| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **White Oak Manor - Tryon** | **70 Oak Street , Tryon, North Carolina, 28782** |

| (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 |
|---|---|---|---|---|
| F0000 | INITIAL COMMENTS<br><br>An unannounced complaint investigation was conducted from 01/28/26 through 02/03/26. The survey team returned onsite on 02/04/26 to validate the credible allegation, therefore the exit date was changed to 02/04/26. Event ID #1E2ACC-H1. Intake #2726738 was investigated and resulted in immediate Jeopardy. One of the one complaint allegation resulted in deficiency.<br><br>Immediate Jeopardy was identified at:<br><br>CFR 483.25 at tag F689 at a scope and severity J.<br><br>Tag F689 constituted Substandard Quality of Care.<br><br>Immediate Jeopardy began on 01/24/26 and was removed on 01/31/26. A partial extended survey was completed. | F0000 | | 02/28/2026 |
| F0689<br>SS = SQC-J | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, record review, manufacturer recommendations, North Carolina Governor's Executive Order, and staff, Family Member, Medical Director, Civilian, Emergency Medical Services (EMS), and Assistant Fire Chief interviews, the facility failed to supervise a cognitively impaired resident, who had a diagnosis of dementia and wore an elopement alarm device due to exit-seeking behavior, from exiting the facility without staff knowledge for 1 of 3 residents reviewed for supervision to prevent accidents (Resident | F0689 | F689<br><br>White Oak Manor – Tryon will ensure that resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents.<br><br>Residents that are at risk for elopement have the potential to elope if not adequately supervised.<br><br>· How will corrective action be accomplished for those residents found to have been affected by the deficient practice?<br><br>Resident #1 exited the facility from the main entrance on Saturday, 01/24/26 at around 10:30am without the facility's knowledge. Resident #1 had removed the applied alarm bracelet from their person and placed it in their purse and had an alarm bracelet applied to rollator that is not recommended by the manufacturer. Resident #1 was noted making comments about wanting to leave the facility. Resident was closely monitored after incident until Resident #1 transferred to another facility with a secured unit on 01/30/26.<br><br>· How will the facility identify other residents having the potential to be affected by the same deficient | 02/28/2026 |

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: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 1<br>#1). On Saturday 01/24/26, Resident #1 exited the facility with her walker, wearing thin, capri pants and a loose-fitting shirt with no jacket in 36-degree Fahrenheit weather. Resident #1 walked through the parking lot and down the hill on a public two-lane road with a posted speed limit of 25 miles per hour approximately 300 to 400 feet toward the stop sign, turned right and continued walking along another public two lane road with no sidewalks approximately 500 to 600 feet where she fell down a 17-foot embankment. At approximately 10:00 AM, a Civilian found Resident #1 down the embankment holding onto a tree limb just above a riverbed and contacted EMS. Fire and EMS personnel used a stokes basket (a rigid, basket-shaped stretcher with raised sides that is designed to fully contain and protect an individual and used by rescue teams to remove individuals from steep inclines and across uneven ground) to lift Resident #1 out of the embankment. Resident #1 was transported to the hospital where she was assessed to have a right frontal forehead contusion (bruise on the upper right side of the head caused by a blunt impact that breaks small blood vessels under the skin typically causing pain, swelling and bruising). This deficient practice had a high likelihood of causing serious injury, serious bodily harm such as hypothermia (abnormally low body temperature caused by being exposed to extremely cold temperatures for a long period of time), or death.<br><br>Immediate jeopardy began on 01/24/26 when Resident #1 exited the facility without staff knowledge, walked along public roadways and fell down an embankment. Immediate Jeopardy was removed on 01/31/26 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective.<br><br>Findings included:<br><br>Review of the undated manufacturer's recommendations, provided by the Administrator, specified in part, "The Secure Care 135DE Door Guardian wander management system uses active, waterproof transmitters (elopement alarm bracelets) that can be worn on either the ankle or the wrist according to manufacturer specifications. Proper placement is critical for ensuring continuous monitoring with recommended placement and attachment guidelines for location: transmitters may be placed on either the ankle or the wrist."<br><br>Resident #1 was admitted to the facility from home on | F0689 | Continued from page 1<br>practice?<br><br>Initial audit was completed by the Quality Information Manager (QIM) and the SSD on 01/25/26 of the current identified residents that have exit seeking behaviors to ensure their alarm bracelets were present and, they have current orders for the alarm bracelet, elopement observations that assess the residents for being at risk for elopement are current, current care plans and that the residents were identified on picture board for staff to be aware of which residents are at risk for elopement.<br><br>Initial audit was completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 01/24/26 to ensure no other current residents were identified at risk for elopement that required an alarm bracelet or closer supervision.<br><br>An initial audit was completed by Maintenance Department on 01/24/26 to ensure the functioning of all the doors alarming when an alarm bracelet is approached and to ensure the currently applied alarm bracelets were functioning.<br><br>An additional audit completed on 2/20/26 by the Administrator to ensure no further changes with risk for elopement of current residents. A review of newly admitted residents since 01/24/26 was also audited to ensure the elopement assessment observations were completed on all residents. For identified residents with exit seeking behaviors, an alarm<br><br>bracelet was applied appropriately on the residents' wrist or leg, physician order initiated and added to the residents' care plan and to the picture board.<br><br>The alarming doors and alarm bracelets on the residents with exit seeking behaviors were previously checked weekly by the Maintenance Department and Nursing Coordinator. The residents' alarm bracelets were checked weekly for placement, functioning, and ensure they are not expired. The alarming doors are tested by using the test box to ensure functioning. The wander alarm bracelets on the residents are tested by escorting the resident near the door to ensure it locks down and when the door is open to ensure the alarm sounds. This process was changed and checks were made more often. The Maintenance Department increased their checks of all door alarms to 3 times a week to ensure the doors alarm function properly. This will be accomplished by using the test box. This increase was initiated on the week of 2/2/26 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **White Oak Manor - Tryon** | **70 Oak Street , Tryon, North Carolina, 28782** |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 2<br>01/22/26 with diagnoses that included dementia-mild without behavioral disturbance, mood disturbance and anxiety.<br><br>A Resident Brief Interview of Mental Status (BIMS, a 15-point screening tool used in long-term care settings to assess a resident's cognitive function) assessment dated 01/22/26 revealed Resident #1 had a BIMS score of ten out of fifteen (score of 8 to 12 indicates moderate cognitive impairment).<br><br>An elopement risk assessment dated 01/22/26 that was completed by the Social Worker revealed Resident #1 was resistive to nursing home placement, verbally expressed a desire to leave the facility or go home, had poor decision-making skills, and had a diagnosis of dementia. The risk assessment score indicated Resident #1 was at risk for elopement.<br><br>A nurse progress note dated 01/22/26 at 7:41 PM written by Nurse #2 revealed Resident #1's roommate reported Resident #1 was packing her clothes and talking about leaving this afternoon. Medical Director was at the facility and gave an order for an elopement alarm device. An elopement alarm bracelet was applied to Resident #1's walker and cane.<br><br>Review of Resident #1's physician orders dated 01/22/26 revealed no order for the elopement alarm device.<br><br>A skilled nursing note dated 01/23/26 at 4:20 PM written by the Weekend Registered Nurse (RN) Supervisor revealed Resident #1 required supervision or touching assistance with transfers, sit-to-stand and walking.<br><br>A nurse progress note dated 01/24/26 at 3:15 PM written by the Director of Nursing (DON) revealed in part, Resident #1's Family Member was visiting at the facility when the Family Member was contacted by EMS. Resident #1's Family Member reported EMS stated Resident #1 was found outside on facility grounds lying near her walker and was transported to the hospital.<br><br>During an interview conducted on 01/28/26 at 3:06 PM, the DON revealed that on 01/24/26 at approximately 10:30 AM, she was working on the 100 Hall medication cart when the Weekend Registered Nurse (RN) Supervisor asked if she had seen Resident #1 as her family was at the facility for a visit, but they could not locate Resident #1. The DON told the Weekend RN Supervisor that she last observed Resident #1 standing by the nurses' station approximately 15 to 20 minutes earlier. The DON stated at that point, she went into "Code Adam" (facility's missing person protocol) mode. She had | F0689 | Continued from page 2<br>The DON, ADON, Unit Coordinators, Activities or Social Services Departments increased their checks for the residents' alarm bracelets to 3 times a week to ensure the alarm bracelets are functioning properly and activate the doors. This will be accomplished by escorting the resident with alarm bracelets to the door to ensure they sound the alarm and activate the doors when closed. This was initiated on the week of 2/2/26.<br><br>· What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?<br><br>The facility staff were initially re-educated by the DON and ADON starting on 01/24/26 and completed by 01/28/26, and will be completed again by 02/27/26 regarding missing person/exit seeking /Code Adam protocol, the risk for elopement boards and where they are located to ensure they always know which residents are at risk and to ensure they can be identified and aware of their wandering, provide re-direction and contact the nurse as needed. Re-education also included regarding door alarms and when a door alarm sounds, to stop and check the surroundings, redirect the resident that is attempting to elope and ensure no residents left the facility unattended. The current education will also include to notify the licensed nurse manager and/or social services department if the resident is voicing that they want to leave facility and removing their alarm bracelet to be assessed for possible need on 1-on-1 monitoring, location and referral to a secured unit. The education further included the door codes were newly assigned, are confidential, and not shared with visitors or residents under any circumstances. Cameras are being used to support resident safety and facility security. Cameras were installed on 2/13/26. A new visitor communication system will be installed on 2/25/26 and has a microphone feature to communicate with individuals at the entrances. This new system is to support resident<br><br>safety and prevent elopement. Newly hired staff will receive this education during their job specific orientation by the Staff Development Coordinator (SDC) or Corporate Consult.<br><br>The Licensed Nurses and Social Services Department were re-educated by the DON, and ADON starting on 01/24/26 and completed by 01/28/26, and will be completed again by 02/27/26 regarding the elopement observation and to precede once a resident is identified with exit seeking behaviors, to apply an alarm bracelet, obtain an order for the alarm bracelet, complete elopement observation, picture binders and boards, and care planned the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 3<br>everyone drop what they were doing and start a search to find Resident #1. She recalled while searching for Resident #1, staff mentioned Resident #1 was last seen looking for the turtles in the facility courtyard, though it was cold outside. The DON explained that staff completed several sweeps of the inside and outside of the facility, including the lobby and courtyards, and one staff member drove around the facility property but Resident #1 was not located. The DON stated around 11:00 AM she was at the nurses' station with Resident #1's family when Resident #1's Family Member received a call from EMS stating Resident #1 was being transported to the hospital. The DON indicated she was unsure how Resident #1 exited the building and explained it was a busy and hectic weekend with visitors coming and going all day due to the impending winter storm. She suggested that it was possible a visitor held the door open, allowing Resident #1 to leave. The DON confirmed Resident #1 had an elopement alarm bracelet which should have caused the alarm to sound when she walked through the exit door. However, the DON stated she did not recall hearing the alarm sound at any point that morning.<br><br>A witness statement written by the Weekend RN Supervisor and dated 01/24/26 revealed in part, Resident #1 was seen frequently by the Weekend RN Supervisor between 7:30 AM and 9:30 AM. Resident #1 was confused, asking about leaving and going outside. Resident #1 was walking in the halls looking for an exit and attempting to open the doors at the nurses' station and on 200 Hall, but they would not open for Resident #1. The Weekend RN Supervisor indicated she redirected Resident #1 multiple times and got Resident #1 to sit down in a chair near the 200 Hall medication cart. A few minutes later around 9:30 AM, Resident #1 got up, started walking toward 100 Hall and that was the last time Resident #1 was seen by the Weekend RN Supervisor.<br><br>During a telephone interview conducted on 01/28/26 at 4:22 PM, the Weekend RN Supervisor confirmed she worked on the 200 Hall medication cart during the hours of 7:00 AM to 7:00 PM on 01/24/26 but was not Resident #1's assigned nurse that day. The Weekend RN Supervisor recalled Resident #1 got up early that morning and was restless, confused and wandering around the facility wanting to find a way out. She did not recall actually seeing the elopement alarm bracelet on Resident #1 but did recall the exit doors and doors by the nurses' station leading out to the lobby locked and wouldn't open when Resident #1 went up to the doors. The Weekend RN Supervisor stated sometime between 9:00 AM and 9:30 AM, Resident #1 was sitting in a chair out in the hall | F0689 | Continued from page 3<br>resident for the exit seeking behavior. Current education also included that when residents are removing their alarm bracelet from their wrist or ankle, then the next step is to provide 1-on-1 monitoring until the behavior subsides or placement for secured unit is obtained. Newly hired licensed nurses will receive this education during job specific orientation by the SDC or Corporate Consultant.<br><br>· How will the facility monitor its corrective actions to ensure the deficient practice will not recur?<br><br>The DON, ADON or Administrator will monitor weekly for 12 weeks that the Maintenance Department is completing checks 3 times a week to the alarming doors to ensure the doors are sounding appropriately.<br><br>The DON or Administrator will monitor weekly for 12 weeks that the ADON, Unit Coordinators, Activities or Social Services Departments are checking for the residents' alarm bracelets 3 times a week. This is ensuring the alarm bracelets are functioning properly and activate the doors by escorting the residents with alarm bracelets to the door.<br><br>The DON, ADON or SSD will monitor by checking 5 residents weekly for 12 weeks to ensure the Elopement Observations are completed, residents are being identified as elopement risk and followed up to ensure the alarm bracelet is applied, physician order obtained, added to photo binders and boards, and care planned with appropriate interventions including the potential need for 1-on-1 or location monitoring and/or need for a referral to a secured unit. The monitoring will also include checking the placement of the alarm bracelet on the resident.<br><br>The Administrator will monitor the completion of the Code Adam drills are being conducted by the DON and/or ADON and completed monthly for 3 months for all shifts including weekends.<br><br>Identified trends or issues from the monitoring tools will be discussed during the morning Quality Improvement (QI) meetings, weekly for 12 weeks, and then further discussions during the Quality Assurance (QA) Committee meetings for recommendations as indicated.<br><br>The DON is responsible for the ongoing compliance of F689. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **White Oak Manor - Tryon** | **70 Oak Street , Tryon, North Carolina, 28782** |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 4<br>while she was at the medication cart and Resident #1 got up stating she needed to find the room to get paid for the work she had done. The Weekend RN Supervisor stated she redirected Resident #1 back to her chair and then a few minutes later, saw her walking toward the 100 Hall and she did not see Resident #1 again after that. She stated when Code Adam was called, all staff members immediately started searching for Resident #1 until the facility was informed Resident #1 was found and at the hospital. The Weekend RN Supervisor did not know how Resident #1 exited the building and explained when a resident with an elopement alarm bracelet went through an alarmed door, you could hear the alarm out at the nurses' desk or out on the hall, but she did not recall hearing the alarm sound that morning.<br><br>A witness statement obtained via phone from Nurse Aide (NA) #1 on 01/24/26 revealed NA #1 reported that between 8:30 AM and 9:30 AM, she noticed Resident #1 had not eaten her breakfast tray. Resident #1 was walking around and when NA #1 asked Resident #1 if she was going to eat, Resident #1 replied no. NA #1 stated she removed Resident #1's meal tray and she did not see Resident #1 again that morning.<br><br>During a telephone interview on 02/03/26 at 12:48 PM, NA #1 confirmed she was assigned to provide care to Resident #1 on 01/24/26 during the hours of 7:00 AM to 7:00 PM and it was the first time she had worked with Resident #1. NA #1 revealed Resident #1 had been walking around the facility all morning, but she had not observed Resident #1 going up to exit doors or verbalizing that she wanted to leave. NA #1 stated sometime between 8:30 AM and 9:00 AM she noticed Resident #1 had not eaten her breakfast and was walking around the hall. NA #1 stated when she asked Resident #1 if she was going to eat her breakfast, Resident #1 replied no and NA #1 removed the breakfast tray from Resident #1's room. NA #1 stated she did not see Resident #1 again after that encounter. NA #1 stated she did not notice if Resident #1's elopement alarm bracelet was in place when she observed her walking around that morning. She stated that at one point, a Code Adam was called, and all the NAs had to go check their assigned residents to make sure the residents with elopement alarm bracelets had them in place. NA #1 did not recall hearing an alarm sound nor did she know when or how Resident #1 exited the facility.<br><br>A witness statement written by Nurse #1 and dated 01/24/26 revealed at 9:40 AM, Resident #1 was observed wandering around the 400 Hall looking for the turtles. Nurse #1 told Resident #1 she was in the wrong place and the turtles were outside. Nurse #1 advised Resident | F0689 | Continued from page 4<br>Compliance date is 02/28/26. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **White Oak Manor - Tryon** | **70 Oak Street , Tryon, North Carolina, 28782** |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 5<br>#1 not to go outside because of the cold weather. Resident #1 replied “ok, I’ll take a look” and then walked toward the nurses’ station.<br><br>During a telephone interview conducted on 02/04/26 at 3:43 PM, Nurse #1 recalled on 01/24/26 at approximately 9:40 AM, he was standing at the 400 Hall medication cart that was placed near the nurses’ desk and adjacent to 300 Hall. Nurse #1 recalled observing Resident #1 wandering around the 400 hall, asking about the location of the turtles. Nurse #1 stated he walked with Resident #1 to the courtyard door on 300 Hall to show her where the turtles were located. He recalled Resident #1 voicing that it was too cold outside, and she then proceeded to walk back down the 300 hall toward the nurses’ station near the front lobby. Nurse #1 stated that was the only time he observed Resident #1 and could not recall for certain if the alarm sounded that morning (01/24/26).<br><br>During a telephone interview conducted on 01/29/26 at 8:57 AM, the Civilian (former Fire Department employee who found Resident #1) recalled sometime after 9:00 AM on 01/24/26 he was driving toward town and observed Resident #1 walking along a public road with her walker. He stated this appeared strange because the road was narrow and lacked sidewalks, which made it dangerous for someone to walk along. He stated he stopped to ask Resident #1 if she was ok, and Resident #1 replied that she was fine and was just out getting some fresh air. The Civilian stated he proceeded into town and when he returned approximately 15 to 20 minutes later, he saw Resident #1’s walker on the side of the road. He immediately stopped, blocked the road with his vehicle and began searching for Resident #1. He stated as he walked down the side of the road, he heard Resident #1 yelling for help. She had fallen approximately 17 feet down a steep embankment near the riverbed and was holding on to a tree limb. After calling 911, the Civilian stated he climbed down the embankment to Resident #1 and upon initial assessment, Resident #1 did not appear to have any life-threatening injuries. He explained Resident #1 was alert but not fully oriented, she was aware of her circumstances, her pupils were reactive to light, and she had no signs or symptoms of brain injury. The Civilian stated when Fire and EMS personnel arrived, he assisted them with slowly moving Resident #1 up the embankment to the stokes basket and ladder for them to pull her the rest of the way up and then she was placed into the ambulance for transport to the hospital. The Civilian stated when he first reached Resident #1, she was wearing one shoe, thin beige capris and a loose fitting, long-sleeve shirt. He stated Resident #1’s hands were still warm; | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **White Oak Manor - Tryon** | **70 Oak Street , Tryon, North Carolina, 28782** |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 6<br>however, due to the cold weather, a warming blanket was placed on her midway through the process of moving her up the embankment. The Civilian estimated Resident #1 had walked approximately one fifth of a mile from the facility before her fall.EMS records dated 01/24/26 revealed medics arrived at the embankment adjacent to the public road where Resident #1 was located at 10:00 AM and observed Resident #1 “standing at the bottom of the embankment with first responders.” EMS records noted that Resident #1 “reported she was walking when she tripped and fell down a 17-foot embankment.” Resident #1 had a minor hematoma (type of bruise that happens when an injury causes blood to collect and pool under the skin) on her forehead with no other injuries noted. Resident #1 was removed from the embankment via a stokes basket, placed on a stretcher with rails in upright position and transported to the hospital by EMS at 10:28 AM.<br><br>During a telephone interview conducted on 01/28/26 at 12:14 PM, EMS Personnel #1 stated that between 9:30 AM and 10:00 AM on 01/24/26, EMS received a call reporting that an elderly female had fallen down a 17-foot embankment. EMS Personnel #1 stated they had to use a ladder and stokes basket to get Resident #1 safely back up the embankment. She stated the outside temperature was 30 degrees at the time Resident #1 was found and she was wearing thin pajamas without a jacket or shoes. EMS Personnel #1 also stated there was no elopement alarm bracelet observed on Resident #1. Upon initial assessment, EMS Personnel #1 stated the only injury noted was a hematoma to the right side of Resident #1’s forehead. EMS Personnel #1 stated she was very surprised that Resident #1 had not been seriously injured considering she had fallen down a 17-foot embankment. EMS Personnel #1 stated once they arrived at the hospital, she had Resident #1 call her family and then using Resident #1’s cellphone, EMS Personnel #1 spoke directly with the Family Member to explain what had happened.<br><br>During telephone interviews conducted on 01/28/26 at 12:22 PM and 01/29/26 at 8:54 AM, the Assistant Fire Chief revealed on 01/24/26 both EMS and the Fire Department were already on scene when he arrived to the location where Resident #1 was found. He stated the Civilian who contacted EMS on 01/24/26 was a former Fire Department employee and had first noticed Resident #1 walking with her walker along the road as he drove by into town. The Assistant Fire Chief did not know how much time had passed when the Civilian returned and observed Resident #1’s walker on the side of the road. He stated the Civilian had pulled over, got out of his vehicle and as he looked around for Resident #1, he | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 7<br>heard her yelling for help. The Assistant Fire Chief stated Resident #1 fell approximately 17 feet down a steep and wooded ravine (deep, narrow valley featuring a winding bottom that might host a stream and be filled with trees, rocks and varied vegetation, creating a rugged and sometimes, hidden landscape) and they had to set up a ladder and use a stokes basket in order to pull her out. The Assistant Fire Chief stated it was roughly 20 minutes from the time the Fire Department arrived on scene and Resident #1 was in EMS care.<br><br>During a telephone interview conducted on 01/29/26 at 12:10 PM, Resident #1's Family Member recalled on 01/24/26 at approximately 10:30 AM, she and her husband arrived at the facility for a visit with Resident #1. She stated Resident #1 wasn't in her room when they arrived and staff reported Resident #1 had been walking around the facility all morning. The Family Member stated she and her husband walked around the facility for approximately 30 minutes but were unable to find Resident #1. She stated at one point, the DON joined them and shortly thereafter, the entire facility staff started looking for Resident #1. The Family Member stated a little after 11:00 AM, she received a call from Resident #1's cellphone and when she answered, it was EMS. She stated EMS informed her that Resident #1 was found outside the facility, she had fallen down a 10-foot embankment and was at the hospital. The Family Member stated prior to their arrival at the facility, no one at the facility knew that Resident #1 was missing. The Family Member stated based on the time it took to get to the hospital, Resident #1 had to have already left the facility before they arrived at 10:30 AM.<br><br>Hospital records dated 01/24/26 revealed Resident #1 presented to the Emergency Department (ED) for evaluation following a fall from a 17-foot embankment. The ED note revealed in part that Resident #1 reported "she was looking for a place to walk for exercise and ended up in a parking lot near her workplace. She attempted to find a residential street with sidewalks but was unsuccessful and while walking, she tripped over thick vines on the ground, leading to a fall." Resident #1 reported that her forehead hurt when she wrinkled it but denied neck pain or any other symptoms. A computed tomography (CT) scan revealed no acute intracranial abnormality. A physical exam revealed Resident #1 was in no acute distress, had full range of motion in all extremities and her head was normocephalic (normal shape and size) with no injury other than a right frontal forehead contusion. Resident #1 was discharged from the hospital in stable condition 01/24/26. | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **White Oak Manor - Tryon** | **70 Oak Street , Tryon, North Carolina, 28782** |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 8<br><br>During a telephone interview on 01/29/26 at 12:30 PM, the Medical Director stated the facility informed the on-call provider of Resident #1's elopement on 01/24/26 and he was made aware of the incident on 01/26/26. When asked his medical opinion regarding the potential harm of Resident #1 being outside unsupervised, the Medical Director stated he felt that the facility acted proactively by implementing an elopement alarm device for Resident #1 upon her admission and facility staff did everything appropriately following the incident. He described Resident #1's elopement as an unfortunate incident and stated he did not believe there was any negligence on the part of facility staff as Resident #1 was definitely on a mission that day, she may not have known where she was going but she was determined to leave. The Medical Director stated since starting at the facility in August 2025, there had been no concerns of elopement issues and as a result of this incident, the facility would definitely become more vigilant going forward.<br><br>An observation and interview were conducted with Resident #1 on 01/28/26 at 10:40 AM. Resident #1 was sitting in a recliner in her room with a one-to-one sitter present. Resident #1's walker was placed directly in front of her and an elopement alarm bracelet was attached to the front bar of the walker. Resident #1 was not observed to have an elopement alarm bracelet on her person. On the right side of Resident #1's forehead was a small abrasion and purple bruising the size of a golf-ball that extended partially into the hairline. Resident #1 revealed there was a knot on her forehead that had gone away and her forehead only hurt when she raised her eyebrows. Resident #1 recalled leaving the facility and stated she felt like going for a walk and just "wanted out of the building." Resident #1 stated she walked down a sidewalk to the road and then fell down a ravine. She stated someone came to help her and took her to the hospital but could not recall any further details. When asked, Resident #1 was unable to state which door she used to exit the facility, how long she was outside, where along the road she fell, or how she fell.<br><br>An observation was conducted on 01/29/26 at 2:15 PM of the location where Resident #1 was found on 01/24/26. The distance from the facility's front parking lot to the stop sign at the bottom of the hill was approximately 300 to 400 feet. The distance from the stop sign to the approximate location along the public road where Resident #1 fell down the embankment was an additional 500 to 600 feet. The public road is a two-lane road with no sidewalks on either side with a | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 9<br>posted speed limit of 25 miles per hour. The embankment adjacent to the road was steep and densely covered with branches and vines, which limited the view of the riverbed located at the bottom of the embankment.<br><br>An online website named Weather Underground was used to obtain the outside weather in Tyron, North Carolina on 01/24/26 which revealed the following data for Tyron, North Carolina at 9:53 AM: cloudy conditions, temperature of 36 degrees Fahrenheit (F) with no precipitation and Northeast wind speed of 9 miles per hour. Further review revealed that at 11:53 PM on the evening of 01/24/26, the temperature dropped to 23 degrees F with a wintry mix (snow, sleet and freezing rain) that continued throughout the day and evening of 01/25/26.<br><br>During interviews on 01/28/26 at 2:10 PM and 02/04/26 at 3:30 PM, the Administrator revealed that on 01/24/26 she received a text message from the DON around 10:40 AM notifying her that a Code Adam had been initiated for a missing resident and she immediately went into the facility. The Administrator stated that Resident #1's family had been walking around the facility looking for Resident #1 after they had arrived around 10:30 AM for a visit but were unable to locate her. She explained while staff were searching inside and outside the facility, Resident #1's family also went outside to look for Resident #1. The Administrator recalled that at approximately 11:10 AM, she was present when Resident #1's family returned to the building and received a call from Resident #1's cellphone. When the Family Member returned the call, EMS answered and reported that Resident #1 had fallen down an embankment and was transported by ambulance to the hospital. After Resident #1's family left to go to the hospital, the Administrator stated she and staff inspected the property and observed an area on facility grounds with tire tracks and numerous broken tree limbs and branches, which they initially believed to be the location where EMS had found Resident #1. The Administrator stated that interviews with staff confirmed that Resident #1 had been observed throughout the facility between 6:45 AM and 9:40 AM. She verified that Resident #1 was last seen at 9:40 AM by Nurse #1 when Resident #1 was looking for the turtles. The Administrator confirmed that Resident #1's whereabouts were unaccounted for from 9:40 AM until 11:10 AM, when EMS notified Resident #1's Family Member that she had been transported to the hospital.<br><br>A continuation of the Administrator interview revealed she was unable to definitively determine how Resident #1 exited the facility. The Administrator recalled it | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 10<br>was a busy weekend with families visiting residents prior to the anticipated winter storm and the most plausible way Resident #1 could have exited the building was through the front entrance. She reported that on 01/22/26, an elopement alarm bracelet was initially placed on Resident #1's wrist that had to be reapplied when she kept removing the device, so staff applied additional elopement alarm bracelets to Resident #1's walker and cane that same day. She indicated that on 01/24/26, Resident #1 had an elopement alarm bracelet attached to the lower right leg of the walker and another on her person; however, staff reported they did not hear the alarm sound when Resident #1 exited the building. The Administrator confirmed that when Resident #1 returned to the facility, the elopement alarm bracelet was still attached to her walker but Resident #1 did not have an elopement alarm bracelet on her person. She stated on 01/24/26, she had Maintenance come to the facility to check all the alarm doors and nothing faulty was identified with the alarm system. The Administrator indicated she could not determine whether the alarm sounded and was turned off by staff when they didn't notice a resident near the door or if the alarm failed to trigger due to the position of the elopement alarm bracelet on Resident #1's walker when she quickly walked through the door. The Administrator revealed on 01/24/26 at 12:39 PM she spoke with Resident #1's Family Member who reported that Resident #1 stated "she went for a walk and ran out of road." The Administrator stated shortly after Resident #1 returned from the hospital, Resident #1 told the Administrator that she had watched someone open the front door, followed them out and she would do it again because they could not stop her. The Administrator stated Resident #1 was placed on one-to-one monitoring until alternate placement could be arranged at a facility with a secured memory care unit.<br><br>The State of North Carolina Executive Order No. 31 revealed the Governor declared a state of emergency, effective 01/21/26, due to the projected winter storm.<br><br>The Administrator was notified of Immediate Jeopardy on 01/29/26 at 1:43 PM.<br><br>The facility provided the following credible allegation of immediate jeopardy removal:<br><br>Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:<br><br>The facility believes Resident #1 exited the facility | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 11<br>from the main entrance on Saturday, 01/24/26 at around 9:40 am without the facility's knowledge, because the other entrances are locked down and require a code with or without an wander alarm bracelet. No cameras are available to determine time of exit. Resident #1 was seen by staff between 7:30 am to 9:30 am. According to the licensed nurse interview, Resident #1 was asking to leave and wanted to go outside around 7:30 am and was redirected. Breakfast tray was removed from the resident at around 8:30 am.<br><br>Staff interviews revealed they did not hear the alarm sounding or observe Resident #1 leaving from the door by the nurse's station. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Certified Dietary Manager (CDM) conducted the staff interviews with nursing, dietary and housekeeping staff that were present and working on 01/24/26 during the time of the elopement.<br><br>Resident #1 had an wander alarm bracelet on their person and on their rollator walker placed by Medication Aide on 01/22/26 at 2:30 pm. Resident #1 reported to the licensed nurses that she was taking a walk and looking for turtles on 01/24/26 around 9:40 am. Family visited around 10:30 am and alerted the staff that she was not in her room and were wondering where she was. When Resident #1 could not be located, then Code Adam was started.<br><br>A Code Adam was initiated by the facility at 10:40 am on 01/24/26 by Director of Nursing (DON).<br><br>The on-call physician was contacted on 01/24/26 by the DON and Administrator, an on-call report and the practice notified the Medical Director on Monday, 01/26/26.<br><br>The Administrator and the DON completed the head count on 01/24/26 of all current residents and indicated on the census that current residents were present and accounted for.<br><br>Emergency Medical Services (EMS) used Resident #1's personal cell phone around 11:10 am to call Resident #1's family and notified them that Resident #1 was outside and found on the ground down a 10-foot embankment from the phone call that the family was having with EMS and witnessed by the Administrator and the DON, but the hospital records report it being a 17-foot embankment. Resident #1 was then transported to the hospital by EMS who found the resident on the ground. Family left the facility, went home and then traveled to the hospital to meet the resident there. | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 12<br><br>The Maintenance Assistant on 01/29/26 at 4:45 pm measured the embankment distance from the facility's northeast entrance by miles .1 miles which converts to approximately 528 feet. This was determined by the Administrator after investigating the facility surroundings where tire tracks were noted on the ground and freshly cut tree branches were noted on 1/24/26.<br><br>The Administrator, on 01/24/26 at around 6:00 pm attempted to get details from EMS personnel or director of where Resident #1 was found exactly with no success.<br><br>Resident #1 was readmitted to the facility the same day (01/24/26) at 4:30 pm. When Resident #1 returned to the facility, she was noted to not have her wander alarm bracelet on her person, but it was found in the resident's purse. Full skin assessment was completed and Resident #1 was noted with soiled feet from being outside by Licensed Nurse and DON. Resident #1 was also noted to have right forehead discoloration and abrasion, no dressing in place, large right lateral upper back discoloration, no swelling or fluid, and left lower arm with small abrasions. Wander Alarm bracelet was still noted on the resident's rollator walker. The wander alarm bracelet was intact, tested by the Administrator with Resident #1's rollator walker passing through the door and it activated the door alarm and was functioning. It was determined that the only door Resident #1 was able to leave the facility through was the front door. The other doors were always locked and required a code and the front door was unlocked for visitors to come and go. Resident #1 reported to the Administrator on 01/24/26 that she waited for the door to be opened and as people left she followed them out the door at the front entrance.<br><br>Elopement Observation is an assessment that is used to assess the residents and determine if they are at risk for elopement. Resident #1's Elopement Observation dated 01/22/26 and completed by the Social Services Director (SSD) indicated Resident #1 was at risk for elopement and an alarm bracelet was applied that day by the Medication Aide at 2:30 pm, but Resident #1 was able to remove the bracelet from her person multiple times and additional alarm bracelets were applied on the resident's rollator walker and cane on 01/22/26 by the Medication Aide.<br><br>When Resident #1 returned from the hospital on 01/24/26 at 4:30 pm, an alarm bracelet was reapplied on Resident #1's left arm by the Licensed Nurse but Resident #1 kept on stretching it out and removing it and replacing on each hand and then refused to keep the alarm | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **White Oak Manor - Tryon** | **70 Oak Street , Tryon, North Carolina, 28782** |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 13<br>bracelet on but a wander alarm continued to be on the rollator walker. Resident #1's rollator walker still had the alarm bracelet intact, activated and sounded the alarm at the front door. The Manufacturer's instructions for the alarm bracelet recommends not to directly attach the device to the resident's equipment.<br><br>When Resident #1 was readmitted from the hospital on 01/24/26, her plan of care for being at risk for elopement continued and was updated by the SSD, ensured the physician order for the wander alarm bracelet was in the electronic medical record, and the elopement board/binders updated with resident's picture and room number. Resident #1's picture was not updated on the board/binders when the wander alarm bracelet was applied on 01/22/26. Resident #1 was placed on 1-on-1 supervision with licensed nurses, nursing assistants and dietary staff on 01/24/26 and upgraded to 15-minute checks as a trial on 01/27/26 and the resident has had no further incidents. The Administrator and the DON initiated the 1-on-1 supervision. Referrals were sent to facilities that had a secure unit by the SSD on 01/26/26. Resident #1 was accepted to another facility with a secure unit and was transferred on 01/30/26.<br><br>An audit was completed by the Quality Information Manager (QIM) and the SSD on 01/25/26 of the current identified residents that have exit seeking behaviors to ensure their alarm bracelets were present, they have current orders for the alarm bracelet, elopement observations that assess the residents for being at risk for elopement are current, current care plans and that the residents were identified on picture board for staff to be aware of which residents are at risk for elopement. The picture boards have pictures of the 15 residents that are at risk for elopement and are located on a board in employee bathrooms and binders on each medication cart, nurse's station and the front desk for staff to be aware of the residents that may exit seek. Resident #1's picture was not updated on the elopement board /binders when the wander alarm bracelet was applied on 01/22/26, prior to Resident #1's elopement on 01/24/26. The alarming doors and alarm bracelets on the residents with exit seeking behaviors are normally checked weekly by the Maintenance Department and Nursing Coordinator. The residents' alarm bracelets are checked weekly for placement, functioning, and ensure they are not expired. The alarming doors are tested by using the test box to ensure functioning. The wander alarm bracelets on the residents are tested by escorting the resident near the door to ensure it locks down and when the door is open to ensure the alarm sounds. | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **White Oak Manor - Tryon** | **70 Oak Street , Tryon, North Carolina, 28782** |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 14<br>An audit was completed by the DON and Assistant Director of Nursing (ADON) on 01/24/26 to ensure no other current residents were identified at risk for elopement that required an wander alarm bracelet, by reviewing the resident's record including progress notes, behavior documentation, care plans and observing the residents.<br><br>An audit was completed by Maintenance Department/Administrator/Unit Secretary on 01/24/26 to ensure the functioning of all the door alarms with use of a test box and escorting the residents with alarm bracelets to the door to ensure the alarm sounded when the resident approached the door.<br><br>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring, and when the action will be complete:<br><br>The facility staff including administration, nursing (including nurses and nurse aides), activities, social services, dietary, housekeeping/laundry, and maintenance department were re-educated starting on 01/24/26 regarding missing person/exit seeking /Code Adam protocol, elopement boards/binders and where they are located to ensure the staff always know which residents are at risk and to ensure they can be identified and aware of their wandering, provide re-direction and contact the nurse as needed. Re-education also included regarding door alarms and when a door alarm sounds, to stop and check the surroundings, redirect the resident that is attempting to elope and ensure no residents left the facility unattended. This re-education was completed by the DON and ADON on 01/28/26. Education was added to include that when residents are known and verbalize that they want to leave the facility and are noted removing their wander alarm bracelet the next step is to provide 1-on-1 monitoring until the behavior subsides, can be upgraded to 15-minute checks or placement for a secure unit is obtained. This education will be completed by the DON, ADON and Corporate Consultants by 01/30/26. Newly hired staff will receive this education during their job-specific orientation by the Staff Development Coordinator (SDC) or Corporate Consult.<br><br>The licensed nurses and Social Service Department (Social Service Director and Social Service Assistant) were re-educated starting on 01/24/26 regarding the elopement observation and how to proceed once a resident is identified with exit seeking behaviors. Once the elopement observation is completed and the resident is identified to be at risk the staff are to | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 15<br>apply an alarm bracelet, obtain an order for the alarm bracelet complete elopement observation, picture book and binder, and care plan the resident for the exit seeking behavior. The Licensed Nurses and Social Services are responsible for completing the elopement observations in the observation section of the resident's electronic medical record to assess the resident's risk for elopement upon admission and when a resident is exhibiting wandering behaviors. This re-education was completed on 01/28/26 by the DON and the ADON verbally in person or by phone with the policy and procedure reviewed. Newly hired licensed nurses and social services staff will receive this education during job specific orientation by the SDC.<br><br>The Social Services Department which consists of the Social Services Director and Social Services assistant, was re-educated on the elopement observation to be completed for all residents upon admission and readmissions after 10 days of being out to the hospital. Another elopement observation is completed when the resident is exhibiting new behaviors of wandering and possibly requiring a wandering alarm bracelet or when the resident is no longer exhibiting the wandering behavior. Residents that are at risk for elopement and have a wander alarm bracelet applied require a new elopement observation to be completed at least every quarter during their Minimum Data Set (MDS) assessment. As a result of Resident #1 not being added to the picture board/binder on 1/22/26 the Social Services Department was re-educated on completing the elopement observation. They are also to ensure nursing department is aware that the resident is at risk, ensure that there is an order in the medical record for the wander alarm bracelet, ensure the bracelet is applied to the resident, ensure the care plan is initiated, and the residents picture is added to the board/binders. The picture boards and binders contain the same information and it is a way for the staff to be familiar of who is at risk for elopement and a quick reference for the staff during a Code Adam. The boards and the binders are supposed to have pictures of the residents that currently have a wander alarm bracelet applied with their name and their room number listed. The Social Services Department is responsible for updating the board and the binders as needed or as the residents at risk change. This re-education was started on 01/26/26 by the Administrator, DON and ADON. Another review of the education completed with the Social Services Department on 01/30/26 by the Corporate Consultant. Newly hired Social Services staff will receive this education during their job specific orientation by the SDC or Corporate Consultant. | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 16<br>A Code Adam drill will be completed monthly for 3 months for all shifts including weekends. This is to ensure the Code Adam is initiated, the staff responds to the door alarms, check the surroundings and do not clear the alarm until it is determined for which resident the alarm went off for. If not determined, the residents with alarm bracelets have to all be accounted for. Drills will be conducted by the DON and/or ADON. The DON and ADON participated in the QAPI discussions to develop a plan and were informed by the Administrator during the QA committee meeting on 01/29/26 of their responsibility for conducting drills.<br><br>The Maintenance Department will increase their checks of all door alarms to 3 times a week to ensure the doors alarm function properly. This will be accomplished by using the test box. The Maintenance Director participated in the QAPI discussions to develop a plan and was informed by the Administrator during the QA committee meeting on 01/29/26 of the increase in monitoring.<br><br>The DON, ADON, Unit Coordinators, Activities or Social Services Departments will increase their checks for the residents' alarm bracelets to 3 times a week to ensure the alarm bracelets are functioning properly and activate the doors. This will be accomplished by escorting the resident with alarm bracelets to the door to ensure they sound the alarm and activate the doors when closed. The DON, ADON, Unit Coordinators, Activities and Social Worker participated in the QAPI discussions to develop a plan and were informed by the Administrator during the QA committee meeting on 01/29/26 of their responsibility for checking the alarm bracelets.<br><br>During the daily Quality Improvement (QI) meetings (Monday – Friday) new admissions, including elopement observations are reviewed. Any new wandering behavior is also reviewed and the team including the SSD will ensure that the appropriate steps have been taken such as the completion of the elopement observation, order for any needed wandering alarm bracelet, care plan, and picture board/binder are all completed.<br><br>The incident was communicated during QI morning meetings and further discussed with the QA committee on 01/29/26 with no further changes recommended. A decision to develop a plan and to monitor was discussed when the incident occurred on 01/24/26 and continued to work on it during the week along with the weather challenges and further discussion on 01/29/26. The Medical Director, Administrator, DON, ADON, Social Services Director, Activities Director, Human | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **White Oak Manor - Tryon** | **70 Oak Street , Tryon, North Carolina, 28782** |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 17<br>Resources, MDS Nurse, Maintenance Director, Medical Records, Business Office Manager Admissions Coordinator, Quality Information Manager, and Rehab Director were in attendance.<br><br>The DON is responsible for the ongoing compliance of F689.<br><br>Date of IJ removal is: 01/31/26.<br><br>On 02/04/26, the credible allegation of immediate jeopardy removal was validated onsite through observations, record review, and staff interviews. The weekly monitoring logs of the facility exit doors for January 2026 were reviewed with no concerns identified. Observations of the exit doors throughout the facility revealed they were locked and required code to open. Elopement binders were observed at each nurses' station that contained a list of names, room numbers and current picture for each resident identified as high risk, the facility's missing person policy and procedure, missing resident (elopement) checklist, and quarterly Code Adam drills that were conducted on all shifts. Observations of nurse medication carts and picture boards in staff bathrooms revealed current pictures, along with the name and room number, for all residents identified as high risk for elopement. Interviews conducted with staff on various shifts and departments revealed they received education on the facility's elopement policy and procedure, Code Adam and residents with exit-seeking behaviors. Staff were able to verbalize where the elopement binders were located and what information they contained, what to do when a resident demonstrated exit-seeking behaviors, making sure exit doors remained locked and responding to alarms, and what to do in the event of a missing resident. Nurses were able to verbalize the steps and process for obtaining an order for an elopement alarm device, entering the order in the resident's electronic medical record, applying the elopement arm device on the resident's ankle or wrist, and checking for placement. Social Workers verbalized they were responsible for completing elopement assessments on residents which included notifying the nurse if the resident was determined to be at risk of elopement. The Social Workers verbalized they were responsible for checking residents elopement alarm bracelets three times a week which included taking the resident to an alarmed door to ensure the elopement alarm bracelet was functioning.<br><br>An observation of the exit doors by the nurses station leading out to the front lobby was conducted with the Maintenance Director on 02/04/26 at 2:20 PM. The alarm | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345127 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/04/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Oak Manor - Tryon | 70 Oak Street , Tryon, North Carolina, 28782 |

| (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 |
|---|---|---|---|---|
| F0689 SS = SQC-J | Continued from page 18<br>sounded when the Maintenance Director opened the door while using the tester to check the alarm function.<br><br>The Social Services Director and Assistant were observed checking the functioning of the wanderguards for three residents identified as high risk for elopement. The residents all had elopement alarm bracelets in place on their ankle or wrist and when assisted to the exit doors by the nurses' station leading out to the front lobby, the doors remained locked and two red lights lit up on the alarm panel.<br><br>The IJ removal date of 01/31/26 was validated. | F0689 | | |