has considered staying with the resident in his home and hiring paid caregivers, however, finances are in issue. Skilled Nursing Facility/LTC has been faxed out and offers are pending. Per RR, resident's Medicaid is also pending. Hospital Case Management asked that the family continue to	F0627		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0627 SS = D	Continued from page 52 consider alternatives for discharge. 5/20/2025 cannot return to local facility. 5/23/2025: Sitter is at the bedside. Pt will remain over the weekend, and CM will continue to work on LTC placement. So far, no bed offers. Hard to place. Will follow. 5/27/2025 LTC at local facility, cannot return to local facility. Psych adjusting medication for agitation. During a telephone interview on 8/8/2025 at 11:04 AM Resident #154's Resident Representative (RR) stated the facility refused to take him back. The RR stated Resident #154 had been sent out on 5/9/2025 related to behaviors. The RR stated Resident #154 had been sent out in April of 2025 and when Resident #154 had returned the Administrator and Social Worker had told the RR if Resident had any further behaviors, they would involuntarily commit Resident #154 to the local hospital. The RR stated while Resident #154 was in the hospital she was told by Hospital Case Management that the facility would not take him back. The RR stated Resident #154 was discharged from the hospital on 6/2/2025 to a different facility. During an interview on 8/8/2025 at 4:45 PM the Admission Nurse stated her responsibility when residents were readmitted was to verify the discharge orders, and if the resident was gone more than 5 days it would be a full readmission. The Admission Nurse stated she was not normally the first contact when the hospital reports a resident is ready to return to the facility, they typically call the Admission Coordinator. The Admission Nurse stated she recalled while Resident #154 was in the hospital, she had answered a call regarding Resident #154, but the decision regarding residents returning from the hospital was not her decision, and the call was forwarded to the Admission Coordinator and Administrator. The Admissions Nurse stated the facility normally readmitted residents from the hospital. During an interview on 8/8/2025 at 4:20 PM the Admission Coordinator stated that when the hospital has a resident ready to return the facility the Hospital Case Manager normally calls her or the Corporate Regional Coordinator. The Admission Coordinator stated she did not recall receiving a call that Resident #154 was ready to return from the hospital. The Admission Coordinator stated the Administrator may have received the call.	F0627		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0627 SS = D	Continued from page 53 During an interview on 8/8/2025 at 4:30 PM the Corporate Regional Coordinator stated she knew Resident #154 had been transferred to the hospital and Hospital Case Management contacted her when Resident #154 was ready to return to the facility but was unsure of the exact date. The Corporate Regional Coordinator stated she passed the information on to the Director of Nursing and Administrator to make the decision. The Corporate Regional Coordinator stated the facility took residents back from the hospital if the facility could meet the residents' needs. During a telephone interview on 8/11/2025 at 9:45 AM the Hospital Case Manager stated she was the case manager that worked with Resident #154 while he was in the hospital from 5/9/2025 to 6/2/2025. The Hospital Case Manager stated the facility normally re-admitted residents that were sent to the hospital. The Hospital Case Manager stated the facility was contacted several times while Resident #154 was in the hospital, and listed the following: 5/13/2025: facility had a corporate level discussion regarding taking Resident #154 back. 5/15/2025: facility still considering 5/19/2025: Corporate Regional Coordinator stated they had decided they were unable to take Resident #154 back; family was notified by the case manager; facility could not take him back due to not being able to meet his needs anymore. The Hospital Case Manager stated the facility did not give a specific reason Resident #154 could not return. The Hospital Case Manager stated she did not recall Resident #154 had used restraints in the hospital. The Hospital Case Manager verified Resident #154 was medically cleared for discharge on 5/14/2025 but remained at the hospital until 6/2/2025. Resident #154 was discharged to another facility on 6/2/2025. During an interview on 8/8/2025 at 5:30 PM the Administrator stated the case managers at the hospital normally contacted the Corporate Regional Coordinator, or the Admission Coordinator when a resident was ready for readmission to the facility. The facility reviews the information, and it only goes through the Administrator if there is an issue, then the Administrator reviewed the information and made the determination of whether the facility can meet the needs of the residents when they are ready to return to the facility. The Administrator stated Resident #154 had lived in the locked unit at the facility, and the	F0627		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0627 SS = D	Continued from page 54 facility had done everything they could to keep the facility safe for everyone. The Administrator stated Resident #154 had been 1:1 when they had staff then 15-minute location tracking was provided. The Administrator stated the facility did not have enough staff to provide 1:1 staffing for a resident at all times, due to the amount of resident and staff the facility had. The Administrator stated she had many conversations with Corporate to make the best decision for Resident #154. The Administrator stated Resident #154 had restraints in the hospital and the hospital had to medicate Resident #154 for behaviors. The Administrator stated the decision was made since Resident #154 had already put so many people at risk due to behaviors. The Administrator stated she had made the best decision for Resident #154 and the facility at the time, and this was the first time a resident had not been accepted back from the hospital.	F0627		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide incontinence care to a resident when needed and was alerted by a family member that Resident #139 had laid in a urine soaked brief, clothes, under pad and sheets for several hours. This deficient practice was for 1 of 3 residents reviewed for providing activities of daily living care (Resident #139). Findings included: Resident #139 was admitted on 12/22/20 with diagnoses which included cerebrovascular accident (stroke), hypertension (high blood pressure). A quarterly Minimum Data Set (MDS) dated 06/27/25 revealed Resident #139 was cognitively intact, received a diuretic (a drug that causes the kidneys to make more urine) daily, was always incontinent of bowel and bladder, and was dependent with incontinence care and toileting. An interview with Resident #139 was conducted on 08/05/25 at 11:32 AM. Resident #139 stated that a few	F0677		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0677 SS = D	Continued from page 55 weeks ago she had an incontinent episode early in the morning. She asked to be changed, and no one came back to change her. She reported that she laid in wet briefs all day until her daughter arrived sometime after lunch. Resident reported she couldn't remember who the aide was on the shift A telephone interview with Nursing Assistant (NA) #6 was conducted on 08/08/25 at 2:00 PM. NA #6 was familiar with Resident #139 and the incident that occurred on 07/20/25. She reported she was out in the hall with NA #7, when Resident #139's daughter stepped into the hall and asked them who her mother's NA was. NA #6 reported she told the daughter it was NA #5 and asked if one of us could get her to come to the room. NA #6 reported she told her NA #5 was out with another resident and asked if we could help her with something. NA #6 indicated the daughter took her and NA #7 into the room and pulled back Resident #139's blankets and Resident #139's clothes, under pad and sheets were wet. NA #6 indicated she apologized and told the daughter she was unsure of what had happened as Resident #139 was not on her assignment and she had just started her shift. NA #6 reported she told the daughter she would go get some clean linens and would bathe Resident #139. NA #6 reported she told NA #7 to let her get the Unit Manager before she began cleaning up Resident #139. NA #6 stated she could tell Resident #139 had been laying in soiled clothes and sheets for a while as there was a ring where the urine had started to dry. NA #6 indicated she could tell it was urine because of the smell. NA #6 stated she made the Unit Manager aware of the situation on her way to get clean linens and the Unit Manager went to the room to assess the resident. NA #6 reported she had never been aware of Resident #139 refusing care A telephone interview with NA #7 was conducted on 08/08/25 at 2:50 PM. NA #7 was familiar with Resident #139 and the incident that occurred on 07/20/25. She reported she was out in the hall with NA #6, when Resident #139's daughter stepped into the hall and asked them who her mother's NA was. NA #6 told her it was NA #5. NA #7 indicated the daughter asked if one of us could get NA #5 to come to the room. NA #6 told the daughter she was out with another resident and asked if they could help her with something. The daughter them into the room and pulled Resident #139's blankets back and she observed wet clothes, under pad and sheets. She (NA #7) and NA #6 apologized and told her we were unsure of what had happened as Resident #139 was not on either of our assignments and they both had just started our shifts. NA #6 told the daughter she would go get some clean linens and bathe Resident #139. NA #7	F0677		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0677 SS = D	Continued from page 56 explained while NA #6 was gone she removed the pillow from under Resident #139's knees and found a soiled brief. NA #6 notified the Unit Manager of the situation, and she came in to assess the Resident. The interview further revealed they all worked together to get Resident #139 cleaned up and in dry clothes and linens. Resident #139 has never refused care when she was on my assignment. Three attempts were made to contact NA #5 and there was no ability to leave a voicemail, and no return call or text was received. A review of Resident #139's skin assessment dated 7/20/25 done after the incident, revealed redness to bilateral buttocks. An interview with the Nurse/Unit Manager #7 was conducted on 08/08/25 at 3:00 PM. Nurse #7 stated Resident #139 was always incontinent of bowel and bladder. Nurse #7 reported, that several weeks ago around 3:00 PM, NA #6 told her, Resident #139 was laying in urine. She reported she went to the room and Resident #139's daughter was quite angry because her mother was soaking wet with urine. Nurse #7 reported that upon entering the room, she noticed a strong urine smell and observed Resident #139 lying in bed with wet clothes, under pad and sheets and a soiled brief lying at the foot of her bed. There were rings around her body on the sheets and under pad where the urine had begun to dry. Nurse #7 recalled Resident #139's daughter asked her had Resident #139 been changed at all today. Nurse #7 reported she told Resident #139's daughter she had to assume Resident #139 had not from the looks of her bed. Nurse #7 stated no one had reported to her that Resident #139 had refused care during the shift. Nurse #7 reported that Resident #139 would refuse care sometimes. An interview with the Director of Nursing (DON) was conducted on 08/08/25 at 3:45 PM. The DON stated Resident #139 was incontinent with bowel and bladder. The DON indicated Resident #139's daughter made her aware of the incident the day it happened. A grievance was filed and an investigation done which resulted in the termination of NA#5. DON reported that NA #5 reported to her during the investigation that Resident #139 had refused care all day. NA #5 did not report this to any unit manager or supervisor. An interview with the Administrator was conducted on 08/08/25 at 4:00 PM. The Administrator stated she expected staff to provide care to all residents and if care is being refused then to report that to the Unit	F0677		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0677 SS = D	Continued from page 57 Manager or the DON. The Administrator stated she was made aware of the situation during the investigation process and was in agreement with the decision to terminate NA #5 due to her not making anyone aware of Resident #139 refusing care and allowing her to remain wet all day.	F0677		
F0700 SS = E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and Nurse Practitioner and staff interviews, the facility failed to accurately assess 3 of 3 severely cognitively impaired residents for bilateral half side rails on their beds (Resident #2, Resident #64, and Resident #77). The findings included: 1. Resident #2 was admitted to the facility on 08/07/22 with diagnoses which included dementia with psychotic disturbance, gastrostomy tube, and atrial fibrillation. Review of Resident #2's consent for use of bed rails	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 58 dated 08/07/22 revealed the facility received telephone consent from the resident's responsible party (RP) but the consent was not signed by the RP or the nurses receiving consent. Review of Resident #2's care plan dated 07/15/25 revealed a focus area for activities of daily living (ADL) deficits related to generalized weakness and cognitive loss secondary to dementia, congestive heart failure (CHF), atrial fibrillation, and stroke with hemiplegia (paralysis on one side of body). The goal was for the resident to be able to participate in some aspects of ADL care with staff assistance through the next review date. The interventions included: padded bilateral half side rails as ordered. Resident #2's annual Minimum Data Set (MDS) assessment dated 07/18/25 revealed she was severely cognitively impaired, unable to make her needs known and staff had to anticipate her needs daily. The assessment also revealed she required extensive assistance of 2 staff members for bed mobility and she was on a turning and repositioning program. Review of a Care Area Assessment dated 07/18/25 for cognitive loss revealed resident had an abdominal binder over her gastrostomy tube, bed bolsters, foot buddy, geri sleeves, high back wheelchair, and padded bilateral half side rails for safety. Review of Resident #2's medical record revealed she had side rail assessments completed on: a. 07/22/25 – padded half side rails – able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – decrease risk of injury, enable/increase bed mobility, enable/increase independence, enables resident to reposition self, provides tactile barrier and repositioning/support; device assists in improving functional status – yes; restricts freedom of movement – no; select device classification – enabler. b. 04/17/25 – padded half side rails – able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness, weakness as evidenced by disease process; reason for device use – decreased risk of injury, enable/increase independence, enables resident to reposition self, and provides tactile barriers; device assists in improving functional status – yes; restricts freedom of movement – no; select device classification – enabler.	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 59 c. 10/22/24 – padded half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness, weakness as evidenced by disease process; reason for device use – decreased risk of injury, enable/increase independence, enables resident to reposition self, and provides tactile barriers; device assists in improving functional status – yes; restricts freedom of movement – no; select device classification – enabler. Review of Resident #2's physician orders dated 08/01/25 revealed an order for padded bilateral half side rails to bed to assist in bed mobility related to muscle weakness related to dementia. Observation of Resident #2 on 08/04/25 at 9:23 AM revealed her lying in bed in her room with half side rails up on either side of her bed. The side rails were padded with gray pool noodle type material and electrical tape. The top of both rails was padded and the rest of the rail was open and metal. The resident was mumbling incoherently and unable to answer questions or follow any directions. Observation of Resident #2 on 08/05/25 at 10:03 AM revealed her lying in bed in her room with half side rails up on either side of her bed. The side rails were padded with gray pool noodle type material and electrical tape. The resident was mumbling incoherently and unable to answer questions or follow any directions. Observation of Resident #2 on 08/06/25 at 4:39 PM revealed her lying in bed in her room with her side rails up on either side of her bed. The Risk Nurse and the Director of Nursing (DON) were in to the room to do a side rail assessment, and the resident was upset and mumbling and unable to follow directions to turn and hold herself over or hold onto the side rail with her hand. The DON stated they would attempt the evaluation later when the resident was not upset. Observation of Resident #2 on 08/06/25 at 5:53 PM revealed her lying in bed in her room with her side rails up on either side. The Risk Nurse and DON instructed the resident to turn on her side and hold onto the side rail and she was unable to turn on her side and had to be turned by the nurses and was unable to hold onto the side rail to hold herself over on her side. The resident made no attempt to put her hand on the rail or hold onto the rail to hold herself over on her side. The DON stated the resident was not appropriate for side rails and they would be removed from her bed.	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 60 An interview on 08/06/25 at 6:15 PM with the interim Administrator revealed she would expect that all residents be evaluated accurately for side rails and side rails initiated based on their assessment. An interview on 08/07/25 at 12:41 PM with the Nurse Practitioner (NP) about side rails revealed she had never really thought much about them at the facility and said she thought the facility put in an “automatic protocol for side rails kind of like a standing order.” The NP stated she really hadn’t thought about whether residents were appropriate for side rails and expected the staff to ensure residents were appropriate for side rails and if there was a change in the resident’s status that they would be re-evaluated for the appropriateness of side rails. The NP further stated there were a lot of residents in the facility with side rails on their beds. An interview on 08/07/25 at 3:01 PM with Nurse Aide (NA) #9 who frequently took care of Resident #2 stated she was total care and was unable to make her needs known. She stated Resident #2 was pleasantly confused and only alert sometimes to her name. NA #9 further stated Resident #2 was on a turning and repositioning program and was unable to assist in her bed mobility and could not use her side rails to hold herself over in the bed. An interview on 08/07/25 at 5:45 PM with the Risk Nurse revealed residents were first assessed for other measures prior to side rails being assessed and initiated. She stated the staff evaluated residents for call bell use, positioning in bed, whether they were fall risk, their mental status, use of bed bolsters and then assessed them for side rails. The Risk Nurse stated that a lot of times when residents were admitted their family members preferred for them to have side rails to keep them from falling out of bed but said the side rails were not utilized to keep residents in bed. She further stated there were times that families insisted on side rails so they had obliged and provided them. An interview on 08/08/25 at 6:15 PM with the DON and Assistant DON (ADON) revealed they were taught by the previous Safety Nurse that if the family consented to side rails then they were to be provided. The ADON stated that basically they went through the motions of the side rail assessment and clicked the boxes they had been taught to click and put in physician orders for the side rails due to family request. She further stated that if the family was not present in the	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 61 building they called the RP and got the request over the phone and two nurses signed the consent. The DON and ADON stated that was the way they had done it since being at the facility. An interview on 08/08/25 at 5:30 PM with the Administrator revealed she thought the assessments not being completed accurately for side rails was due to new nurses and some veteran nurses in new roles not understanding the process. The Administrator stated she was not clinical and did not typically micro-manage her nurses but said she expected them going forward to follow the protocol and complete the assessments accurately. 2. Resident #64 was admitted to the facility on 09/07/21with diagnoses which included left sided hemiplegia (paralysis of one side of the body), following stroke, aphasia, dysphagia, and vascular dementia. Review of Resident #64's consent for use of bed rails revealed the facility received written consent signed by the RP on 09/06/21. Review of Resident #64's care plan dated 07/06/25 revealed a focus area for ADL deficits related to generalized weakness, cognitive loss and decreased mobility, secondary to stroke with hemiplegia and hypertension. The goal was for Resident #64 to improve in bathing, dressing, toileting, grooming and functional transfers through skilled therapy services. The interventions included: bilateral half rails as ordered. Resident #64's quarterly Minimum Data Set (MDS) assessment dated 07/07/25 revealed she was severely cognitively impaired, unable to make her needs known and staff had to anticipate her needs daily. The assessment also revealed she required maximal assistance to dependence of 1 to 2 staff members for bed mobility and she was on a turning and repositioning program. Review of Resident #64's medical record revealed she had side rail assessments completed on: a. 07/07/25 – half side rails – able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes;	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 62 device restricts freedom of movement – no; device classification – enabler. b. 04/14/25 – half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device classification – enabler. c. 03/18/25 - half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device classification – enabler. d. 12/16/24 - half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device classification – enabler. e. 08/30/24 - half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device classification – enabler. Review of Resident #64's physician orders dated 08/01/25 revealed an order for bilateral half side rails to bed to assist in bed mobility related to muscle weakness related to stroke and dementia. Observation of Resident #64 on 08/04/25 at 9:33 AM revealed her lying in bed in her room with half side rails up on either side of her bed. The resident was alert and talking incoherently and unable to answer questions or follow any directions.	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 63 Observation of Resident #64 on 08/05/25 at 10:15 AM revealed her lying in bed in her room with half side rails up on either side of her bed. The resident was alert and talking incoherently and unable to answer questions or follow any directions. An interview on 08/06/25 at 6:15 PM with the interim Administrator revealed she would expect that all residents be evaluated accurately for side rails and side rails initiated based on their assessment. An interview on 08/07/25 at 12:41 PM with the Nurse Practitioner (NP) about side rails revealed she had never really thought much about them at the facility and said she thought the facility put in an “automatic protocol for side rails kind of like a standing order.” The NP stated she really hadn’t thought about whether residents were appropriate for side rails and expected the staff to ensure residents were appropriate for side rails and if there was a change in the resident’s status that they would be re-evaluated for the appropriateness of side rails. The NP further stated there were a lot of residents in the facility with side rails on their beds. An interview on 08/07/25 at 3:01 PM with Nurse Aide (NA) #8 who frequently took care of Resident #64 stated she was total care and was unable to make her needs known. She stated Resident 64 was pleasantly confused most of the time and only alert sometimes to her name. NA #8 further stated Resident #64 was on a turning and repositioning program and was unable to assist in her bed mobility and could not use her side rails to hold herself over in the bed when providing her care. She indicated Resident #64 stayed in bed and did not get up much out of bed. An interview on 08/07/25 at 5:45 PM with the Risk Nurse revealed residents were first assessed for other measures prior to side rails being assessed and initiated. She stated the staff evaluated residents for call bell use, positioning in bed, whether they were fall risk, their mental status, use of bed bolsters and then assessed them for side rails. The Risk Nurse stated that a lot of times when residents were admitted their family members preferred for them to have side rails to keep them from falling out of bed but said the side rails were not utilized to keep residents in bed. She further stated there were times that families insisted on side rails, so they had obliged. An interview on 08/08/25 at 6:15 PM with the DON and Assistant DON (ADON) revealed they were taught by the previous Safety Nurse that if the family consented to	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 64 side rails, then they were to be provided. The ADON stated that basically they went through the motions of the side rail assessment and clicked the boxes they had been taught to click and put in physician orders for the side rails due to family request. She further stated that if the family was not present in the building they called the RP and got the request over the phone and two nurses signed the consent. The DON and ADON stated that was the way they had done it since being at the facility. An interview on 08/08/25 at 5:30 PM with the Administrator revealed she thought the assessments not being completed accurately for side rails was due to new nurses and some veteran nurses in new roles not understanding the process. The Administrator stated she was not clinical and did not typically micro-manage her nurses but said she expected them going forward to follow the protocol and complete the assessments accurately. 3. Resident #77 was admitted to the facility on 06/25/24 and readmitted on 07/31/24 with diagnoses which included dementia with agitation, diabetes mellitus, and chronic kidney disease. Review of Resident #77's consent for use of bed rails revealed the facility received written consent signed by the RP on 06/25/24. Review of Resident #77's care plan dated 06/26/25 revealed no focus area or interventions for the resident using half side rails on her bed. Resident #77's quarterly Minimum Data Set (MDS) assessment dated 07/07/25 revealed she was severely cognitively impaired, unable to make her needs known and staff had to anticipate her needs daily. The assessment also revealed she required maximal assistance to dependence of 1 to 2 staff members for bed mobility and she was on a turning and repositioning program. Review of Resident #77's medical record revealed she had side rail assessments completed on: a. 05/28/25 – half side rails – able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 65 classification – enabler. b. 03/07/25 – half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device classification – enabler. c. 02/11/25 - half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device classification – enabler. d. 12/09/24 - half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device classification – enabler. e. 09/10/24 - half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device classification – enabler. f. 08/20/24 - half side rails - able to remove on command consistently – no; factors/symptoms/medical symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – enable/increase bed mobility, enable/increase independence, and enables resident to reposition self; device assists in improving functional status – yes; device restricts freedom of movement – no; device classification – enabler g. 07/22/24 – padded half side rails – able to remove on command consistently – no; factors/symptoms/medical	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 66 symptoms – poor safety awareness and weakness as evidenced by disease process; reason for device use – decrease risk of injury, enable/increase bed mobility, enable/increase independence, enables resident to reposition self, provides tactile barrier and repositioning/support; device assists in improving functional status – yes; restricts freedom of movement – no; device classification – enabler. Review of Resident #77's physician orders dated 08/01/25 revealed an order for bilateral half side rails to bed to assist in bed mobility related to muscle weakness related to hemiplegia and stroke. Observation of Resident #77 on 08/04/25 at 8:54 AM revealed her lying in bed in her room with her eyes closed and her half side rails up on either side of her bed. She opened her eyes to her name being called but was unable to answer questions or follow any type of directions. Observation of Resident #77 on 08/05/25 at 10:34 AM revealed her lying in bed in her room with her eyes open and her half side rails up on either side of her bed. She responded to her name being called but again was unable to answer questions or follow directions. An interview on 08/06/25 at 6:15 PM with the interim Administrator revealed she would expect that all residents be evaluated accurately for side rails and side rails initiated based on their assessment. An interview on 08/07/25 at 12:41 PM with the Nurse Practitioner (NP) about side rails revealed she had never really thought much about them at the facility and said she thought the facility put in an "automatic protocol for side rails kind of like a standing order." The NP stated she really hadn't thought about whether residents were appropriate for side rails and expected the staff to ensure residents were appropriate for side rails and if there was a change in the resident's status that they would be re-evaluated for the appropriateness of side rails. The NP further stated there were a lot of residents in the facility with side rails on their beds. An interview on 08/07/25 at 5:01 PM with Nurse Aide (NA) #9 who frequently took care of Resident #77 stated she was total care and was unable to make her needs known. She stated Resident #77 was pleasantly confused most of the time and only alert sometimes to her name. NA #9 further stated Resident #77 was on a turning and repositioning program and was unable to assist in her bed mobility and could not use her side rails to hold	F0700		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0700 SS = E	Continued from page 67 herself over in the bed and the staff did most of the work when providing her care. An interview on 08/07/25 at 5:45 PM with the Risk Nurse revealed residents were first assessed for other measures prior to side rails being assessed and initiated. She stated the staff evaluated residents for call bell use, positioning in bed, whether they were fall risk, their mental status, use of bed bolsters and then assessed them for side rails. The Risk Nurse stated that a lot of times when residents were admitted their family members preferred for them to have side rails to keep them from falling out of bed but said the side rails were not utilized to keep residents in bed. She further stated there were times that families insisted on side rails, so they had obliged. An interview on 08/08/25 at 6:15 PM with the DON and Assistant DON (ADON) revealed they were taught by the previous Safety Nurse that if the family consented to side rails, then they were to be provided. The ADON stated that basically they went through the motions of the side rail assessment and clicked the boxes they had been taught to click and put in physician orders for the side rails due to family request. She further stated that if the family was not present in the building, they called the RP and got the request over the phone, and two nurses signed the consent. The DON and ADON stated that was the way they had done it since being at the facility. An interview on 08/08/25 at 5:30 PM with the Administrator revealed she thought the assessments not being completed accurately for side rails was due to new nurses and some veteran nurses in new roles not understanding the process. The Administrator stated she was not clinical and did not typically micro-manage her nurses but said she expected them going forward to follow the protocol and complete the assessments accurately.	F0700		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F0757		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0757 SS = D	Continued from page 68 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, staff, pharmacy and Nurse Practitioner (NP) interviews, the facility failed to prevent a drug regimen free from unnecessary drugs for 1 of 17 residents reviewed for unnecessary medications. Resident #142 was administered a tuberculosis skin test using tubersol. Record Review indicated to only perform a screening as Resident #142 had an allergy to tubersol. The findings included: 1. Resident #142 was admitted to the facility on 03/04/21 with diagnosis that included vascular dementia, hypertension, and unspecified respiratory tuberculosis. Record review of admission paperwork dated 03/04/21 revealed Resident #142 had listed an allergy to tubersol (an intradermal solution used to perform a Mantoux test which test for dormant or active tuberculosis (TB)). No origin of allergy or reaction was noted on paperwork. Review of physician order dated 08/01/21 revealed Resident #142 was to receive TB screening sheet annually on March 1. Review of Resident #142 March 2025 Medical Administration Record (MAR) revealed Resident #142 was	F0757		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0757 SS = D	Continued from page 69 to receive a TB screening sheet. Review of nursing note dated 03/01/2025 at 7:51PM by Nurse #10 indicated in part that Resident #142 was given a Mantoux test in right mid forearm around 12 pm on her shift, after which she realized Resident #142 had an allergy to tubersol. NP was immediately notified and at that time Resident #142 was showings no signs or symptoms of adverse reactions. NP gave an order for as needed antihistamine. The responsible party (RP) was notified and inquired about previous adverse reaction to the tubersol. RP stated in the past he had a mild skin reaction to the tubersol given. RP made aware that Resident #142 would be closely monitored. Review of nursing note dated 03/02/2025 at 3:47 PM by Nurse #10 indicated in part that Resident #142 was assessed and a round slightly pink area noted at the injection site approximately 5x4 centimeters slightly raised. Resident #142 was stable with no other concerns. Nurse #10's note stated she notified the NP and got new orders for ice to the area as needed and a chest x-ray. Nurse #10's notes also indicated she called the RP to make them aware of the changes. Review of nursing note dated 03/05/25 indicated the injection site to right forearm continues with discoloration but has decreased in size. Record review on 03/03/25 of chest x-ray results revealed no definite acute infiltrate, pheumothorax, congestion or pleural effusion and no Tuberculosis seen. Nurse #10 was not available for interview. An interview with the Director of Nursing (DON) on 08/07/25 at 9:25 AM revealed she started in her position with the facility in April 2025 and discovered medication errors were a concern for the facility. She reported she began a new program to reduce the medication errors. She reported that she had begun doing audits on all medical administration records (MAR) and if a medication aide made a medication error once it was an immediate write up, if the medication aide had a second medication error offense they were removed from the position and had to be retrained, if a medication error was made by a nurse, the first offense	F0757		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET , KINGS MOUNTAIN, North Carolina, 28086

(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
F0757 SS = D	Continued from page 70 was a write up and the second offense was termination. The DON reported she had reviewed the medication administration policy with all staff responsible for giving medications. An interview with a pharmacist on 08/07/25 at 12:15 PM indicated that anytime a medication is given to someone who has a listed allergy to the medication there could be a significant risk to that person. She reported that allergies are marked on the resident's charts and on the MAR and should be checked before administering any medications. An interview with the NP on 08/07/25 at 1:10 PM revealed she had been made aware of the medication given in error. She reported she expected nurses and medication aides to check orders twice before administering medications of any kind. The NP stated they monitored Resident #142 closely for several days after the tubersol was administered and he had no adverse reactions. An interview with the Administrator on 08/07/25 at 1:40 PM revealed she was familiar with Resident #142 and him receiving a medication that was listed as being allergic to. She stated she realized medication errors had been a problem for several months within the facility and she contributed that to the DON position being filled with multiple, temporary DON's from October 2024 to April 2025. She reported the current DON had made it a priority and had put measures in place to reduce the error rate.	F0757		