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 02/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - SHELBY	**401 N MORGAN STREET SHELBY, NC 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
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to protect a cognitively impaired resident (Resident #3) from inappropriate touching from a cognitively intact resident (Resident #2) for 1 of 1 resident reviewed for abuse. The Findings included: Review of Resident #3's medical record revealed she was readmitted to the facility on 12/14/17 from a psychiatric hospital where she was admitted for evaluation. Her diagnoses Alzheimer's disease and major neurocognitive disturbances. The recent quarterly Minimum Data Set (MDS) dated 01/18/18 indicated she had short and long term memory problems and had moderately impaired cognitive skills for daily decision making. The MDS also indicated Resident #3 was ambulatory, required	F 600	F600 White Oak Manor-Shelby does ensure residents are free from abuse, neglect, misappropriation of resident property, and exploitation. Both residents have been discharged from the facility. Resident #3 was discharged to a secure-care facility on February 12, 2018. Resident #2 was discharged to another skilled nursing facility on February 21, 2018. As noted in the 2567, "Resident #3 did not show any emotion over the incident". On the date of the occurrence, February 8, 2018, the two residents were immediately separated. At that time, an occurrence report was initiated and the facility investigation began. The Social Services Director reported to the facility to	3/5/18

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

Electronically Signed | 03/02/2018

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

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F 600	Continued From page 1 supervision during locomotion on the unit and could walk independently. Review of Resident #3's Occurrence Report (OR) dated 02/08/18 at 7:30 PM revealed she was witnessed by Nurse Aide (NA) #1 to be grabbed/touched inappropriately by another resident (Resident #2). The OR was completed by Nurse #1. Review of Resident #3's nurses' notes written by Nurse #1 and dated 02/08/18 at 11:20 PM revealed NA #1 informed her that she observed Resident #2 grab Resident #3's breast while saying to her "come here" then NA #1 removed Resident #3 from Resident #2's room and redirected Resident #3 to her room. During an interview with NA #1 on 02/12/18 at 10:58 AM she stated that on the night of 02/08/18 she was coming out of another resident's room when she observed Resident #2 sitting in his wheel chair in the doorway of his room and calling out for Resident #3 to come into his room. As Resident #3 got to Resident #2's room, he wheeled himself backwards further into his room and Resident #3 followed him into his room. NA #1 stated by the time she got into Resident #2's room, Resident #3 was bent down to Resident #2 and Resident #2 had his right hand underneath the top of Resident #3's V necked shirt rubbing on Resident #3's left breast. After Resident #2 stopped rubbing on Resident #3's breast Resident #3 raised up and turned around then walked out of Resident #2's room. Resident #2 proceeded to call Resident #3 back but Resident #3 continued to walk out of Resident #2's room. NA #1 stated as Resident #3 walked out of his room NA #1 passed her then told	F 600	ensure required notifications were completed, including the initial report made to the State and notification of local law enforcement. The Social Services Director also initiated staff interviews at that time. Resident #2 was care planned regarding inappropriate behaviors but had never touched another resident on the breast or breast area. After the initial separation, Resident #2 was placed on 15-minute checks, had a room change to another nursing unit in the facility, and was later placed on 1:1 monitoring by staff before being discharged on February 21, 2018. In addition, Resident #2 had a behavioral health assessment completed on February 12, 2018, was seen by the Nurse Practitioner on February 9th and 12th, 2018, and was also assessed in the Emergency Department at the local hospital on February 13, 2018 (resident returned the same day). The Shelby Police Department completed the investigation and after a full investigation, the assistant district attorney declined to prosecute the case. While staff identification of and reporting of resident to resident abuse was completed properly, the facility did initiate re-education/reinservicing on the Abuse and Neglect policy, reporting of abuse/neglect, and resident to resident abuse, to all departments via multiple meetings held by the Administrator on February 20, 2018 and February 21, 2018. Staff members who were/are on	

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F 600	Continued From page 2 Resident #2 that she observed what had happened and would report it to the nurse. NA #1 stated Resident #3 did not show any emotion regarding the incident. During an interview with Nurse #1 on 02/12/18 at 9:15 AM she stated she was alerted by NA #1 that she observed Resident #2 put his hand down Resident #3's shirt and rub her breast. Nurse #1 stated she then went to assure Resident #3 was alright and by the time she got to Resident #3 she was in her room getting ready for bed. Review of Resident #2's medical record revealed he was readmitted to the facility from an acute hospital on 12/01/16 with diagnoses which included Parkinson disease, anxiety and depression. The recent quarterly Minimum Data Set (MDS) dated 01/25/17 indicated he was cognitively intact and used a wheel chair and a walker for mobility. Review of Resident #2's nurses' notes dated 02/08/18 at 11:13 PM and written by Nurse #1 indicated NA #1 informed her that she observed Resident #2 grab Resident #3's breast while saying to her "come here" then NA #1 removed Resident #3 from Resident #2's room and redirected Resident #3 to her room. During an interview with NA #1 on 02/12/18 at 10:58 AM she stated that on the night of 02/08/18 she was coming out of another resident's room when she observed Resident #2 sitting in his wheel chair in the doorway of his room and calling out for Resident #3 to come into his room. As Resident #3 got to Resident #2's room, he wheeled himself backwards further into his room and Resident #3 followed him into his room. NA	F 600	approved leave of absences/vacation/etc. will have their inservicing completed prior to or upon reporting back to work. Newly hired staff will be educated during their specific job orientation by the Staff Development Coordinator or Social Services Director. The Abuse/Neglect policy (including reporting and resident to resident abuse) will be reviewed annually with all staff and as needed throughout the calendar year. There are currently no residents at the facility who are exhibiting inappropriate sexual behaviors toward any other resident(s). All indications of potentially sexually inappropriate behaviors will be closely monitored for four weeks to determine the extent/severity of any behavior(s) and will include assessment of the need for alternate placement and the protection of all residents in the facility. This will also be completed monthly for 3 months and as needed thereafter. Ongoing monitoring will also be achieved by review of any sexually inappropriate behaviors as defined by and completed on the MDS (Minimum Data Set). The Social Services Director will conduct the monitoring. Results from the monitoring will be reviewed in the Morning QI meeting Monday-Friday for any issues, additional discussion, and/or recommendations and will be further discussed at the monthly Quality Assurance meeting and additional recommendations, if needed.	

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F 600	Continued From page 3 #1 stated by the time she got into Resident #2's room, Resident #3 was bent down to Resident #2 and Resident #2 had his right hand underneath the top of Resident #3's V necked shirt rubbing on Resident #3's left breast. After Resident #2 stopped rubbing on Resident #3's breast Resident #3 raised up and turned around then walked out of Resident #2's room. Resident #2 proceeded to call Resident #3 back but Resident #3 continued to walk out of Resident #2's room. NA #1 stated as Resident #3 walked out of his room NA #1 passed her then told Resident #2 that she observed what had happened and would report it to the nurse. NA #1 stated that Resident #3 did not show any emotion over the incident.	F 600	The Administrator and Social Services Director are responsible for ongoing compliance to F600.	