STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR/SHELBY	401 N MORGAN STREET , SHELBY, North Carolina, 28150

(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 An unannounced on-site complaint investigation survey was conducted on 7/16/2025, additional information was reviewed on 7/23/2025, therefore the exit date was changed to 7/23/25. Event ID: 1D13EE-H1. The following intakes were investigated 880443, 880444, 880445, and 880446. 1 of the 5 allegations resulted in deficiency.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550		

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

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

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F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, Resident Representative, and staff interviews, the facility failed to provide dignity for a cognitively impaired resident who waited for incontinence care to be provided. Resident #1 was severely cognitively impaired and Resident Representative stated that Resident #1 would have felt "awful and embarrassed" when left in wet brief without incontinence care. This deficient practice affected 1 of 3 resident sampled for dignity and respect (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/24/2023. Resident #1's diagnoses included dementia, cystitis with hematuria (inflammation of the bladder with bleeding), and overactive bladder. Resident #1 was discharged on 07/02/2025. An annual Minimum Data Set (MDS) dated 01/09/25 indicated Resident #1 was severely cognitively impaired. MDS further indicated she required extensive assistance for toileting, bathing, and personal hygiene. Resident #1 was always incontinent of urine. A review of Resident #1's care plan revealed a plan initially dated 09/19/23 and revised 06/25/25 for urinary incontinence. Stated goal was Resident #1 would have no urinary discomfort. Interventions included administer medications and monitor for medication effectiveness, provide incontinence care, and monitor for bladder discomfort. A review of facility grievances revealed a grievance for Resident #1 dated 01/13/25. Grievance revealed the Resident Representative reported "incontinence care was not provided for hours on 1st shift 01/11/25". Investigation was completed by previous Director of Nursing (DON) and Social Worker. Investigation notes	F0550		

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F0550 SS = D	Continued from page 2 indicated that NA #5 received disciplinary action for failing to provide care. Folow-up with Resident #1's Representative was completed by Social Worker at care plan meeting on 01/16/25. Follow-up stated that all questions were addressed, and no new concerns were identified. A care plan meeting was scheduled. Grievance was signed completed by the Administrator on 04/04/25. An interview statement with Resident #1's Representative dated 01/13/25 was completed by Social Worker. The statement revealed Resident #1's Representative had visited on 01/11/25 and at 1:00 PM, inquired to Nurse #2 about Resident #1's hematuria. When Nurse #2 asked NA #5 about Resident #1's urine that day, NA #5 responded to Nurse #2 and Resident Representative that she had not yet provided incontinence care to Resident #1 during her shift which began at 7:00 AM. Incontinence care was provided for Resident #1 by NA #5 and NA #1. An interview with the Resident Representative on 07/16/25 at 12:14 PM revealed concerns Resident #1's incontinence care was not performed 01/11/25. Resident Representative stated that NA #5 had not change Resident #1 during NA #5's shift until asked to do so at 1:00 PM. Resident Representative stated she was satisfied with the facility's resolution of grievance and reported no further concerns about Resident #1's incontinence care. A review of NA #5's personnel file revealed a hire date of 10/15/24. Documented counseling form dated 01/17/25 described the reason for counseling was "employee failed to provide incontinent care to resident for an overly extended amount of time" on 01/11/25. NA #5 was not available for interview. A telephone interview with NA #1 on 07/16/25 at 11:36 AM revealed that she could not recall the specific date of 01/11/25. NA #1 stated that she could not recall any specific concerns about Resident #1's care. A review of Nurse #2's written statement dated 01/12/25 revealed that Resident #1 was "not changed on 7:00 AM to 3:00 PM shift until NA #5 was asked to change Resident #1". Interview with Nurse #2 on 07/16/25 at 2:24 PM who provided care for Resident #1 on 01/11/25. Nurse #2 stated that she could not specifically recall the 01/11/25 shift. Nurse #2 stated that although she could not recall that specific date, Nurse #2 had to remind	F0550		

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F0550 SS = D	Continued from page 3 NA #5 often to provide incontinence care to residents including Resident #1. Nurse #2 indicated she verbalized her concerns to previous Director of Nursing (DON) who no longer worked at the facility but could not recall specific date or time of report. A telephone interview on 07/16/25 at 4:16 PM with NA #6 revealed she worked on 01/11/25 from 3:00 to 11:00 PM and was assigned to care for Resident #1. She stated she was familiar with Resident #1's care. NA #6 stated that she would often follow behind NA #5 who worked from 7:00 AM to 3:00 PM. When NA #6 arrived after NA #5, Resident #1 was often in her bed and her bed sheets would be saturated in urine with a brown ring around Resident #1. NA #6 reported that NA #5 left at 3:00 PM on 01/11/25. NA #6 stated that she would make a point to check Resident #1 first on rounds because NA #5 would not change her. NA #6 had previously verbalized concerns to nurses when Resident #1 was left with wet brief by NA #5 but could not recall specific nurses or times. NA #6 indicated that she could not recall if Resident #1 was left with wet brief on 01/11/25 and could not recall any specific concerns that day. An interview with Social Worker on 07/16/25 at 4:33 PM revealed that the grievance investigation indicated Resident #1 was left wet with urine on 01/11/25. The Social Worker stated that she could not recall specific evidence related to the incident. The Resident Representative reported that Resident #1 was left wet with urine through the 7:00 AM to 3:00 PM shift until 1:00 PM. The Social Worker stated that NA #5 received disciplinary action for failure to provide incontinence care. The Resident Representative revealed no further concerns when Social Worker followed up. The previous DON was not available for interview. An interview with the current DON on 07/16/25 at 04:33 PM revealed that she was aware of Resident #1's Resident Representative report that Resident #1 did not receive incontinent care by NA #5 on 01/11/25. The current DON stated that she was Assistant Director of Nursing on 01/11/25 and provided the documented counseling to NA #5. The previous DON had investigated, and Nurse #2 validated that Resident #1 was left wet on 01/11/25. The current DON indicated that NA #5 had ongoing issues with time management and NA #5 was transferred to another hall and time management improved. DON stated incontinent care should be provided to residents every 2 hours.	F0550		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices	F0689		

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F0689 SS = G	Continued from page 4 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed to provide care in a safe manner when Resident #1, who had a history of falls, slid out of a standard wheelchair onto the floor. The standard wheelchair was not the wheelchair Resident #1 was care planned to use when out of bed. Resident #1 later complained of pain and an x-ray revealed a femur fracture. Resident #1 was transferred to the hospital and diagnosed with a femur and knee fracture. The deficient practice occurred for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 was admitted to the facility on 12/24/2023 with diagnoses that included unspecified dementia, Parkinson's, type 2 diabetes mellitus, acute congestive heart failure, low back pain, other chronic pain, vitamin D deficiency, hypomagnesemia, major depressive disorder, unspecified atrial fibrillation, anxiety disorder, pain unspecified. Review of Resident #1's medical record revealed Resident #1 had received hospice services that started on 1/27/2025 related to end stage Parkinson's disease. On 2/18/2025 documentation revealed hospice services would not cover Resident #1's intravenous antibiotic therapy, and Resident #1's family agreed to revoke hospice services. Palliative services were requested by Resident #1's family on 2/21/2025, and a referral for Palliative services was sent on 2/24/2025. Review of Resident #1 physician's orders revealed active orders that read: · Eliquis 5 milligram (mg) tablet one tablet by mouth every 12 hours for atrial fibrillation. · Tramadol 50mg one tablet by mouth three times daily	F0689		

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F0689 SS = G	Continued from page 5 for chronic pain. · Acetaminophen 325 mg tablet two tablets by mouth every 4 hours as needed for chronic pain. Resident #1's quarterly Minimum Data Set (MDS) assessment dated 4/24/2025 indicated Resident #1 was severely cognitively impaired and indicated Resident #1 had impairment with range of motion for bilateral lower extremities, used a wheelchair for mobility, used a mechanical lift for transfers, required partial/moderate assist with rolling left and right in bed, and was dependent on staff for all other activities of daily living and mobility, and indicated Resident #1 received anticoagulant (blood thinner) medication. Review of Resident #1's comprehensive care plan last reviewed 6/25/2025 revealed Resident #1 was care planned at risk for falls due to narcotic use and dependence with mobility and history of falls with major injury with interventions that included: High back wheel chair with foam wedge cushion, elevating leg rests, and drop leg pad, when out of bed, assess transfer status as needed. Review of a progress note written by Nurse #1 on 7/1/2025 at 5:50 PM revealed Nurse #1 was called to Resident #1's room on 7/1/2025 at 2:45 PM by Nursing Assistant (NA) #1 and found Resident #1 lying on the floor in front of her wheelchair. NA #1 reported Resident #1 was sliding out of the wheelchair and NA#1 assisted Resident #1 to the floor. Resident #1 was assessed; range of motion was completed without complaint of pain. Resident #1 was transferred from the floor to the bed using the mechanical lift. Nurse #1 completed a skin audit and found no injuries. Family and provider were notified, and Resident #1 had no further complaints. During an interview on 7/16/2025 at 10:48 AM NA #1 stated on 7/1/2025 she worked from 7:00 AM to 3:00 PM and cared for Resident #1. NA #1 was told Resident #1 needed to be up in the wheelchair to go to a hair appointment. NA #1 stated she didn't normally work with Resident #1, and there were three chairs in Resident #1's room, a recliner and two wheelchairs. NA #1 stated NA #2 told her which wheelchair to use and it was the one that did not have a high back or attachments on the leg rests. NA #1 and NA#2 transferred Resident #1 into the standard wheelchair. NA #1 stated the hairdresser took Resident #1 to the beauty shop and brought Resident #1 back to her room when the hair appointment was finished. NA #1 stated she saw Resident #1 was back	F0689		

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F0689 SS = G	Continued from page 6 in her room around 2:35 PM, and Resident #1 requested to be put back in bed. NA #1 prepared Resident #1 to be transferred back to bed with the mechanical lift. NA #1 stated she brought the mechanical lift into Resident #1's room, positioned Resident #1 in the wheelchair next to the wall, locked the wheelchair and adjusted the footrests to the sides of the wheelchair and waited for another staff to assist with the transfer. NA #1 stated she noticed Resident #1 had started to slide out of the wheelchair. NA #1 stated she attempted to keep Resident #1 from sliding out of the wheelchair but was unable to reposition Resident #1 back into the wheelchair, and NA #1 assisted Resident #1 to the floor. NA #1 stated Resident #1's legs did not go behind her or under the wheelchair. NA#1 stated Resident #1's right leg went down straight in front of Resident #1 and her left leg bent out to the side. NA #1 stated it did not look out of place, and that Resident #1's left leg normally had a slight bend out and did not ever completely straighten out. NA #1 stated she called for a nurse to assess Resident #1. NA #1 stated Resident #1 was assessed by the nurses and no injury was noted. NA #1 stated after the nurse assessed Resident #1, she moved Resident #1's left leg to what appeared to be a more comfortable position before Resident #1 was transferred back to bed and Resident #1 had no complaint of pain. NA #1 stated Resident #1 complained of back pain while on the floor and after Resident #1 was transferred back to bed she voiced back pain that alternated with complaints of leg pain but was not consistent. NA #1 stated she did not see any injury, redness or swelling on Resident #1's legs. During an interview on 7/16/2025 at 11:08 AM Nurse #1 stated she entered Resident #1's room on 7/1/2025 at 2:45 PM and saw Resident #1 lying on her back on the floor. Resident #1 was assessed for injury, range of motion was within normal limits, no injury, bruising or swelling, and nothing out of the ordinary was noted during assessment. Nurse #1 stated after assessment Resident #1 was transferred back to bed using a mechanical lift, and another assessment was completed that revealed no injury. Nurse #1 stated Resident #1 frequently complained of back pain and voiced back pain after transfer so as needed (PRN) acetaminophen was administered. Nurse #1 stated if she had noted any swelling, or signs of injury she would have reported it to the provider immediately. Nurse #1 in a follow up interview on 7/21/2025 at 3:21 PM, stated the PRN acetaminophen administered to Resident #1 on 7/1/2025 at 3:09 PM was given for general discomfort, which was charted as pain, but due to the time the medication was documented in the electronic MAR, it was later in the shift the comment "resident care" was entered to	F0689		

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F0689 SS = G	Continued from page 7 explain the late documentation. Review of Resident #1's July Medication Administration Record (MAR) revealed: · Resident #1 received PRN acetaminophen on 7/1/2025 at 3:09 PM for pain at a level of 8 out of 10, and it was documented with a comment of: resident care and follow up was documented as somewhat effective. · Resident #1 received PRN acetaminophen on 7/1/2025 at 8:41 PM for leg pain at a level of 7 out of 10, and it was documented at follow up as somewhat effective. · Resident #1 received a scheduled tramadol 50mg three times daily as ordered on 7/1/2025. During an interview on 7/16/2025 at 11:45 AM NA #2 stated on 7/1/2025 she worked 7:00 AM- 7:00 PM, and she assisted NA #1 while Resident #1 was transferred from bed to wheelchair. NA #2 stated Resident #1 used a standard wheelchair, not the high back wheelchair for hair appointments, because Residents #1's family and hairdresser said they were unable to complete the hair appointment when Resident #1 was in the high back wheelchair. NA#2 stated she was not present when Resident #1 slid from the wheelchair. During a telephone interview on 7/21/2025 at 4:10 PM NA #7 verified she had worked 3:00 PM to 11:00 PM on 7/1/2025 and cared for Resident #1. NA #7 stated Resident #1 had voiced pain in her leg, NA #7 reported it to the nurse. NA #7 did not recall any bruising, swelling or increased complaints of pain with movement. During a telephone interview on 7/22/2025 at 9:58 AM NA #8 verified she had worked 11:00 PM – 7:00 AM on 7/1/2025 and cared for Resident #1. NA #8 stated she did not recall the specific report she received. NA #8 stated Nurse #3 assisted her while she provided care to Resident #1. NA #8 stated Resident #1 voiced pain during care but was asleep prior to and after care was provided. NA #8 stated no bruising or swelling was noted to Resident #1's lower extremities, but care was provided very gently due to pain with movement. NA #8 stated Resident #1 had a lot of stiffness normally around her knees, which caused her legs to appear bent, but NA #8 did not recall any signs of injury. Review of a nursing progress note written by Nurse #3, revealed Resident #1 had vocalized pain throughout Nurse #3's shift. Nurse #3 wrote when her shift started at 7:00 PM on 7/1/2025 she received report Resident #1 had fallen during the day. Nurse #3 documented Resident	F0689		

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F0689 SS = G	Continued from page 8 #1 had episodes of yelling throughout the shift and had voiced pain in left leg near buttock and vocalized pain when staff provided incontinence care. Resident #1 received PRN acetaminophen, and staff attempted to position Resident #1 in a more comfortable position. Nurse #3 completed a Situation, Background, Assessment, and Recommendation (SBAR) form (a structured communication framework used primarily in healthcare settings to facilitate prompt and appropriate communication among professionals) so the provider would see Resident #1 in the morning. During a telephone interview on 7/21/2025 at 4:00 PM Nurse #3 verified she worked from 7:00 PM to 7:00 AM on 7/1/2025 and was assigned to Resident #1. Nurse #3 stated she received a report at the start of her shift at 7:00 PM, that Resident #1 had a fall- slid out of her wheelchair- assisted by staff earlier that day, and had no injuries. Nurse #3 stated Resident #1 yelled out related to her confusion and dementia at baseline. Nurse #3 stated on 7/1/2025 Resident #3 voiced pain in her leg when turned by staff, Nurse #3 assisted NA #8 as Resident #1 was turned, cleaned, changed and repositioned in bed. Nurse #3 stated she saw no bruising, swelling or signs of injury on Resident #1, or she would have called the on-call provider immediately. Nurse #3 stated she administered PRN acetaminophen to Resident #1 at 8:44 PM for leg pain, and it was somewhat effective. Nurse #3 stated after the PRN was administered Resident #3 was quieter and rested. Nurse #3 stated Resident #3 voiced leg pain when turned early in the morning of 7/2/2025. Nurse #3 stated she administered PRN acetaminophen at 3:11 AM on 7/2/2025 to Resident #1 for leg pain after she was turned and repositioned, and Resident #1 went back to sleep. Nurse #3 stated the acetaminophen appeared to be effective since Resident #1 went back to sleep. Nurse #3 stated she had not noted any sign of an obvious injury based on her assessment, but thought Resident #1 was sore from her fall. Nurse #3 stated she completed an SBAR so the Nurse Practitioner (NP) would assess Resident #1 in the morning, to see in an x-ray was needed. · Resident #1 received PRN acetaminophen on 7/2/2025 at 3:11 AM for a pain level of 7 out of 10, and it was documented effective. · Resident #1 received a scheduled tramadol 50mg three times daily as ordered on 7/2/2025. Review of Resident #1's medical record revealed an order dated 7/2/2025 for a STAT (needed immediately) left hip, femur, pelvis and lumbar spine x-ray, entered	F0689		

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F0689 SS = G	Continued from page 9 by Nurse #1 at 9:54 AM. During a telephone interview on 7/22/2025 at 11:25 AM Nurse #4 verified on 7/2/2025 she worked 7:00 AM to 7:00 PM and Resident #1 was assigned to one of the halls she worked. Nurse #4 stated she had assessed Resident #1's leg on the morning of 7/2/2025 and had not seen any bruising swelling or signs of injury. Nurse #4 stated Resident #1 had appeared at her baseline. Nurse #4 stated she was only involved with sending Resident #1 to the hospital after x-ray results were received. Nurse #4 stated she thought the order for the x-ray had been obtained by another nurse, and Nurse #1 or the DON had helped with Resident #1. Nurse #4 stated she did recall the NP had assessed Resident #1 on the morning of 7/2/2025. Review of a nursing progress note written by the Director of Nursing (DON) on 7/2/2025 at 1:06 PM revealed x-rays were obtained on Resident #1 related to complaints of left hip pain after a fall on 7/1/2025. The provider reviewed x-ray results which noted a left femur fracture. Resident #1's family was notified and requested transfer to the hospital and the Nurse Practitioner (NP) agreed. 911 was called and Resident #1 was transferred to the hospital. Review of Resident #1's hospital records from 7/2/2025 through 7/8/2025 revealed Resident #1's left lower leg had swelling and tenderness. X-ray results revealed left distal femoral (thigh bone) fracture, the fracture extended into or was in close proximity to the knee replacement, and a fracture in a bone of the left knee joint. Resident #1's left leg was placed in a brace. An orthopedic surgery consult recommended conservative management with continued use of immobilizer to left leg, and non-weight bearing status on left lower extremity with follow up with orthopedic surgery in the outpatient setting after discharge. Resident #1 had a Palliative care consultation, and by family request was discharged to a hospice facility on 7/7/2025. During an interview on 7/16/2025 at 1:27 PM the Nurse Practitioner (NP) stated Resident #1 used a mechanical lift for transfers. The NP stated she had only seen Resident #1 in the recliner or bed; it had been a while since the NP had seen Resident #1 in a wheelchair. NP was aware Resident #1 used a wheelchair for hair appointments and when Resident #1 went out of the facility. The NP stated she was not aware of which wheelchair Resident #1 was supposed to use, that she left that to therapy and nursing. The NP stated she was notified on 7/2/2025 that Resident #1 had slid out of the wheelchair on 7/1/2025. The NP stated when she was	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR/SHELBY	401 N MORGAN STREET , SHELBY, North Carolina, 28150

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F0689 SS = G	Continued from page 10 notified Resident #1 had complained of pain in her legs she had ordered STAT x-rays. The NP stated if Resident #1 had a care plan to use a specific wheelchair when out of bed, that is the wheelchair that should be used. The NP stated if Resident #1 needed another wheelchair for hair appointments, then the NP would expect it to be discussed with therapy and care planned for use. During a follow up telephone interview on 7/21/2025 at 4:17 PM the NP stated she did not work on 7/1/2025, but on- call providers are available. The NP stated Resident #1 had dementia and some yelling behaviors at baseline, but if Resident #1 had complained of consistent pain that was not relieved by medication, she would have expected the on-call provider to be notified. The NP stated the SBAR was an appropriate communication for her to receive when she returned on 7/2/2025, if there was no sign of injury and pain medication was effective. During an interview on 7/16/2025 at 2:25 PM the Occupational Therapist (OT) stated Resident #1 had been assessed and approved for the high back wheelchair with wedge cushion, elevated footrests and leg drop pad, no other wheelchair. The OT stated she did not see any referrals for evaluation of another wheelchair for Resident #1. The OT stated she was unaware Resident #1 had used a different wheelchair for hair appointments. The OT stated an evaluation of the wheelchair should have been completed to ensure it met Resident #1's needs. During an interview on 7/16/2025 at 2:45 PM the MDS Nurse stated if Resident #1 required a different chair for hair appointments, it should have been added to the care plan. During a telephone interview on 7/16/2025 at 3:45 PM NA #3 stated it had been awhile since he had taken Resident #1 to a hair appointment but he recalled part of the high back wheelchair could be removed for the hair dresser to complete the appointment, or the high back chair could be leaned back and the hair dresser had equipment used to wash Resident #1's hair. During a telephone interview on 7/16/2025 at 3:55 PM NA #4 stated she thought Resident #1's high back chair had a piece that could be removed for hair appointments. During an interview on 7/16/2025 at 4:05 PM the Social Worker stated Resident #1's family had a hairdresser, that did not work for the facility, that came in to do Resident #1's hair. The Social Worker stated the hairdresser had reported she was unable to complete Resident #1's hair appointment when Resident #1 was in	F0689		

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F0689 SS = G	Continued from page 11 her normal wheelchair and a regular wheelchair was used when Resident #1 went to the beauty shop. The Social Worker stated she thought a regular wheelchair was used so Resident #1's hair could be washed in the sink. The Social Worker stated she thought nursing had assessed Resident #1 using a standard chair for the beauty shop, and a standard chair had been used for Resident #1's hair appointments for quite a long time. The Social Worker was unsure of exactly how long a standard chair had been used for Resident #1 in the beauty shop. During an interview on 7/16/2025 at 4:33 PM the Director of Nursing (DON) stated Resident #1 only used the standard wheelchair for hair appointments at the beauty shop because Resident #1's family and hairdresser had told them Resident #1's hair could not be completed in Resident #1's regular chair. The DON stated she did not recall exactly how long Resident #1 had used the standard wheelchair for hair appointments but had stated it had been used for a couple years. The DON stated she could not verify Resident #1 was not assessed to use the standard wheelchair for hair appointments but verified there was no documentation of an assessment or orders for therapy referral. The DON stated since Resident #1 had a care plan for a specific chair when out of bed, and that wheelchair was not being used for hair appointments, there should have been an assessment and documentation regarding the wheelchair used for hair appointments. During an interview on 7/16/2025 at 5:31 PM the Administrator stated she was notified Resident #1 had slid out of her wheelchair onto the floor. The Administrator stated at the time she was notified of the fall she was not aware Resident #1 had used a standard wheelchair, and not Resident #1's care planned wheelchair. The Administrator stated she was then told the hairdresser had asked for Resident #1 to be in a lower back chair. The Administrator stated she asked the DON, after the fact, if Resident #1 had looked appropriate in the standard wheelchair and that the DON had stated Resident #1's positioning was appropriate in the standard wheelchair. The Administrator stated if a resident had to use a wheelchair that was not the care planned wheelchair, she expected there to be assessment and documentation regarding the use of a different wheelchair.	F0689		