STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 12/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interviews, record review and review of the "Plan For The Prevention of Elder Abuse policy, the facility failed to submit the 24 hour and 5 day report to the state agency and complete a thorough investigation for 1 of 1 sampled resident with injuries of unknown origin (Resident #26). The findings included: Review of the policy titled "Plan for the Prevention of Elder Abuse" dated May 2017, read in part: section VII, reporting/response: employees would promptly report any incident of suspected incident of neglect or resident abuse, including injuries of unknown origin. Upon receipt of allegation of abuse or neglect, the administrator or designee will notify the appropriate state agency as soon as practicable, but not to exceed twenty four (24) hours. Resident representative would also be notified as soon as practicable. If injury is evident, then resident ' s physician will be notified. Depending on the degree of the alleged	F 607	White Oak of Burlington will ensure the development and implementation of the Abuse/Neglect Policy that includes injury of unknown source. The facility staff did not contact the Administrator and/or designee to discuss the potential of a reportable with an injury of unknown source due to facility staff not fully understanding the regulation, and did not report the discoloration as an injury of unknown source to the state agency. Resident #26's discoloration to the forearm, thigh and right upper arm are resolved and could not be determined as a result of abuse. Re-education on the Abuse/Neglect Policy was completed for all current staff prior to 01/05/2018 by the Staff Development Coordinator (SDC). Newly hired staff will be educated during their job specific	1/5/18

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

Electronically Signed | 12/29/2017

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F 607	Continued From page 1 abuse or neglect, local law enforcement maybe contacted. Following the investigation, a five (5) day report would be filed with the appropriate state agency summarizing the investigation, corrective action taken, and outcome of the investigation. Resident and/or resident representative would also be notified of the outcome of the investigation. During an interview on 12/4/17 at 4:30 PM, the Director of Nursing (DON), Social Worker (SW), Safety Coordinator and Staff Development Coordinator (SDC) was present. The DON reported the nurse who initiated the incident report on 11/29/17 of her observation of the forearm and thigh discoloration did not inform her of the observation until 11/30/17. The DON reviewed the chart and confirmed there was no further investigation regarding the cause of the injury once it was documented on the incident report and nurse ' s note. DON stated it was her expectation of the nurse to contact her and determine how and what happened. After review of the incident report dated 11/29/17 and the nursing notes, there was no clear indication of what happened and what was done after 5:30 PM on 11/29/17. DON added that she was not notified of the injury to the upper arm until 12/1/17. The DON stated she went down and looked at the arm herself and a full body check was done and there was a bruise on the forearm, thigh and a large bruise on the upper part of the right arm. The team met and discussed how the bruises may have occurred, but was unable to identify the actual cause. In review of the record there were no identified treatments to the bruised area. During an interview on 12/6/17 at 11:52AM, the	F 607	orientation by the SDC or Social Services Director (SSD). The Abuse/Neglect Policy will be reviewed annually with all staff and as needed throughout the calendar year. For current and newly admitted residents, the indication of an injury of unknown source will be reported to the Administration (Administrator, Director of Nursing (DON), SSD or Assistant Director of Nursing (ADON), appropriately reported to the state agency and a thorough investigation will be completed. All indications of injury of unknown source will be monitored for 4 weeks to determine the Abuse/Neglect Policy was followed appropriately, then monthly for 3 months and as needed thereafter. The DON and/or designee will conduct the monitoring. Results from the monitoring will be discussed Monday through Friday during the Quality Improvement (QI) morning meetings and any identified issues or trends will be further discussed with the team and recommendations made as indicated. This will continue for the duration of the monitoring, weekly for 4 weeks, monthly for 3 months and as needed thereafter. The DON is responsible for ongoing compliance to F607	

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F 607	Continued From page 2 Director of Nursing, Administrator and SDC were present. The DON stated the team did not feel the injuries were related to abuse. If there was a suspicion of abuse the expectation would be for the staff to initiate the abuse protocol, which included a complete investigation of events and submission of the 24 hour and 5 day report.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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 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.	F 609		1/5/18

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F 609	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interviews, record review the facility failed to submit the 24 hour and 5 day report to the state agency for 1 of 1 sampled resident with injuries of unknown origin (Resident #26). The findings included: Resident #26 was readmitted to the facility on 6/3/17 with diagnoses including hypertension, osteoporosis, hyperlipidemia, anxiety, bipolar disorder, cardiovascular heart disease, visual impairment, depression and psychotic disorder. The quarterly Minimum Data Set (MDS) dated 9/7/17, revealed moderate impaired cognition. Resident #26 required limited one person assistance with ambulation, transfers, toileting and set up assistance only for eating. There were no resistive behaviors coded on the MDS. During an observation on 12/4/17 at 10:05AM, Resident #26 was observed siting in her wheelchair outside of room. The resident ' s door had two stop signs. Resident stated her shoulder hurt. She was able to point to the right shoulder in the presence of the assigned nursing assistant (NA) #1. Resident #26 showed NA #1 where her shoulder was hurting and stated "Somebody pulled on it." NA #1 informed the resident she would let the nurse know. Nurse #1 came in to check the resident on 12/4/17 at 10:08 AM. The nurse removed the shirt and there was no bruising on the front or back of the shoulder, however, there was a large blue/purple bruising to inner (right) upper arm to the elbow and a bruise to the forearm larger than quarter.	F 609	White Oak of Burlington will ensure the reporting of alleged violation of the Abuse/Neglect Policy including injury of unknown source. The facility staff did not contact Administrator and/or designee to discuss the potential of a reportable with an injury of unknown source due to the facility staff not fully understanding the regulation, and did not report the discoloration as an injury of unknown source to the state agency. Resident #26's discolorations to the forearm, thigh and right upper arm are resolved and could not be determined as a result of abuse. Re-education of the Abuse/Neglect Policy was completed for all current staff prior to 01/05/2018 by the SDC and/or the SSD. Newly hired staff receive this education during their job specific orientation by the SDC or SSD. The Abuse/Neglect Policy will be reviewed annually with all staff and as needed throughout the calendar year. For current and newly admitted residents, the indication of an injury of unknown source will be reported to Administration (Administrator, DON, ADON or SSD), appropriately reported to the state agency and a thorough investigation will be completed. All indications of injury of unknown source	

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F 609	Continued From page 4 During a telephone interview on 12/4/17 at 3:10 PM, Resident #26 family member stated, a few weeks ago, he reported several times to nursing and director of nursing (DON), that the resident told him that a man came in and grabbed her during care and rough handled her. The family member said that nothing was done about it. At that time there were no noted injuries. He could not provide the exact date of when he reported the concern to the DON. Resident #26 family member stated that he visited the resident on 11/29/17 during the evening around 6:20 PM. She did not have any bruises on the right arm or complain of shoulder pain when he left. He stated he did not speak with any of the nurses on Wednesday (11/29/17) evening about any bruises on the forearm or thigh. The family member reported he received a call around 8:00 AM, on 11/30/17, that the resident reported shoulder pain and there was a bruise on the right forearm and that an x-ray would be done for the shoulder pain. He further stated that he received a call around 9:21 PM on 11/30/17, about the results of the shoulder x-ray, which revealed an old rotator cup injury. He stated he was not told about the bruising under the arm when he was called about the results of the x-ray. He came in on 12/1/17 around 8:30 AM and saw the large bruising under the arm to the elbow "I wanted to know what happened." The bruise was red-purple from under the right arm pit to the elbow. He stated the resident told him she had been grabbed by a male staff and had been handled roughly. He was told in the meeting on 12/1/17 around 9:30 AM, the bruise under the arm could have occurred during the x-ray process. He was also told there had not been a male staff working with the resident and that the resident could have mistaken the female staff for a male. "The time	F 609	will be monitored for 4 weeks to determine the Abuse/Neglect Policy was followed appropriately, then monthly for 3 months and as needed thereafter. The DON and /or designee will conduct the monitoring. Results from the monitoring will be discussed Monday thru Friday during the QI morning meetings and any identified issues or trends will be further discussed with the team and recommendations made as indicated. This will continue for the duration of the monitoring, weekly for 4 weeks, monthly for 3 months and as needed thereafter. The DON is responsible for ongoing compliance to F609	

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F 609	Continued From page 5	F 609		

line of events did not make sense to me because I was there Wednesday 11/29/17 evening and (the resident) had no injuries when I left after 7:00PM, I was not told about the forearm injuries and shoulder pain until Thursday 11/30/17 morning. The nurse only discussed the old rotator cuff injuries the evening of 11/30/17. When I came in on Friday 12/1/17, I saw how large the bruise was on the upper inner arm. The bruise looked like someone had grabbed or pulled on my mother ' s arms, there was no way an x-ray plate did that type of bruising. I have not heard anything else about them checking to see if a staff actually mishandled the resident. I feel like they just blew me off."

During an interview on 12/4/17 at 10:05 AM, Nurse #1 stated that on 11/30/17, the 3rd shift nurse and aide reported there was a quarter size purplish bruise on the resident ' s thigh, a and quarter size purplish discoloration on the resident ' s forearm. The 3rd shift aide did not tell her what happen, just that it was found and the location. Nurse #1stated she went in and looked at the bruises on thigh and forearm and it was what described in the verbal report. The resident normally complained of shoulder pain even before the incident and was on scheduled Tylenol for pain. She was on scheduled Tylenol for pain twice a day. After the Nurse Practitioner (NP) saw the resident on 11/30/17, the Tylenol was changed to Norco. Nurse #1 reported she did not recheck Resident #26 after the NP had examined her.

During an interview on 12/4/17 at 12:06 PM, the Staff Development Coordinator (SDC) stated the x-ray technician came and asked for assistance for positioning. The resident held arm in guarded

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F 609	Continued From page 6	F 609		

position. Resident was somewhat resistant as they were attempting to put resident's arm on machine. No complaint of pain. The resident was doing a lot of twisting and leaning in opposite direction of the machine in a resistant manner. Nurse reported continued assistance during the process. The SDC stated she was present during the x-ray process and there was no bruising under the arm noted after the x-ray was done.

During an interview on 12/4/17 at 4:30 PM, the Director of Nursing (DON), Social Worker (SW), Safety Coordinator and Staff Development Coordinator (SDC) was present. The DON reported the nurse who initiated the incident report on 11/29/17 of her observation of the forearm and thigh discoloration did not inform her of the observation until 11/30/17. The DON reviewed the chart and confirmed there was no further investigation regarding the cause of the injury once it was documented on the incident report and nurse ' s note. DON stated it was her expectation of the nurse to contact her and determine how and what happened. After review of the incident report dated 11/29/17 and the nursing notes, there was no clear indication of what happened and what was done after 5:30 PM on 11/29/17. DON added that she was not notified of the injury to the upper arm until 12/1/17. The DON stated she went down and looked at the arm herself and a full body check was done and there was a bruise on the forearm, thigh and a large bruise on the upper part of the right arm. The team met and discussed how the bruises may have occurred, but was unable to identify the actual cause. In review of the record there were no identified treatments to the bruised area.

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F 609	Continued From page 7	F 609		

During an interview on 12/6/17 at 11:52AM, the Director of Nursing, Administrator and SDC were present. The DON stated the team did not feel the injuries were related to abuse. If there was a suspicion of abuse the expectation would be for the staff to initiate the abuse protocol, which included a complete investigation of events and submission of the 24 hour and 5 day report.

During an interview on 12/7/17 at 2:53PM, the Nurse Supervisor stated on 11/29/17 that she had received report later in the evening after 9:00 PM by Nurse #2, that Resident #26 had a small discoloration to the right forearm and thigh. She also stated that when she had gone down to check on the resident. The resident had already received her pain medication and was asleep so "I never did check the resident to see what the condition of her skin was. If the nurse had told me earlier on the shift I could have assessed and checked the resident and spoke with the resident directly myself." The nurse added that on 11/30/17 around 7:00 PM, she had gone down to the resident's room and repositioned the resident in bed. The resident had guarded her arm as she pulled away. She did not assess the severity of the resident's pain level or check the forearm or thigh from the 11/29/17 report. Nurse Supervisor indicated she did inform nurse#2 about her pain observation. "I don ' t ' recall whether Nurse#2 went back and checked on the resident after we discussed my observation. " In addition, Nurse#2 had told her toward the end of the shift on 11/30/17, around 10:00 PM or later about her observation regarding the discoloration on the upper right arm. "The resident was sleep so I did not go down and check the condition of the resident's skin. I should have gone and evaluated

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F 609	Continued From page 8 the resident myself and I did not do that." "I know the son was contacted about the results of the x-ray because I overheard that part of the conversation, but I am not sure whether the bruise under the arm was discussed at the time or if the nurse called the son a second time." The Nurse Supervisor further stated it was not until 12/1/17 when "I returned to work that I had gone down to look at the upper arm and do a body visual and saw the bruising on the forearm, thigh and upper inner arm. The bruise to the forearm was red/blue purplish, the thigh area was slightly red and the upper inner arm was large from under the armpit toward the elbow, deep purple/red." The expectation was for the nurse to report the observations and document the condition of the resident with a clear description in the chart at the time of the incident and not report late in the shift. The Nurse Supervisor also stated she had spoken with the NA's on the shift on 12/1/17 about what they saw but did not document or obtain statements of what was discussed or observed. Record review revealed the 24 hour and 5 day report was not done in related to the bruising. In addition, there was not a complete investigation of what happened or whether the resident had been grabbed by another person. There were no statements from the aides assigned to Resident #26 on 11/29/17, 11/30/17 and 12/1/17.	F 609		
F 610 SS=D	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:	F 610		1/5/18

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F 610	Continued From page 9 §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: Based on observation, staff and family interviews, record review and the facility failed to complete a thorough investigation for 1 of 1 sampled resident with injuries of unknown origin (Resident #26). The findings included: Resident #26 was readmitted to the facility on 6/3/17 with diagnoses including hypertension, osteoporosis, hyperlipidemia, anxiety, bipolar disorder, cardiovascular heart disease, visual impairment, depression and psychotic disorder. The quarterly Minimum Data Set (MDS) dated 9/7/17, revealed moderate impaired cognition. Resident #26 required limited one person assistance with ambulation, transfers, toileting and set up assistance only for eating. There were no resistive behaviors coded on the MDS. During an observation on 12/4/17 at 10:05AM, Resident #26 was observed siting in her wheelchair outside of room. The resident ' s door	F 610	White Oak of Burlington will ensure a thorough investigation is completed for residents with injury of unknown source. The facility staff did not contact Administration to discuss the potential of a reportable with an injury of unknown source due to the facility staff did not fully understand the regulation, and did not report the discoloration as an injury of unknown source to the state agency. Resident #26's discolorations to the forearm, thigh and right upper arm are resolved and could not be determined as a result of abuse. Re-education on the Abuse/Neglect Policy was completed for all current staff prior to 01/05/2018 by the SDC and/or the SSD. Newly hired staff will receive this education during their job specific orientation by the SDC or SSD. The	

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F 610	Continued From page 10 had two stop signs. Resident stated her shoulder hurt. She was able to point to the right shoulder in the presence of the assigned nursing assistant (NA) #1. Resident #26 showed NA #1 where her shoulder was hurting and stated "Somebody pulled on it." NA #1 informed the resident she would let the nurse know. Nurse #1 came in to check the resident on 12/4/17 at 10:08 AM. The nurse removed the shirt and there was no bruising on the front or back of the shoulder, however, there was a large blue/purple bruising to inner (right) upper arm to the elbow and a bruise to the forearm larger than quarter. During a telephone interview on 12/4/17 at 3:10 PM, Resident #26 family member stated, a few weeks ago, he reported several times to nursing and director of nursing (DON), that the resident told him that a man came in and grabbed her during care and rough handled her. The family member said that nothing was done about it. At that time there were no noted injuries. He could not provide the exact date of when he reported the concern to the DON. Resident #26 family member stated that he visited the resident on 11/29/17 during the evening around 6:20 PM. She did not have any bruises on the right arm or complain of shoulder pain when he left. He stated he did not speak with any of the nurses on Wednesday (11/29/17) evening about any bruises on the forearm or thigh. The family member reported he received a call around 8:00 AM, on 11/30/17, that the resident reported shoulder pain and there was a bruise on the right forearm and that an x-ray would be done for the shoulder pain. He further stated that he received a call around 9:21 PM on 11/30/17, about the results of the shoulder x-ray, which revealed an old rotator cup injury. He stated he was not told about the	F 610	Abuse/Neglect Policy will be reviewed annually with all staff and as needed throughout the calendar year. For current and newly admitted residents, the indication of any injury of unknown source will be reported to Administration with appropriate reporting to the state agency and a thorough investigation will be completed. All indications of injury of unknown source will be monitored for 4 weeks to determine the Abuse/Neglect Policy was followed and investigated appropriately, then monthly for 3 months and as needed thereafter. The DON and/or designee will conduct the monitoring. Results from the monitoring will be discussed Monday thru Friday during the QI meeting with any identified issues or trends discussed with the team with recommendations made as indicated. This will continue while the monitoring is being done, weekly for 4 weeks, monthly for 3 months and as needed thereafter. The DON is responsible for ongoing compliance to F610	

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WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD BURLINGTON, NC 27217

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bruising under the arm when he was called about the results of the x-ray. He came in on 12/1/17 around 8:30 AM and saw the large bruising under the arm to the elbow "I wanted to know what happened." The bruise was red-purple from under the right arm pit to the elbow. He stated the resident told him she had been grabbed by a male staff and had been handled roughly. He was told in the meeting on 12/1/17 around 9:30 AM, the bruise under the arm could have occurred during the x-ray process. He was also told there had not been a male staff working with the resident and that the resident could have mistaken the female staff for a male. "The time line of events did not make sense to me because I was there Wednesday 11/29/17 evening and (the resident) had no injuries when I left after 7:00PM, I was not told about the forearm injuries and shoulder pain until Thursday 11/30/17 morning. The nurse only discussed the old rotator cuff injuries the evening of 11/30/17. When I came in on Friday 12/1/17, I saw how large the bruise was on the upper inner arm. The bruise looked like someone had grabbed or pulled on my mother ' s arms, there was no way an x-ray plate did that type of bruising. I have not heard anything else about them checking to see if a staff actually mishandled the resident. I feel like they just blew me off."

During an interview on 12/4/17 at 4:30 PM, the Director of Nursing (DON), Social Worker (SW), Safety Coordinator and Staff Development Coordinator (SDC) was present. The DON reported the nurse who initiated the incident report on 11/29/17 of her observation of the forearm and thigh discoloration did not inform her of the observation until 11/30/17. The DON reviewed the chart and confirmed there was no

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further investigation regarding the cause of the injury once it was documented on the incident report and nurse ' s note. DON stated it was her expectation of the nurse to contact her and determine how and what happened. After review of the incident report dated 11/29/17 and the nursing notes, there was no clear indication of what happened and what was done after 5:30 PM on 11/29/17. DON added that she was not notified of the injury to the upper arm until 12/1/17. The DON stated she went down and looked at the arm herself and a full body check was done and there was a bruise on the forearm, thigh and a large bruise on the upper part of the right arm. The team met and discussed how the bruises may have occurred, but was unable to identify the actual cause. In review of the record there were no identified treatments to the bruised area.

During an interview on 12/6/17 at 11:52AM, the Director of Nursing, Administrator and SDC were present. The DON stated the team did not feel the injuries were related to abuse. If there was a suspicion of abuse the expectation would be for the staff to initiate the abuse protocol, which included a complete investigation of events and submission of the 24 hour and 5 day report.

During an interview on 12/6/17 at 3:39 PM, Nurse # 2 indicated that she observed the discoloration on the forearm and thigh on 11/29/17 and the discoloration on upper inner armpit on 11/30/17. Nurse #2 stated she reported the observations to the nurse supervisor.

During an interview on 12/7/17 at 2:53PM, the Nurse Supervisor stated on 11/29/17 that she had received report later in the evening after 9:00 PM

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by Nurse #2, that Resident #26 had a small discoloration to the right forearm and thigh. She also stated that when she had gone down to check on the resident. The resident had already received her pain medication and was asleep so "I never did check the resident to see what the condition of her skin was. If the nurse had told me earlier on the shift I could have assessed and checked the resident and spoke with the resident directly myself." The nurse added that on 11/30/17 around 7:00 PM, she had gone down to the resident's room and repositioned the resident in bed. The resident had guarded her arm as she pulled away. She did not assess the severity of the resident's pain level or check the forearm or thigh from the 11/29/17 report. Nurse Supervisor indicated she did inform nurse#2 about her pain observation. "I don ' t ' recall whether Nurse#2 went back and checked on the resident after we discussed my observation. " In addition, Nurse#2 had told her toward the end of the shift on 11/30/17, around 10:00 PM or later about her observation regarding the discoloration on the upper right arm. "The resident was sleep so I did not go down and check the condition of the resident's skin. I should have gone and evaluated the resident myself and I did not do that." "I know the son was contacted about the results of the x-ray because I overheard that part of the conversation, but I am not sure whether the bruise under the arm was discussed at the time or if the nurse called the son a second time." The Nurse Supervisor further stated it was not until 12/1/17 when "I returned to work that I had gone down to look at the upper arm and do a body visual and saw the bruising on the forearm, thigh and upper inner arm. The bruise to the forearm was red/blue purplish, the thigh area was slightly red and the upper inner arm was large from

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F 610	Continued From page 14 under the armpit toward the elbow, deep purple/red." The expectation was for the nurse to report the observations and document the condition of the resident with a clear description in the chart at the time of the incident and not report late in the shift. The Nurse Supervisor also stated she had spoken with the NA's on the shift on 12/1/17 about what they saw but did not document or obtain statements of what was discussed or observed. Record review revealed the 24 hour and 5 day report was not done in related to the bruising. In addition, there was not a complete investigation of what happened or whether the resident had been grabbed by another person. There were no statements from the aides assigned to Resident #26 on 11/29/17, 11/30/17 and 12/1/17.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		1/5/18

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F 656	Continued From page 15 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to develop a comprehensive care plan for one of four residents reviewed for pressure ulcers (Resident #328). Findings included: Resident #328 was admitted 10/27/17 with diagnoses that included cerebral infarction, chronic embolism, and congestive heart failure. The quarterly Minimum Data Set (MDS) dated 02/01/17 indicated severe cognitive impairment with extensive assistance needed or total dependence for activities of daily living. The MDS	F 656	White Oak of Burlington develops a comprehensive person centered care plan for each resident. The care plan for Resident #328 was not updated to reflect the presence of a pressure ulcer related to an oversight by the MDS Coordinator, who had updated the MDS but forgot to update the care plan. Resident #328 no longer resides at White Oak of Burlington.	

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F 656	Continued From page 16 documented the presence of one unstageable pressure ulcer measuring 5.0 centimeters by 5.0 centimeters. A review of Pressure Ulcer Reports for Resident #328 revealed that an unstageable wound of the right heel was first identified 12/08/16. Weekly assessments and measurements were completed by the Wound Nurse until the time of resident discharge on 02/10/17. A medical order dated 12/09/16 and signed by Physician Assistant #1 directed staff to " ...apply skin prep to eschar [right heel] - allow to dry, cover with dry gauze, wrap with Kerlix, change QOD [every other day] and PRN [as needed]." A progress note dated 01/04/17 written by Physician Assistant #1 indicated that resident was "with eschar to right heel ...bunny boot in place ...Dressing placed to right foot-discussed wound on right heel with wound nurse." The care plan for Resident #328 last updated 02/01/17 noted the potential for skin breakdown but there was no entry or reference to the presence of a wound on the right heel or of any interventions in place. Resident #328 was not present in the facility at the time of the survey. In an interview on 12/07/17 at 3:15 p.m., the Wound Treatment Nurse stated that information on resident wounds was shared in the daily stand-up report attended by the Director of Nursing (DON), Administrator, Unit Managers, and MDS Coordinators. The information was also discussed at the weekly Wound and Weight	F 656	The Care Plan Nurses were re-educated by the Corporate MDS Nurse on updating care plans to reflect the Resident's current status, this was completed on 12/22/2017. Newly hired MDS/Care Plan Nurses receive this training during their job specific orientation with the Corporate MDS/Care Plan Nurse. An audit of care plans has been completed for any resident with a current pressure area to assure the care plan addresses the presence of a pressure ulcer. The audit was completed by the Care Plan Nurses prior to 01/05/2018. Any concerns noted with the audit will be corrected at that time. Nursing Administration (DON, ADON, and/or SDC) will monitor the care plans for residents with pressure areas weekly for 4 weeks,, then monthly for 2 months and periodically thereafter to assure ongoing compliance to F656. Identified trends found during the monitoring will be reviewed by the QI committee weekly for 4 weeks, monthly for 2 months and periodically thereafter with the committee making recommendations as indicated. The DON is responsible for ongoing compliance to F656.	

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F 656	Continued From page 17 meeting attended by the DON, nurse managers, registered dietician, care plan nurse, and nurse aides level two. In an interview on 12/07/17 at 3:20 p.m., MDS Coordinator #1 indicated that she updated the MDS for Resident #328 to include the presence of the pressure ulcer as a skin condition but had not updated the resident ' s care plan. She did not confirm whether she attended the daily or weekly meetings when wounds were discussed nor did she offer a reason for the lack of care plan revisions. In an interview on 12/0717 at 3:30 p.m., the DON acknowledged that the pressure ulcer had not been added to the care plan and shared her expectation that any decline in skin integrity be reflected on resident care plans with appropriate interventions listed.	F 656		