STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. BUILDING _____ B. WING _____	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - SHELBY	**401 N MORGAN STREET SHELBY, NC 28150**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #06OV11.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the dignity of residents requiring assistance with meals by staff calling residents " feeders" during 3 of 6 dining observations. Findings included: During an observation of the dining room on 6/6/16 at 12:20 PM, staff members were observed to refer to residents seated at the back 3 tables of the dining room, who needed assistance with their meals as " the feeders" . This statement was made in front of other residents, staff and visitors in the dining area. During an observation of the North 300 Hall on 6/6/16 at 12:40 PM, Nurse Aid (NA) #2 was observed referring to a resident who needed assistance with meals as a " feeder."	F 241	White Oak Manor-Shelby is submitting this POC to comply with State Operations Manual Section 7304D. This plan of correction does not constitute an admission of any facts, allegations or conclusions stated in the CMS 2567 and is not intended for any other purpose other than compliance with Sections 7304D of the State Operations Manual and authorizing regulations. White Oak Manor-Shelby does promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. There were no specific resident(s) referenced in the 2567.	6/29/16

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

Electronically Signed | 06/29/2016

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F 241	Continued From page 1 During an observation of the dining room on 6/8/16 at 5:09 PM, NA #3 was observed to refer to residents seated at the back 3 tables of the dining room, who needed assistance with their meals as " feeders" This statement was made in front of other residents, staff and visitors in the dining area. An interview was conducted on 6/9/2016 at 10:05 AM with the Director of Nursing (DON) regarding residents requiring assistance with meals being referred to as "feeders." The DON stated that it is her expectation that staff would refer to residents who needed assistance with meals as residents who need "assistance with feeding." She further stated that staff should not be referring to residents as "feeders" An interview was conducted with the Administrator on 6/9/16 at 11:12 AM. During this interview the Administrator stated that she would not expect staff to refer to residents who needed assistance with meals as " feeders "	F 241	Re-education/inservicing was immediately initiated on June 9, 2016 for Nursing (Nurses, CNAs)staff present in the facility. This re-education/inservicing addressed how to ensure dignity and respect for residents by addressing all residents appropriately and avoiding the use of labels, such as "feeders". This re-education/inservicing was conducted by the Administrator and Director of Nursing. 2. How Corrective Action will be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice. The re-education/inservicing on how to ensure dignity and respect for residents by addressing all residents appropriately and avoiding the use of labels, such as "feeders", that was initiated on June 9, 2016 to Nursing staff (Nurses, CNAs) was expanded to include all active staff members. This re-education/inservicing was conducted by the Administrator and Director of Nursing and was completed on June 28, 2016. Staff members who are on approved leave of absences will have their inservicing completed upon reporting back to work. This inservicing will be repeated with newly hired staff during Orientation by the Staff Development Nurse. This training will also be reinforced as necessary to ensure compliance by the Staff Development Nurse and/or the Administrator. 3. Address What Measures Will be Put	

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F 241	Continued From page 2	F 241	Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. Current staff have been inserviced on ensuring dignity and respect for residents by avoiding use of labels. This re-education/inservicing was conducted by the Administrator and Director of Nursing and was completed on June 29, 2016. Staff members who are on approved leave of absences will have their inservicing completed upon reporting back to work. This inservicing will be repeated with newly hired staff during Orientation by the Staff Development Nurse. This training will also be reinforced as necessary to ensure compliance by the Staff Development Nurse and/or the Administrator. Ongoing compliance to F241 will be monitored by the Administrator, Director of Nursing, Assistant Director of Nursing and Department Managers by completing random observations of residents eating/being assisted in the Dining Room. At least three (3) random observations will be completed in the Dining Room on a weekly basis for three months, then three (3) times monthly for three months, then once a quarter for three quarters, and then as needed thereafter. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete.	

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F 241	Continued From page 3	F 241	Ongoing compliance to F241 will be monitored by review of the random observations of residents eating/being assisted in the Dining Room. The results of these observations will be reviewed by the QI team upon completion of at least three (3) random observations completed in the Dining Room on a weekly basis for three months, then three (3) times monthly for three months, then once a quarter for three (3) quarters, and then as needed thereafter for any additional recommendations. The results of these random observations will also be reviewed during the monthly QA Meeting for further discussion and recommendations, if needed. The Administrator and the Director of Nursing are responsible for ongoing compliance to F241. Compliance date for F241: June 29, 2016	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		6/29/16

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F 279	Continued From page 4 The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on a closed medical record review and staff interviews the facility failed to develop a care plan to address weight loss for 1 out of 4 residents sampled (resident #111) reviewed for nutrition. Findings included: Resident #111 was admitted to the facility on 2/8/16 and discharged on 3/15/16. Resident #111 diagnosis included urinary tract infection (UTI) gram negative sepsis, heart failure, non-rheumatic aortic stenosis, hyperlipidemia, and pain. The Admission/5day minimum data set (MDS) ARD: 2/15/16 indicated resident # 111 was cognitively intact with score of 14 on BIMS, required supervision one person assist with eating, and weight of 172 pounds (lbs.). Indicated mechanically altered, therapeutic diet and no oral or dental issues. Medical record review revealed weights: 2/08/16 - 172.4 lbs. 2/11/16 - 172.2 lbs. 2/18/16 - 163.4 lbs.	F 279	White Oak Manor-Shelby does use the results of the assessment to develop, review and revise the resident's comprehensive plan of care and develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. Resident #111 was successfully discharged home on March 15, 2016. The Medical Director believed the resident's change in weight was an expected change in weight. On June 9, 2016, the Corporate Consultant Dietician completed re-inservicing with the Dietary Director and the Assistant Dietary Manager. This	

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F 279	Continued From page 5 2/22/16 - 160.6 lbs. 2/25/16 - 161 lbs. 3/04/16 - 157 lbs. 3/10/16 - 158.4 lbs. Medical record review revealed a dietary note dated 2/22/16 by certified dietary manager (CDM) #1 indicated resident #111 had significant weight changes since admission 2/8/16. Resident was chair bound, could feed himself, made food wishes known. Medical record review revealed a nutritional screening review dated 3/7/16 by CDM #1 indicated weight of 157.3 #, height 68 inches, no weight loss per review. Indicated resident #111 ate all of his meals in his room, by mouth intake 51-100%. Indicated no significant weight changes in 30 days. There was no care plan with measurable goals or individualized interventions initiated for resident #111 in regards to his significant weight loss. 06/09/2016 11:24:56 AM Interview with CDM #1 stated if a resident had weight loss she would ask for a re-weigh, then she would look at the medications to see if on Lasix. CDM #1 stated that she would talk with the resident and ask them if they would like ice cream, or rich soup. She further stated if a resident had significant weight loss she would start a care plan, order supplements or enriched meals. CDM #1 also stated if a resident wanted to lose weight she would document that. She stated for resident #111 she went to his room and looked at him and he didn't look like he was losing weight. CDM #1 stated resident #111 was eating really good and wanted a menu for lunch and dinner every day.	F 279	re-inservicing addressed standards of care regarding weight changes, documentation and assessment guidelines, appropriate interventions, and communication and review with the Care Plan team. 2. How Corrective Action will be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice. On June 9, 2016, the Corporate Consultant Dietician completed re-inservicing with the Dietary Director and the Assistant Dietary Manager. This re-inservicing addressed standards of care regarding weight changes, documentation and assessment guidelines, appropriate interventions, and communication and review with the Care Plan team. In addition, the Care Plan team members (RAC Nurses, Dietary, Activities, Social Services, Restorative) received inservicing conducted by the Administrator that addressed the responsibility of the Care Plan team to review residents' weights, ensure interventions in place as needed for weight loss, and development or revision of the plan of care to address weight loss if needed. This inservicing was initiated on June 24, 2016 and again on June 28, 2016. This training will be repeated by the Administrator for any newly hired Care Plan team member during Orientation. This training will also be reinforced as necessary by the Administrator to ensure compliance.	

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F 279	Continued From page 6 She further stated that she didn't want to start on aggressive care plan for resident #111 because he looked really fine. 06/09/2016 11:36:23 AM Interview with CDM #2 stated on 2/8/16 Centrum, a multivitamin was started for nutritional support for resident #111. CDM #2 stated resident #111 did not have a care plan initiated for nutrition or weight loss. 06/09/2016 11:57:39 AM Interview with administrator stated her expectations were for when identifying weight loss, the dietary staff should notify the RD, DON, and possibly the physician. The administrator stated the dietary staff would need to identify if the weight loss was expected or unexpected. She also stated there should be documentation in the progress notes what interventions are in place. The administrator further stated that dietary documentation should show communication with nursing staff and potentially developing a care plan.	F 279	The Corporate Consultant Dietician also completed a review of all current residents to ensure residents having significant weight changes had appropriate documentation, interventions, and care plan(s) in place. This review was completed on June 24, 2016. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. On June 9, 2016, the Corporate Consultant Dietician completed re-inservicing with the Dietary Director and the Assistant Dietary Manager. This re-inservicing addressed standards of care regarding weight changes, documentation and assessment guidelines, appropriate interventions, and communication and review with the Care Plan team. In addition, the Care Plan team members (RAC Nurses, Dietary, Activities, Social Services, Restorative) received inservicing conducted by the Administrator that addressed the responsibility of the Care Plan team to review residents' weights, ensure interventions in place as needed for weight loss, and development or revision of the plan of care to address weight loss if needed. This inservicing was initiated on June 24, 2016 and again on June 28, 2016. This training will be repeated by the Administrator for any newly hired Care Plan team member during Orientation. This training will also be reinforced by the	

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F 279	Continued From page 7	F 279		

Administrator as necessary to ensure compliance.

Ongoing compliance to F279 will be monitored by the Administrator, Director of Nursing, Dietary Manager, and the Corporate Consultant Dietician. This will be achieved by the Corporate Consultant Dietician completing random audits of current residents in their assessment window to ensure significant weight changes are addressed by documentation, interventions as appropriate, and development of or revision of the plan of care as appropriate. Five (5) audits will be completed weekly for one (1) month, then five (5) monthly for three (3) months, and then five (5) per quarter for three (3) quarters, and then as needed thereafter. The results of these audits will be reviewed with the Administrator, Director of Nursing, and the Dietary Manager.

4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete.

Ongoing compliance to F279 will be monitored by review of the random audits of current residents in their assessment window that are completed by the Corporate Consultant Dietician. These will be reviewed by the Administrator, the Director of Nursing, and the Dietary Manager. The results of these audits will be reviewed by the QI team upon completion: Five (5) audits completed

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F 279	Continued From page 8	F 279	weekly for one (1) month, then five (5) monthly for three (3) months, and then five (5) per quarter for three (3) quarters, and then as needed thereafter for any further discussion and/or recommendations. The results of these random audits will also be reviewed during the monthly QA Meeting for further discussion and recommendations. The Administrator, Director of Nursing, and Dietary Manager are responsible for ongoing compliance to F279.	