STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE BOX 220130 CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide an unidirectional cushion (a seat cushion used to prevent falls) for 1 of 3 sampled residents at risk for falls (Resident #9) and the facility failed to identify a hot water temperature of 121.3 degrees Fahrenheit (F) and 120.4 degrees F in 2 of 6 sampled sinks available for resident use (Rooms #E-13 and #E-29). The findings are: 1. Resident #9 was admitted to the facility on 09/13/99 with diagnoses which included dementia and osteoporosis. Review of a nursing note and occurrence report dated 01/17/13 revealed Resident #9 fell out of a wheelchair reaching for the sink faucet without injury. The report indicated Resident #9 used a unidirectional pad in the wheelchair. Review of Resident #9's annual Minimum Data Set (MDS) dated 03/28/13 revealed an assessment of severely impaired cognition with a	F 323	The facility ensures that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistive/safety devices to prevent accidents. Resident # 9's unidirectional Cushion was placed in wheelchair at the time of the survey on 04-17-2013. The unidirectional cushion was discontinued on 05-01-2013 due to a change. All residents with interventions of assistive/safety devices including cushions were audited and assured to be in place.	04-17-2013 04-29-2013

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

Amanda Pack Administrator 5-7-13

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

DHSR Black Mountain Received MAY 0 8 2013 by: PAM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE BOX 220130 CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 history of falls since the prior assessment. Resident #9 required the extensive assistance of one person with transfers. Review of Resident #9's care plan dated 04/11/13 revealed a risk for falls related to impaired safety awareness and getting up without assistance. Interventions included transfers with a gait belt with a unidirectional pad to wheelchair seat. Review of an occurrence report dated 04/15/13 revealed Resident #9 fell on the floor in the room at 2:00 AM which resulted in a bruise on the top of the right hand. Resident #9 fell between the bed and a wheelchair. Observation on 04/15/13 at 4:28 PM revealed Resident #9 seated in a wheelchair. The seat of the wheelchair did not have a pad or cushion. Observations on 04/16/13 at 8:55 AM, 9:02 AM, 11:30 AM and at 3:00 PM revealed Resident #9 seated in a wheelchair. The seat did not have a pad or cushion. Observation on 04/17/13 at 7:52 AM revealed Resident #9 seated in a wheelchair. The seat did not have a pad or cushion. Observation on 04/17/13 at 8:02 AM revealed Resident #9 removed a clothing protector and bent forward and down to her feet during an attempt to place the clothing protector over both feet. At 8:05 AM, Resident #9 bent forward and down and place the clothing protector on both feet. Resident #9's wheelchair did not have a pad or cushion. .	F 323	An Assistive/Safety Device Audit was Conducted to test the knowledge of nursing staff to resident assistive/ safety devices and care guides. Three nursing staff, from each shift, test for seven days. 05-05-2013 Nursing employees were re-educated on assistive/safety devices, how to identify residents with assistive/safety devices, and how to locate a device if needed. 04-28-2013 A list of assistive/safety devices for Each resident from their care guides located at each nurse's station and on each Medication Cart. These lists are kept current by the Restorative and Safety Nurses. 04-29-2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE BOX 220130 CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 Observation on 04/17/13 at 8:45 AM revealed Resident #9 seated in a wheelchair. The seat did not have a pad or cushion. Observation on 04/17/13 at 9:52 AM revealed Nurse Aide (NA) #1 and NA #2, restorative nurse aide, transferred Resident #9 with a gait belt from the wheelchair to the bed. There was no pad or cushion on the wheelchair seat. Interview with NA #1 on 04/17/13 at 9:55 AM revealed Resident #9 did not use any cushion or pad on the wheelchair seat. NA #1 explained she cared for Resident #9 on the day shift and was not aware of any special seat cushions required. Interview with Nurse #1 on 04/17/13 at 9:57 AM revealed she did not know if Resident #9 required a special cushion for the wheelchair seat but would check the care plan. On 04/17/13 at 10:04 AM, Nurse #1 reported the care plan indicated Resident #9 should have a unidirectional cushion on the wheelchair seat. Observation on 04/17/13 at 10:06 AM revealed a search conducted of Resident #9's room by Nurse #1 for the unidirectional cushion. No cushion was found. Interview with Nurse #2, the facility's safety nurse, on 04/17/13 at 10:10 AM revealed Resident #9 should have a unidirectional cushion on the wheelchair seat to prevent falls. Interview with the Director of Nursing (DON) on 04/17/13 at 10:17 AM revealed she expected nursing staff to implement Resident #9's care	F 323	Assistive/Safety Device Audits are being conducted every Monday, Wednesday and Friday for eight weeks, then weekly for four weeks to monitor for established knowledge, and ongoing supervision that assistance devices are in place. Ongoing compliance will be monitored by the Restorative Nurse on each resident according to the Plan of Care/Care Guide. The Restorative Nurse and Director of Nursing are responsible for ongoing compliance with assistive/safety devices. Ongoing monitoring will be overseen by the CQI/QA Meeting, Monday-Friday with concerns addressed immediately and data reviewed for trends.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE BOX 220130 CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 plan and place a unidirectional cushion on the wheelchair seat. 2. During an environmental tour with the maintenance director on 04/18/13 at 3:48 PM the hot water temperature on the east hallway at a sink in resident room #E-13 was checked with a digital thermometer by the maintenance director and had a temperature reading of 121.3 degrees Fahrenheit. The hot water at a sink in resident room #E-29 was checked with a digital thermometer by the maintenance director and revealed a hot water temperature reading of 120.4 degrees Fahrenheit. The maintenance director went into a work room that contained a hot water tank with a mixing valve on top of it and adjusted the mixing valve. He then returned to room #E-13 at 3:55 PM and checked the hot water temperature with a digital thermometer and it was 122 degrees Fahrenheit. The maintenance director stated he was not sure why the temperature of the hot water was not dropping and he let the hot water run in the sink. At 4:04 PM the hot water temperature had decreased to 106.9 degrees Fahrenheit. During an interview on 04/18/13 at 4:18 PM the maintenance director explained he or his maintenance assistant checked the hot water temperatures in 1 resident room on each nursing unit on the East, West and South hallways weekly on Friday and kept the temperatures logged in a notebook in his office. He stated the temperature range for the hot water temperatures in residents' rooms was supposed to be between 106 to 115 degrees Fahrenheit. He explained they had replaced the mixing valve on Monday morning on 04/15/13 and they had been adjusting it during the week and that was probably why the hot water	F 323	The equipment responsible for the water temperatures was inspected by the Maintenance Director to assure the water temperatures are with acceptable ranges. 04-18-2013 An audit of water temperatures was conducted daily for five days, then checks Monday, Wednesday and Friday for four weeks, and then ongoing monitoring weekly by the Maintenance Department.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE BOX 220130 CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 temperatures were too high. He further stated he had not been told of any resident or staff complaints that the hot water temperature in residents' rooms was too hot. The maintenance director confirmed he was not aware that the hot water temperatures in room #E-13 and #E-29 were above 115 degrees Fahrenheit. He also verified that he would not have known the water was too hot until they were checked during the routine hot water temperature checks on Friday. The maintenance director confirmed he did not have any documentation of hot water temperatures on the temperature logs for this week and called the maintenance assistance on a hand held radio. He explained the maintenance assistant told him that he checked the water temperatures on the east hallway this week by putting his hand under the faucet but didn't use a thermometer to check the hot water temperatures. He further explained he had told the maintenance assistant to keep an eye on the hot water temperatures since they had replaced the mixing valve because he wanted to make sure the hot water temperatures in residents' rooms was within the range of 106 to 115 degrees Fahrenheit. He stated it was his expectation that hot water temperatures should be checked with a thermometer and the temperature recorded in the log book. During an interview on 04/18/13 at 5:40 PM the administrator stated it was her expectation for hot water temperatures to be maintained within the range of 106 to 115 degrees Fahrenheit. She further stated the water temperatures should be tested with a thermometer and the temperatures should be recorded in a log book in the maintenance office.	F 323	Staff were re-educated on using manual test on water temperatures prior to resident use to determine if water is too hot to touch. 04-18-2013 The Maintenance Director is responsible for ongoing compliance with water temperatures. The CQI/QA Committee will have ongoing review of the water temperatures Monday-Friday, and address any issues or trends with the water temperatures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE BOX 220130 CHARLOTTE, NC 28211

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