PRINTED: 10/03/2018 FORM APPROVED OMB NO. 0938-0391

	B. WING		
34555	J D. WING		C 09/07/2018
NAME OF PROVIDER OR SUPPLIER WHITE OAK OF WAXHAW	1	STREET ADDRESS, CITY, STATE, ZIP COL 700 HOWIE MINE ROAD WAXHAW, NC 28173	•
(X4) ID SUMMARY STATEMENT OF DEFICIENC PREFIX (EACH DEFICIENCY MUST BE PRECEDED B TAG REGULATORY OR LSC IDENTIFYING INFOR	Y FULL PREF	•	N SHOULD BE COMPLETION EAPPROPRIATE
F 656 SS=D Develop/Implement Comprehensive Care Plans §483.21(b) (1) The facility must develop a implement a comprehensive person-cent care plan for each resident, consistent w resident rights set forth at §483.10(c)(2) §483.10(c)(3), that includes measurable objectives and timeframes to meet a resimedical, nursing, and mental and psychoneeds that are identified in the comprehe assessment. The comprehensive care pledescribe the following - (i) The services that are to be furnished to or maintain the resident's highest practice physical, mental, and psychosocial well-trequired under §483.24, §483.25 or §483.40 but a provided due to the resident's exercise of under §483.10, including the right to refut treatment under §483.10(c)(6). (iii) Any specialized services or specialize rehabilitative services the nursing facility provide as a result of PASARR recommendations. If a facility disagrees findings of the PASARR, it must indicate rationale in the resident's mesident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potent future discharge. Facilities must docume whether the resident's desire to return to community was assessed and any referr local contact agencies and/or other appropentities, for this purpose. (C) Discharge plans in the comprehensive	and ered th the ered th the ered th the ered th the ered	TITLE	(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/24/2018

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.

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345550	B. WING		C 09/07/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/07/2010	
				700 HOWIE MINE ROAD		
WHITE OA	AK OF WAXHAW			WAXHAW, NC 28173		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 656	Continued From page	e 1	F 650	3		
	requirements set fort section.	in accordance with the h in paragraph (c) of this is not met as evidenced				
	Based on resident in resident council meet facility failed to imple interventions for 3 of (Resident's #4, #30, and range of motion Findings included: 1.a. Resident #4 was	#35) to maintain ambulation with Restorative Therapy. admitted to the facility on agnosis that included Heart diabetes Melius,		White Oak of Waxhaw develops ar implements comprehensive care pl their residents. The lack of implementation of the intervention frestorative therapy was due to the restorative staff being re-assigned resident care and the assigned staff able to implement the program as oplanned. Resident #4, #30, and #35 have be	for for for for grant for	
	depression. The quarterly Minimulassessment dated 03 #4 was cognitively into the supervision of on mobility. He required for transfers, toilet us Resident # 4 required staff member for dressin corridor. Further rehad no impairment for #4's mobility devices wheelchair. The yearly MDS asset	m Data Set (MDS) 3/20/2018 indicated Resident tact. Resident #4 required to staff member with bed supervision and set up help to e, and personal hygiene. Illimited assistance from one using, bathing, and walking to view revealed resident #4 to range of motion. Resident used included a walker, and the sesment dated 06/05/18		reassessed for the restorative prog to assure ambulation and range of is still appropriate. The residents w receive the restorative therapy as recommended by the nursing staff frequency needed. The residents' or plans will be updated to reflect the appropriate restorative programs by 10/4/18. Resident #4, #30 and #35 not had a decline in their range of r from previous assessment. An audit and reassessment will be completed for all other residents or	rams motion ill at the care y have motion	
	Resident #4 required member for bed mob review revealed Resi corridor. Resident #4 during this MDS asse wheelchair. A review of the active	4 was cognitively intact. the supervision of one staff ility, and transfers. Further dent #4 did not walk in the 's mobility device used essment included a e care plan originally created ated in September 2018 had		restorative therapy, for appropriate and frequency of the program by fa nursing staff by 9/28/18. The restorative staff will be re-educ on the importance of the delivery of restorative therapy by the Director Nursing (DON) by 9/25/18.	cated f	

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 50.125	_		1 ,	С
		345550	B. WING				07/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				70	00 HOWIE MINE ROAD		
WHITE OA	AK OF WAXHAW			W	VAXHAW, NC 28173		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 656	Continued From page	e 2	F	656			
		cus area for Resident #4		000	The facility will train additional CNAs a	nd	
		eased mobility due to muscle			licensed nurses on the delivery of the	Iu	
	_	was for the resident to be			restorative program/therapy to assure t	he	
		ve range of motion every day			delivery of the restorative programs. The		
	-	up to 20 minutes each			training will be completed by the DON		
		ew. Interventions included			and/or Physical Therapy department a	nd	
		ge of motion program every			completed by 10/4/18.		
		, 6 days per week due to					
	muscle weakness. Re	esident #4 also had a focus			Newly hired restorative and nursing sta		
	area for decreased m	a for decreased mobility. The goal was for the			will receive the education on delivery o	f	
	resident to be able to				the restorative program during their job	,	
		every day with a rolling			specific orientation with the Staff		
		rthoses brace six days per			Development Coordinator.		
	week until the next re				T		
		d restorative ambulation			The additionally trained nursing staff w	ıII	
		walker and left foot orthoses			deliver the restorative program in the	ro	
	due to muscle weakn	ery day for six days per week			absence of the restorative staff to assu		
		7/18 at 12:40pm with Nurse			the programs are being delivered. Active nursing staff recruitment and orientation		
		# 4 had an active care plan			being conducted weekly to fill nursing	. 1	
		y. She stated she reviews			positions in order to lower or eliminate	the	
		an which is printed by the			frequency that the restorative staff are		
		pervisor and delivered to			re-assigned.		
	_	ne stated the restorative					
	aides are often pulled	d to work on the resident			The DON/Assistant DON will monitor the	ne	
	halls.				implementation and documentation of t		
		ative therapy logs for the			restorative program as care planned by		
		ough 09/05/18, revealed			auditing 3 residents on the program pe	r	
	Resident #4 missed	•			week for 4 weeks, then 3 residents		
	therapy out of the 61	-			monthly for 3 months, and as needed		
		ducted on 09/07/18 at 11:02			thereafter.		
	am with Resident #4.				Describe forms the many training training		
		es are pulled to work on the			Results from the monitoring will be	0.00	
	resident halls he does				discussed Monday through Friday during	ıg	
		had been a week since he			the Quality Improvement (QI) morning		
		herapy. He stated since			meetings and any identified issues or trends will be further discussed at the		
		hysical therapy had helped mbulate. Resident #4 stated			Quality Assurance meeting with the tea	ım	
	he needed help main				and recommendations made as indicat		
	ino nocaca ncip main	can may and admity to	1		and recommendations made as indicat	Ju.	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345550	B. WING _				C 07/2018	
NAME OF PE	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	0772010	
					700 HOWIE MINE ROAD			
WHITE OA	K OF WAXHAW				VAXHAW, NC 28173			
0/0.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 656	Continued From page 3			56				
	ambulate.							
	1.b. Resident #30 wa 08/08/17 with a diagrartery disease, hyper accident, hemiplegia, The annual MDS ass indicated Resident #30 require one staff member for He required limited as member for locomotic the corridor. Resident room. Mobility device wheelchair. A review of the Care had a focus area for I for decreased mobility as related to hemiple Resident #30 to be all active range of motion to 20 minutes through 10/03/18. Intervention range of motion daily week due to hemiples included restorative a encouragement, and A review of the restor dates of 07/06/18 through the restor dates of 07/06/18 through the restor of the feature was the rapy out of the 61	essment dated 07/04/18 30 was cognitively intact. d extensive assistance of bed mobility and transfers essistance of one staff on on the unit and walking in t #30 did not walk in his is used included a cane and Plan initiated on 03/15/18, Resident #30 being at risk y due to muscle weakness gia. The goal was for ble to tolerate restorative in daily 6 days per week up in the next review dated of ins included restorative active up to 20 minutes 6 days per gia. Other interventions aids to offer praise, rest periods as needed. rative therapy logs for the bugh 09/05/18, revealed d 29 days of restorative days scheduled.			The DON is responsible for ongoing compliance of F656.			
	An interview on 09/07							
		ed restorative therapy had						
		g his cane in the hallway for						
		nth. Resident #30 stated his						
	with restorative thera	due to being unable to walk py.						
	1.c. Resident # 35 wa	as admitted to the facility on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345550	B. WING			C 9/07/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 HOWIE MINE ROAD WAXHAW, NC 28173		9/0//2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	accident, anxiety and The quarterly MDS d Resident #35 was co required extensive as member for bed mob toilet use, walking in Resident #35 did not review revealed Resimotion limitations to lextremities on one sicane/crutch, and a w A review of the Care had a focus area for for decreased joint m weakness as related The goal for Residen tolerate up to 15 min minimum assist and upper extremity while extremity daily 6 days review date of 10/10/restorative transfer particular with minimum assist through left upper extremity interventions included praise, encouragement needed. An interview on 09/07 #2 revealed resident for restorative therap stated the restorative work on the restorative work on the restorative dates of 07/06/18 through left upper states of 07/06/18 through left upper s	nosis that included pidemia, cerebrovascular depression. ated 7/10/18 indicated gnitively intact. Resident #35 sistance of one staff lility, transfers, dressing, the corridor and bathing. walk in his room. Further dent #35 had range of his upper and lower de. Mobility devices included heelchair. Plan initiated on 11/09/17, Resident #35 being at risk obility due to muscle to a diagnosis of hemiplegia. It #35 was to be able to utes at parallel bars with weight bearing through left areaching with right upper so per week through the next 18. Interventions included rogram standing at parallel sist and weight bearing stremity while reaching with up to 15 minutes. Other did the restorative aids to offer int and rest periods as 17/18 at 12:47pm with Nurse 18/35 had an active care plan by per physician orders. She aides are often pulled to halls. 18/35 at 18/35 revealed de 21 days of restorative	F 6	56		

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) 07/2018
3772010
(X5) COMPLETION DATE

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345550	B. WING		C 09/07/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 700 HOWIE MINE ROAD WAXHAW, NC 28173		1 03/07/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 688 SS=D	Director of Nursing rethe facility was for the as much as they car obtain more knowled therapy program sind An interview on 09/0 Administrator reveal regarding staffing. So orientations weekly the stated she had investigating staffing recorded.	17/18 at 11:12am with the evealed the expectation of e resident to receive therapy in She stated she needed to dge of the facilities restorative ce she was newly hired. 17/18 at 12:56pm with the led the facility is having issues the stated she is having to attempt to gain staff. She stigated further options cruitment.	F 65		10/4/18	
	resident who enters range of motion does range of motion unles condition demonstrated from the motion is unavoid. §483.25(c)(2) A resident from the motion receives appropriate assistance to maintain the maximum practice reduction in mobility. This REQUIREMEN by: Based on resident in resident council meeting and motion to motion the motion of the motion in mobility.	acility must ensure that a the facility without limited is not experience reduction in east the resident's clinical test that a reduction in range able; and dent with limited range of ropriate treatment and range of motion and/or to ease in range of motion. Ident with limited mobility eservices, equipment, and ain or improve mobility with eable independence unless a is demonstrably unavoidable. To is not met as evidenced enterview, staff interview, eting and record review the de care planned restorative		White Oak of Waxhaw ensures that the a resident with limited range of motion receives appropriate treatment and		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 5012511				c l
		345550	B. WING _				/07/2018
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	70772010
					HOWIE MINE ROAD		
WHITE OA	AK OF WAXHAW				AXHAW, NC 28173		
	0.111.11.12.11				<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From pag	ge 7	F 6	886			
		tion and range of motion for 3 dent 's #4, #30, #35) due to			programs to maintain or increase rang motion and or prevent further decrease		
		ng pulled to cover for nurse			range of motion. The lack of restorative		
	aide staff.				therapy/program implementation was o		
	Findings included:				to the restorative staff being re-assigned	∍d	
		as admitted to the facility on			for resident care and the assigned staf	f	
		liagnosis that included Heart			not able to implement the program as		
	failure, hypertension				care planned.		
		ebrovascular accident,			Posident #4 #20 and #25 have been		
	depression.	num Data Set (MDS)			Resident #4, #30, and #35 have been reassessed for the restorative program	ne	
	' '	03/20/2018 indicated Resident			to assure ambulation and range of mo		
		ntact. Resident #4 required			is still appropriate. The residents will	1011	
		ne staff member with bed			receive the restorative therapy as		
		d supervision and set up help			recommended by the nursing staff at the	ne	
		use, and personal hygiene.			frequency needed. The residents' care		
	Resident # 4 require	ed limited assistance from one			plans will be updated to reflect the		
		essing, bathing, and walking			appropriate restorative programs by		
		review revealed resident #4			10/4/18. Resident #4, #30 and #35 have		
		for range of motion. Resident			not had a decline in their range of moti	on	
	#4 's mobility devic and wheelchair.	es used included a walker,			from previous assessment.		
	, ,	sessment dated 06/05/18			An audit and reassessment will be		
		#4 was cognitively intact.			completed for all other residents on		
		ed the supervision of one staff			restorative therapy, for appropriatenes		
		bility, and transfers. Further			and frequency of the program by facilit	У	
		sident #4 did not walk in the			nursing staff by 9/28/18.		
		4 's mobility device used			The master than staff will be an adventage	_	
	wheelchair.	sessment included a			The restorative staff will be re-educate	a	
		ve care plan originally created			on the importance of the delivery of restorative therapy by the Director of		
		dated in September 2018 had			Nursing (DON) by 9/25/18.		
	-	sident #4 being at risk for			rearrang (DOIT) by 9/20/10.		
		due to muscle weakness. The			the facility will train additional CNAs ar	ıd	
		ident to be able to complete			licensed nurses on the delivery of the	-	
		ion every day six days per			restorative program/therapy to assure	the	
	_	ninutes each through the next			delivery of the restorative programs. The		
	-	s included restorative active			training will be completed by the DON		
		gram every day up to 20			and/or Physical Therapy department a	nd	1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CATION NUMBER		ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345550	B. WING			,	C	
NAME OF D	ROVIDER OR SUPPLIER	0.10000		97	TREET ADDRESS, CITY, STATE, ZIP CODE		09/07/2018	
NAME OF FI	NOVIDER OR SUFFLIER							
WHITE OA	K OF WAXHAW				00 HOWIE MINE ROAD			
				W	/AXHAW, NC 28173			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 688	Continued From pag	ge 8	F	886				
	minutes, 6 days per	week due to muscle			completed by 10/4/18.			
		#4 also had a focus area for			, , , , , , , , , , , , , , , , , , ,			
	decreased mobility.	The goal was for the resident			Newly hired restorative and nursing sta	aff		
	to be able to tolerate	e up to 150 ft ambulation			will receive the education on delivery o			
	program every day v	vith a rolling walker and left			the restorative program during their job)		
		six days per week until the			specific orientation with the Staff			
		1/18. Interventions included			Development Coordinator.			
		on program with rolling walker						
		s brace up to 150 ft every day			The additionally trained nursing staff w	ill		
	for six days per wee			deliver the restorative program in the	ro.			
		07/18 at 12:40pm with Nurse t # 4 had an active care plan			absence of the restorative staff to assurance the programs are being delivered. Active			
		by. She stated she reviews			nursing staff recruitment and orientatio			
	-	an which is printed by the			being conducted weekly to fill nursing			
		supervisor and delivered to			positions in order to lower or eliminate	the		
	_	She stated the restorative			frequency that the restorative staff are			
	aides are often pulle	ed to work on the resident			re-assigned.			
	halls.							
		upational Therapy and			The DON/Assistant DON will monitor the			
		scharge summary revealed			implementation and documentation of			
		charged from physical			restorative program as care planned by			
		06/28/18. Review revealed			auditing 3 residents on the program pe			
		charge instructions to remain			week for 4 weeks, the 3 residents mon	-		
	maintain ambulation	h restorative therapy to			for 3 months and as needed thereafter	•		
		orative therapy logs for the			Results from the monitoring will be			
		rough 09/05/18, revealed			discussed Monday through Friday duri	na		
		17 days of restorative			the Quality Improvement (QI) morning	19		
	therapy out of the 61				meetings and any identified issues or			
		nducted on 09/07/18 at 11:02			trends will be further discussed at the			
		. He stated when the			Quality Assurance meeting with the tea	ım		
	restorative nurse aid	les are pulled to work on the			and recommendations made as indicat			
		esn ' t receive therapy.						
		t had been a week since he			The DON is responsible for ongoing			
		therapy. He stated since			compliance of F688.			
	, ,	physical therapy had helped					 	
	_	o ambulate. Resident #4						
		elp maintaining his ability to						
	ambulate.							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	` ′	ATE SURVEY MPLETED
		345550	B. WING _			C 09/07/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 HOWIE MINE ROAD WAXHAW, NC 28173		35,6112010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 688	08/08/17 with a diagartery disease, hyperaccident, hemiplegia The annual MDS as indicated Resident #Resident #30 requirements one staff member for He required limited a member for locomount the corridor. Resider room. Mobility device wheelchair. A review of the Carehad a focus area for for decreased mobil as related to hemiple Resident #30 to be active range of motion 20 minutes through 10/03/18. Intervention range of motion dail week due to hemiple included restorative encouragement, and Resident #30 was continued the services on discharge instruction services. Resident #30 had discharge in restorative therapy the services of the services of the services of the services and the services are with the services of the services and the services are services are services and the	as admitted to the facility on mosis that included Coronary rlipidemia, cerebrovascular a, and depression. sessment dated 07/04/18 to was cognitively intact. The ded extensive assistance of a bed mobility and transfers. The desistance of one staff ion on the unit and walking in the thing of the thing o	F6	,		
	dates of 07/06/18 th Resident # 30, miss therapy out of the 6 An interview on 09/0	orative therapy logs for the rough 09/05/18, revealed ed 29 days of restorative				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION G	COMPLETED	
		345550	B. WING		C 09/07/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 700 HOWIE MINE ROAD WAXHAW, NC 28173			
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F 688	the first time in a mo mobility had declined with restorative thera 1.c. Resident # 35 w 05/22/17, with a diag hypertension, hyperl accident, anxiety and The quarterly MDS or Resident #35 was corequired extensive a member for bed mobilet use, walking in Resident #35 did not review revealed Resmotion limitations to extremities on one scane/crutch, and a wange of the Carehad a focus area for for decreased joint in weakness as related The goal for Resident tolerate up to 15 min minimum assist and upper extremity while extremity daily 6 day review date of 10/10 restorative transfer par with minimum as through left upper extremity interventions included praise, encouragement of the restorative therapter of the restorative therapter of the restorative therapter of the first terminal model.	ng his cane in the hallway for nth. Resident #30 stated his d due to being unable to walk apy. as admitted to the facility on gnosis that included ipidemia, cerebrovascular d depression. dated 7/10/18 indicated ognitively intact. Resident #35 ssistance of one staff oility, transfers, dressing, the corridor and bathing. It walk in his room. Further ident #35 had range of his upper and lower ide. Mobility devices included	F 68			

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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 700 HOWIE MINE ROAD WAXHAW, NC 28173				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 688	dates of 07/06/18 the Resident # 35, misses therapy out of the 61 Resident #35 was diservices on 11/15/17 discharge instruction restorative therapy. If from physical therape Resident #35 had disermain in current ski transfer to the restor. An interview on 09/0 #35 revealed resident therapy for the first ti 1.d. A meeting with the 09/06/18 at 3:14 pm regarding restorative #4, #30, and #35 stanurse aides (NA) we hallways and the restorative therapy. An interview on 09/0 Nursing Supervisor mand #35 were current The interview further complaints about restorative care. She therapy nurse aides the facility units as Notherapy nurse aides the facility. An interview on 09/0 Rehabilitation Manage #30, and #35 were to the therapy services. She therapy program is in therapy and physical	halls. rative therapy logs for the rough 09/05/18, revealed ed 21 days of restorative days scheduled. scharged from occupational resident #35 had as to continue receiving Resident #35 was discharged by services on 07/16/18. scharge instructions to alled nursing facility and ative therapy program. 6/18 at 3:14pm with Resident at received restorative me today in 3 weeks. The facility resident council on revealed resident concerns therapy services. Resident ted the restorative therapy re often pulled to work on the idents were not receiving. 6/18 with the Restorative care. The revealed she had received	F 68	38			

* * *		IDENTIFICATION NUMBER.		E CONSTRUCTION	COMF	(X3) DATE SURVEY COMPLETED	
		345550	B. WING			C / 07/2018	
NAME OF PROVIDER OR SUPPLIER WHITE OAK OF WAXHAW				STREET ADDRESS, CITY, STATE, ZIP CODE 700 HOWIE MINE ROAD WAXHAW, NC 28173	1 09/	0//2018	
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 688	(NA's) on how to pro	ovide restorative services to	F 68	В			
F 725 SS=D	facility MDS nurse re and #35 each had an care plan. An interview on 09/07 Restorative Therapy pulled to work as a N day for the past 2 we unable to complete h when pulled to work an interview on 09/07 Director of Nursing re the facility was for the as much as they can obtain more knowled therapy program since An interview on 09/07 Administrator revealer regarding staffing. Shorientations weekly to stated she had invest regarding staffing reconstructions with the state of the state	7/18 at 10:35am with the vealed Resident # 4, #30, active restorative therapy 7/18 at 10:46am with a NA revealed she had been A on the resident halls every eks. She stated she was er restorative therapy task as a NA on the resident halls. 7/18 at 11:12am with the evealed the expectation of eresident to receive therapy. She stated she needed to ge of the facilities restorative es she was newly hired. 7/18 at 12:56pm with the ed the facility is having issues the stated she is having to attempt to gain staff. She tigated further options eruitment. 2. Staff. 2. Staff. 3. Staff. 4. Sufficient nursing staff with evencies and skills sets to related services to assure train or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care	F 72:			10/4/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR			(X3) DATE SURVEY COMPLETED		
	345550		B. WING			C 09/07/2018		
NAME OF PROVIDER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/1	0772010		
WHITE OAK OF WAXHAW				7	00 HOWIE MINE ROAD			
WHITE OAK OF W	AANAV			٧	NAXHAW, NC 28173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
at §483.3 by suf types nursin reside (i) Exc this se (ii) Oth limited \$483.3 paragi design nurse This F by: Based record sufficie service of 3 re Reside to cov Findin This coreside facility service of 3 re	ficient numbers of personnel or g care to all result care plans: the providence of t	cility must provide services sof each of the following in a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not is. It when waived under section, the facility must nurse to serve as a charge of duty. To is not met as evidenced exterview, staff interview, and cility failed to provide evide care planned restorative on and range of motion for 3 ent #4, Resident #30, or restorative staff being pulled	F	725	White Oak of Waxhaw will provide sufficient nursing staff to ensure care planned restorative services/programs ambulation and range of motion are delivered to residents on restorative programs. The lack of the restorative sering re-assigned for resident care and the assigned staff not able to implement the program as care planned. Staff turnover has also been a factor in the restorative staff being re-assigned as a result of staff pursuing other employme opportunities, and the competition in the area to gain new employees. An increase of the nurse assistants' was scale across current staff and new hire has been approved and implemented the assist with recruitment and retention or 9/14/18.	etaff ad ant ent ne age		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		345550	B. WING		00	C 9/ 07/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 08	9/0//2010	
				700 HOWIE MINE ROAD			
WHITE OA	AK OF WAXHAW			WAXHAW, NC 28173			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 725	Continued From page	14	F 7	Adjustments are being made with staffs' schedule in order to have a scheduling system or permanent days. Employee engagement committe staff appreciation events are bein monthly to assist with retention. Resident #4, #30, and #35 have it reassessed for the restorative proto assure ambulation and range of is still appropriate. The residents receive the restorative therapy as recommended by the nursing star frequency needed. The residents plans will be updated to reflect the appropriate restorative programs 10/4/18. Resident #4, #30 and #3 not had a decline in their range or from previous assessment. An audit and reassessment will be completed for all other residents or restorative therapy, for appropriate and frequency of the program by nursing staff by 9/28/18. The restorative staff will be re-edion the importance of the delivery restorative therapy by the Director Nursing (DON) by 9/25/18. The facility will train additional CN licensed nurses on the delivery or restorative program/therapy to as delivery of the restorative program training will be completed by the land/or Physical Therapy departments.	es with g held es with g held peen params of motion will strate the by 15 have f motion e on teness facility ucated of the sure the ms. This DON		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		345550	B. WING		0.0	C	
NAME OF D	DOVIDED OD SLIDDI IED	040000	5: 1:::10 _	STREET ADDRESS, CITY, STATE, ZIP CODE	09	9/07/2018	
NAME OF FI	NAME OF PROVIDER OR SUPPLIER			700 HOWIE MINE ROAD			
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				WAXHAW, NC 28173		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 725	Continued From page	e 15	F 7	completed by 10/4/18.			
				Newly hired restorative and nursir will receive the education on deliv the restorative program during the specific orientation with the Staff Development Coordinator.	ery of		
				The additionally trained nursing st deliver the restorative program in absence of the restorative staff to the programs are being delivered. nursing staff recruitment and orier being conducted weekly to fill nursipositions in order to lower or elimi frequency that the restorative staff re-assigned.	the assure Active ntation sing nate the		
				The DON/Assistant DON will mon implementation and documentation restorative program as care plann auditing 3 residents on the progra week for 4 weeks, then 3 resident monthly for 3 months, and as nee thereafter.	on of the ned by im per is		
				Staffing secretary will report during morning Monday through Friday Comprovement meetings on the nur staff for each day and the number currently in orientation.	Quality mber of		
				Results from the monitoring will be discussed Monday through Friday the Quality Improvement (QI) mor meetings and any identified issues trends will be further discussed at Quality Assurance meeting with the and recommendations made as in	during rning s or the team		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	PLE CONSTRUCTION		COMPLETED	
		345550	B. WING			C 09/07/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 HOWIE MINE ROAD WAXHAW, NC 28173	,	09/07/2016	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 725	Continued From page	e 16	F 72	The DON is responsible for one compliance of F725.	going		
F 812 SS=D	Food Procurement,S CFR(s): 483.60(i)(1)(tore/Prepare/Serve-Sanitary 2)	F 81			10/4/18	
	§483.60(i) Food safe The facility must -	ty requirements.					
	approved or consider state or local authorit (i) This may include f from local producers, and local laws or reg (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision do from consuming food	3.60(i)(1) - Procure food from sources roved or considered satisfactory by federal, e or local authorities. his may include food items obtained directly a local producers, subject to applicable State local laws or regulations. This provision does not prohibit or prevent lities from using produce grown in facility dens, subject to compliance with applicable growing and food-handling practices. This provision does not preclude residents in consuming foods not procured by the facility.					
	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:						
	facility failed to disca	ons and staff interviews, the rd expired nutritional and medication storage rooms		White Oak of Waxhaw ensures is safely procured, stored and p the facility. The expired nutrition supplement (Osmolite) was left medication room due to the cer staff member not having access	orepared in nal in the ntral supply s to the		
	An observation, on 09/07/18 at 08:30 AM, was conducted of the medication storage room on the Maple Terrace (300 Hall). There were 15 out of 15 unopened cans of the Osmolite (1.5 High			medication rooms and the nurs was not consistently monitoring expired dates on the nutritional supplements that were being st medication room.	g for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345550	B. WING			C 09/07/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
WHITE OA	AK OF WAXHAW			700 HOWIE MINE ROAD			
	I			WAXHAW, NC 28173			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG				
F 812	Continued From page	e 17	F 81	2			
	Protein, High Calorie, 8 fluid ounce) nutritional supplement found in the cabinet of the 300 Hall medication storage room with an expiration date of February 2018. An interview was conducted with Nurse #3 on 09/07/18 at 08:30 AM. She stated that none of the residents on the 300 Hall had received any Osmolite. She had no knowledge of those cans being stored in the medication storage room. She revealed that her expectation, regarding expired nutritional supplements, was to discard the supplements immediately.			The identified Osmolite was immediately discarded when brought to the facility's attention during survey. Nutritional Supplements such as Osmolite are no longer stored in the medication rooms. The nutritional supplements will be stored in central supply where it can be consistently monitored for expiration by the central supply staff. All licensed nurses have access to the central supply closet, and can obtain needed nutritional			
						pe /	
	An interview with the Director of Nursing (DON) was conducted on 09/07/18 at 12:00 PM. She indicated that the consultant pharmacist performed routine monthly audits of the medication storage rooms and medication carts. The DON revealed that the expectation was that the pharmacist reported any expired nutritional supplements and medications to the nurses. She further revealed that the expectation of the nurses on each hall was to check the medication storage rooms on a weekly basis and discard any expired nutritional supplements and medications immediately.			The current central supply staff and licensed nurses will be trained on the new process of the storage of the nutritional supplements by 9/28/18 by the Administrator. Newly hired central supply staff and licensed nurses will receive the training of the new process during their job specific orientation with the Staff Development Coordinator. The Administrator will monitor the nutritional supplements including Osmolite for expiration dates weekly for 4 weeks and monthly for 3 months, then as needed thereafter. results from the monitoring will be discussed Monday through Friday during the Quality Improvement (QI) morning		of te	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345550	B. WING			C / 07/2018
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	10115211 011 001 1 21211			700 HOWIE MINE ROAD		
WHITE OA	AK OF WAXHAW			WAXHAW, NC 28173		
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F 812	F 812 Continued From page 18		F 81	and recommendations made as indi	cated.	
				The Administrator is responsible for ongoing compliance of F812.		