STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345151	A. BUILDING _____ B. WING _____	C 10/12/2018

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WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET KINGS MOUNTAIN, NC 28086

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey 10/12/18. Event Id # DB1k11.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		11/9/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair metal corner guards that were loose and sticking outward with rough edges on 2 of 3 units (next to resident room #129, soiled utility room next to resident room #101 and resident rooms #103, #112, #113, central bath door next to room #113 and resident room #203). The facility also failed to repair doors with broken and splintered laminate and wood on resident room doors on 2 of 3 units (resident rooms #101, #102, #107 and main dining room doors). Findings included: 1. a. Observations on 10/09/18 at 2:30 PM revealed a metal corner guard next to resident room #129 was bent outward at the floor and was sticking outward into the hallway with rough edges. Observations on 10/10/18 at 9:30 AM revealed a metal corner guard next to resident room #129 was bent outward at the floor and was sticking outward into the hallway with rough edges. Observations on 10/11/18 at 10:57 AM revealed a metal corner guard next to resident room #129 was bent outward at the floor and was sticking outward into the hallway with rough edges.	F 584	F584 1A. The loose metal corner guards in the following locations have been removed to minimize the possibility of resident injury: * Resident rooms 103, 112, 113, 129, and 203. * Soiled utility room next to resident room 101. * Central bath door next to resident room 113. 1B. The areas of broken or splintered laminate/wood on doors edges in the following locations are being repaired or covered to minimize the possibility of resident injury: * Resident rooms 101, 102, and 107 * Dining Room 2. The LNHA and the Maintenance Director will do a facility-wide audit of corner guards in resident areas to ensure all corner guards are either securely affixed to wall/door frames or removed to minimize possible resident injury. 3. The LNHA and the Maintenance	

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F 584	Continued From page 2 b. Observations on 10/09/18 at 2:31 PM revealed a metal corner guard at the soiled utility room next to resident room #101 was bent outward at the floor with rough edges. Observations on 10/10/18 at 9:31 AM revealed a metal corner guard at the soiled utility room next to resident room #101 was bent outward at the floor with rough edges. Observations on 10/11/18 at 10:59 AM revealed a metal corner guard at the soiled utility room next to resident room #101 was bent outward at the floor with rough edges. c. Observations on 10/09/18 at 2:35 PM revealed a metal corner guard at resident room #103 was loose at the bottom at the floor and was bent outward with rough edges. Observations on 10/10/18 at 9:35 AM revealed a metal corner guard at resident room #103 was loose at the bottom at the floor and was bent outward with rough edges. Observations on 10/11/18 at 11:05 AM revealed a metal corner guard at resident room #103 was loose at the bottom at the floor and was bent outward with rough edges. d. Observations on 10/09/18 2:43 PM revealed a metal corner guard at resident room #112 was loose at the bottom at the floor and was bent outward with rough edges. Observations on 10/10/18 at 9:58 AM revealed a metal corner guard at resident room #112 was loose at the bottom at the floor and was bent outward with rough edges. Observations on 10/11/18 at 11:15 AM revealed a metal corner guard at resident room #112 was loose at the bottom at the floor and was bent outward with rough edges.	F 584	Director will conduct monthly environmental rounds to ensure ongoing compliance. 4. The results of the environmental rounds will be reported and discussed in the weekly IDT QAPI meetings, as well as in the monthly QI meetings in which the medical director attends. 5. The LNHA will ensure ongoing compliance.	

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F 584	Continued From page 3	F 584		

e. Observations on 10/09/18 at 2:48 PM revealed a metal corner guard at resident room #113 was loose at the bottom at the floor and was bent outward with rough edges.
Observations on 10/10/18 at 10:08 AM revealed a metal corner guard at resident room #113 was loose at the bottom at the floor and was bent outward with rough edges.
Observations on 10/11/18 at 11:18 AM revealed a metal corner guard at resident room #113 was loose at the bottom at the floor and was bent outward with rough edges.

f. Observations on 10/09/18 at 2:50 PM revealed a metal corner guard next to the Central Bath Door on the 100 hall next to resident Room #113 was loose at the bottom at the floor and was bent outward with rough edges.
Observations on 10/10/18 at 10:20 AM revealed a metal corner guard next to the Central Bath Door on the 100 hall next to resident Room #113 was loose at the bottom at the floor and was bent outward with rough edges.
Observations on 10/11/18 at 11:21 AM revealed a metal corner guard next to the Central Bath Door on the 100 hall next to resident Room #113 was loose at the bottom at the floor and was bent outward with rough edges.

g. Observations on 10/09/18 at 2:59 PM revealed a metal corner guard at resident room #203 was loose at the bottom at the floor and was bent outward with rough edges.
Observations on 10/10/18 at 10:21 AM revealed a metal corner guard at resident room #203 was loose at the bottom at the floor and was bent outward with rough edges.
Observations on 10/11/18 at 11:09 AM revealed a metal corner guard at resident room #203 was

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F 584	Continued From page 4	F 584		

loose at the bottom at the floor and was bent outward with rough edges.

2. a. Observations on 10/09/18 at 2:32 PM revealed resident door #101 had a hole in the laminate on the lower part of the door with rough and splintered edges and the edges of the door had broken and splintered edges on the lower half of the door that were rough to touch.
Observations on 10/10/18 at 9:32 AM revealed resident door #101 had a hole in the laminate on the lower part of the door with rough and splintered edges and the edges of the door had broken and splintered edges on the lower half of the door that were rough to touch.
Observations on 10/11/18 at 11:01 AM revealed resident door #101 had a hole in the laminate on the lower part of the door with rough and splintered edges and the edges of the door had broken and splintered edges on the lower half of the door that were rough to touch.

b. Observations on 10/09/18 at 2:34 PM revealed resident door #102 had rough and splintered edges on the lower half of the door that were rough to touch.
Observations on 10/10/18 at 9:34 AM revealed resident door #102 had rough and splintered edges on the lower half of the door that were rough to touch.
Observations on 10/11/18 at 11:03 AM revealed resident door #102 had rough and splintered edges on the lower half of the door that were rough to touch.

c. Observations on 10/09/18 at 2:39 PM revealed resident door #107 had rough and splintered edges on the door that were rough to touch.
Observations on 10/10/18 at 9:39 AM revealed

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F 584	Continued From page 5	F 584		

resident door #107 had rough and splintered edges on the door that were rough to touch. Observations on 10/11/18 at 11:10 AM revealed resident door #107 had rough and splintered edges on the door that were rough to touch.

d. Observations on 10/09/18 at 11:22 AM revealed the main dining room doors had rough and splintered edges on the lower half of the doors with a string of fabric caught in the splintered edges.
Observations on 10/10/18 at 9:22 AM revealed the main dining room doors had rough and splintered edges on the lower half of the doors with a string of fabric caught in the splintered edges.
Observations on 10/11/18 at 10:55 AM revealed the main dining room doors had rough and splintered edges on the lower half of the doors with a string of fabric caught in the splintered edges.

During an environmental tour and interview on 10/11/18 at 1:26 PM, the Maintenance Director verified they used a work order system and he had a mailbox at each nurse's station to put the work orders in. He explained he had an assistant and they picked up work orders when they made rounds or staff called them to fix things when repairs were needed. He stated he and his assistant covered calls for each other when they were not in the facility. He further stated it was his preference for staff to fill out a work order for everything that needed to be repaired because that prevented confusion. He confirmed the work order system was reviewed with newly hired staff during orientation and he told staff to put their name on the work order and put them in the mailboxes at the nurse's station. He stated there

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F 584	Continued From page 6 were no major projects going on at the present time. During the environmental tour he stated he was not aware the metal corner guards were bent outward or were loosely attached to the wall and no one had filled out a work order to let him know about them. He further stated he was not aware of the damage to resident room doors. During a tour and interview on 10/11/18 at 2:05 PM, the Administrator stated they had a program where staff were assigned rooms to check and they knew which rooms they were responsible for. He further stated the expectation was for staff to look out for anything the resident needed and it should also include for them to observe and ensure corner guards and kick plates were not damaged.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code a Minimum Data Set Assessment for the attempt of a gradual dose reduction of an antipsychotic for 1 of 6 residents reviewed for unnecessary medications (Resident #92). The findings included: A review of Resident #92's medical record revealed the resident was admitted to the facility on 02/28/14 with diagnoses that included, but were not limited to, generalized anxiety disorder,	F 641	F641 1. Resident #92's MDS dated 8/29/18 has been corrected and re-submitted to the state, indicating resident had a gradual dose reduction (GDR)on 7/20/18. 2. The social service staff will audit new admissions, as well as quarterly and significant change MDS assessments with ARD's, to ensure the accuracy of assessments. Social service staff will audit two (2) resident medical records per week x (3) months and document the	11/9/18

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F 641	Continued From page 7	F 641		

major depressive disorder, unspecified dementia without behaviors, vascular dementia without behaviors and paranoid personality disorder. A review of Resident #92's most recent minimum data set (MDS) assessment dated 08/29/18 revealed resident to be cognitively impaired and required assistance with her activities of daily living (ADLs). Further review of the reviewed MDS revealed Resident #92 had received antipsychotics on a routine basis, that a gradual dose reduction (GDR) had not been attempted and that a GDR had not been contraindicated by her physician.

Review of Resident #92's June 2018 physician orders revealed an order for Abilify Maintena ER (an antipsychotic medication) syringe at a dose of 400mg IM monthly related paranoia with behaviors causing significant distress. Review of Resident #92's July 2018 physician orders revealed an order to reduce the resident's dosage of Abilify Maintena ER to 300mg IM once a month. This order was observed to have an initial order dated of 06/26/18.

Review of Resident #92's July 2018 Medication Administration Record (MAR) revealed on 07/20/18 the resident's Abilify Maintena ER was reduced to 300 milligrams as ordered by the physician.

During an interview with MDS Nurse #1 on 10/12/18, she reported she looked at Resident #92's last completed MDS of 08/29/18 along with current and previous physician orders to determine if a GDR had been attempted since the last MDS was complete. She reported "I just missed it" and stated that she did not have a reason for why she had not coded Resident #92's

accuracy of MDS in regard to GDR status. Corrections will be made immediately by the assigned MDS RN, as indicated.

3. The results of the audits will be discussed in the weekly IDT QAPI meetings, as well as in the monthly QI meeting in which the medical director attends.

4. The LNHA and the DON will ensure ongoing compliance.

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F 641	Continued From page 8 MDS dated 08/29/18 as not having had an attempted GDR. She reported that a GDR had been attempted with the reduction of Resident #92's Abilify Maintena ER from 400mg to 300mg at the end of June 2018. She stated the reduction should have should have been coded on the Resident #92's 08/29/18 MDS and reported she would immediately complete a correction and resubmit the assessment with the correct coding. An interview with the Administrator on 10/12/18 at 10:46 AM revealed it was his expectation that MDS assessments be completed accurately and correctly. During an interview with the Director of Nursing on 10/12/18 at 10:56 AM revealed she expected that MDS assessments be completed accurately. She reported Resident #92's MDS dated 08/29/18 should have reflected the GDR of the prescribed antipsychotic.	F 641		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		11/9/18

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	345151	A. BUILDING _____ B. WING _____	C 10/12/2018

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F 690	Continued From page 9 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and physician interviews the facility failed to secure indwelling urinary catheter tubing for 1 of 1 resident reviewed for incontinence care (Resident #117). The findings included: Resident #117 was admitted to the facility on 01/02/18 with diagnoses which included cerebral vascular accident, anxiety disorder, and depression. The most recent quarterly Minimum Data Set (MDS) assessment dated 05/24/18 indicated Resident #117 was cognitively intact. The MDS	F 690	F690 1. Resident #117's indwelling urinary catheter has been secured with a leg strap device per policy to minimize tension and dislodging of catheter and to minimize the possibility of urethral tear. 2. All nursing staff have been in-serviced regarding appropriate urinary catheter care and orders per policy. 3. All residents with indwelling urinary catheters have been checked for appropriate orders and equipment. 4. The ADON or designee will audit all	

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F 690	Continued From page 10 also indicated Resident #117 required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. A care plan dated 08/16/18 indicated Resident #117 had an indwelling urinary catheter related to benign prostatic hypertrophy (enlarged prostate) and had the potential for urinary tract infections. The goal specified Resident #117 would remain free of signs and symptoms of urinary tract infection. The approaches included staff were to monitor urine output and its characteristics and notify the physician of any changes and provide catheter care as ordered. On 10/11/18 at 9:57 AM the wound nurse was observed providing incontinence care to resident #117. Resident #117 was noted without any device to secure the indwelling urinary catheter tubing to prevent tension and dislodging of the catheter and to prevent urethral (opening to the bladder) tear. Resident #117's urethral opening did not have any observed signs of bleeding or trauma from the unsecured indwelling catheter tubing. On 10/11/18 at 10:03 AM an interview was conducted with the wound nurse who stated Resident #117 did not have a leg strap device in place to secure the indwelling urinary catheter to prevent tension and dislodging of the catheter and to prevent urethral tear. The wound nurse stated the indwelling catheter tubing should have been secured to the resident's thigh with a device to hold the catheter tubing in place and the wound nurse was unable to determine how long Resident #117 had been without a leg strap device to secure the indwelling catheter tubing. The wound care nurse obtained a leg strap	F 690	in-dwelling urinary catheter orders for accuracy, including leg strap placement, on current residents and new admissions weekly x (4) weeks and monthly x (3) months and document findings. 5. The results of the audits will be discussed in the weekly IDT QAPI meetings, as well as in the monthly QI meetings in which the medical director attends. 6. The LNHA and the DON will ensure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET KINGS MOUNTAIN, NC 28086

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F 690	Continued From page 11	F 690		

device and applied the device to Resident#117's right thigh and secured the indwelling catheter tubing.

On 10/11/18 at 10:18 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident #117's indwelling urinary catheter tubing would have been secured with a leg strap device to secure the tubing to prevent tension and dislodgement of the catheter and to prevent urethral tear. The DON stated it was her expectation that a leg strap device would be applied to Resident #117 to secure the indwelling catheter tubing.

On 10/11/18 at 10:20 AM an interview was conducted with the Corporate Nurse Consultant who stated it was her expectation that Resident #117 would have a leg strap device in place to secure the indwelling urinary catheter tubing to prevent tension and dislodgement of the catheter and to prevent urethral tear. The Corporate Nurse Consultant stated it was her expectation that a leg strap device would be applied to Resident #117 to secure the indwelling catheter tubing.

On 10/11/18 at 10:25 AM an interview was conducted with the Administrator who stated his expectation was that Resident #117 would have had a leg strap device in place to secure the indwelling urinary catheter tubing to prevent tension and dislodgement of the catheter.

On 10/11/18 at 11:01 AM a telephone interview was conducted with the physician who stated his expectation was that Resident #117's indwelling urinary catheter tubing would have been secured with a leg strap device to prevent tension and

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	345151	A. BUILDING _____ B. WING _____	C 10/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 12 dislodgement of the catheter and to prevent urethral tear.	F 690		