| 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 07/02/2021 |

| 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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced onsite Recertification and complaint investigation survey was conducted on 06/14/21 through 06/18/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# CIV811. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced onsite Recertification and complaint investigation survey was conducted on 06/14/21 through 06/18/21. There were 16 allegations investigated and 6 were substantiated and cited. The facility was notified on 07/01/21 of Substandard Quality of Care identified after management quality review. An extended survey was conducted on 07/02/21. Therefore, the exit date was changed to 07/02/21. Event ID# CIV811.<br><br>Substandard Quality of Care was identified at:<br><br>CFR 483.10 at F 550 at a scope and severity (H)<br>CFR 483.35 at F 725 at a scope and severity (H)<br><br>An extended survey was coducted on 07/02/21. | F 000 | | |
| F 550 SS=H | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each | F 550 | | 8/1/21 |

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

Electronically Signed | 07/09/2021

| 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 07/02/2021 |

| 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 550 | Continued From page 1<br>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.<br><br>§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.<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, staff interviews, and resident interviews the facility failed to treat residents in a dignified manor when staff did not provide incontinence care and the resident heard staff talking about her being difficult to change (Resident #16), when staff rolled their eyes when a resident asked to be put | F 550 | White Oak of Shelby treats all residents in a dignified and respectful manner.<br><br>Residents #16, #55 and #73 are provided assistance with incontinence care in a dignified and respectful manner. | |

| 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 07/02/2021 |

| 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 550 | Continued From page 2<br>to bed (Resident #79), when staff told a resident they were going on break before providing incontinence care (Resident #55) and when staff yelled at a resident for trying to get assistance with care and trying to get assistance with incontinence care for her roommate (Resident #73). The residents expressed feelings of being upset, uncomfortable, unclean, and felt the nursing home did not care about them. This affected 4 of 4 residents reviewed for dignity and respect (#16, #79, #55, and #73).<br><br>The findings included:<br><br>1. Resident #16 was admitted to the facility on 01/09/18 and was re-admitted on 01/03/21 with diagnoses of hypertension, and muscle weakness.<br><br>A review of the annual Minimum Data Set (MDS) dated 04/05/21 indicated Resdient#16 was cognitively intact and required extensive assistance with activities of daily living (ADL). The MDS noted Residetn #16 was always incontinent of urine and frequently incontinent of bowel movements.<br><br>An observation and interview conducted on 06/15/21 at 2:30 PM revealed Resident #16 pointed towards Nurse Aide (NA) #7 and NA #8 stating she did not want to be in the facility anymore and was tired of staff being ugly. Resident #16 revealed she had not been changed since breakfast and was soaked through to her clothes. She stated the NAs were making comments about prior shift staff not changing her and stated she was a pain to change because they had to put her back in the bed. Resident #16 stated she was upset, angry and felt that staff | F 550 | Resident #79 will be provided assistance with transfer to bed as resident wishes.<br><br>Residents who have urinary incontinence will be provided assistance by staff in a dignified and respectful manner.<br><br>Residents who need assistance with bed transfers will be provided assistance in a dignified and respectful manner.<br><br>NA #7 received sensitivity training on 6/15/21 by the Social Worker and NA #8 received sensitivity training on 7/8/21 by the Social Worker. The sensitivity training includes treating all residents with dignity and respect at all times.<br><br>A Resident Council meeting was conducted that included residents #16, 55, 73 and 79 with questions to review dignity and respectful treatment by staff by the Social Services and conducted on 7/8/21. Resident Council was ask and gave the Social Services staff permission to attend the meeting.<br><br>The Nursing staff will be re-educated on treating all residents with dignity and respect at all times, this will be done by providing sensitivity training. This training will be conducted by the Social Workers and completed prior to 8/1/21.<br><br>Newly hired nursing staff receive this education during their job specific orientation with Nurse Management (DON - Director of Nursing, SDC - Staff Development Coordinator, or other | |

| 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 07/02/2021 |

| 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 550 | Continued From page 3<br>does not care about her.<br><br>An interview conducted with NA #8 on 06/15/21 at 4:25 PM revealed Resident #16 was found dripping wet because prior shift did not change her. She further revealed she was upset and should have not portrayed being aggravated in front of the resident.<br><br>An interview conducted with NA #7 on 6/15/21 at 5:00 PM revealed Resident #16 was mad because she and NA #8 were talking about prior shift while caring for the resident and Resident #16 believed they were speaking about her. She further revealed she was frustrated with short staffing and should have been paying attention to Resident #16 during care.<br><br>An interview conducted with the Director of Nursing (DON) on 06/18/21 at 5:00 PM revealed it was expected there to be no conversation about anything other than the resident when giving care and all residents should be treated with dignity and respect.<br><br>An interview conducted with the Administrator on 06/18/21 at 6:15 PM revealed during one on one care staff should be focused on the resident and it was expected for all residents to feel comfortable with staff.<br><br>2. Resident #79 was admitted to the facility on 05/07/21 and re-admitted on 05/21/21.<br><br>A review of the admission Minimum Data Set (MDS) dated 05/06/21 indicated Resident #79 was cognitively intact and required extensive assistance with activities of daily living (ADL). | F 550 | designated Nurse).<br><br>The Social Workers will interview residents with questions that relate to dignity and respect. The series of questions consist of treatment of residents, staff tone of voice, attention directed to residents during care, staff approach, communication and providing appropriate and timely response to personal care when asked by the resident. The monitoring will include interviews with 5 residents a week for 4 weeks, then 3 residents for 4 weeks, then 2 residents for 4 weeks and periodically thereafter to assure compliance to F550.<br><br>A Social Worker will attend the monthly Resident Council meetings, with the permission of the Resident Council, to review treatment of all residents with dignity and respect to ensure compliance to F550 for 3 months.<br><br>The facility management team (Administrator, DON, SDC and/or Department Managers) will also monitor by observing staff interactions with cognitively impaired residents that require incontinent care and the overall treatment of dignity and respect for 5 residents each week for 4 weeks, 3 residents a week for 4 weeks, then 2 residents a week for 4 weeks and periodically thereafter to assure compliance to F550.<br><br>Results of the interviews and observations will be discussed during their morning QI (Quality Improvement) meeting weekly for | |

| 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 07/02/2021 |

| 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 550 | Continued From page 4<br>An observation conducted on 06/05/21 at 4:09 PM revealed Resident #79 sitting in her wheelchair outside of her room stating she was in a lot of pain and wanted to go back to bed. The Director of Nursing (DON) walked up to the Nurse Aide (NA) #7 and requested to put Resident #79 back into bed. It was further observed NA #7 rolled her eyes and Resident #79 starting crying and continued to apologize multiple times to NA #7 who did not acknowledge the resident.<br><br>An interview conducted with Resident #79 on 06/16/21 at 9:15 AM revealed the resident was very upset on how NA #7 did not acknowledge her and continued to ignore her when she was apologizing for having to be put back to bed. She further revealed NA #7 always seemed mad about giving care and has been rude to Resident #79 on multiple occasions.<br><br>An interview conducted with NA #7 on 06/15/21 at 5:00 PM revealed she was frustrated because three different residents were needing assistance at the same time. She further revealed she did not recall rolling her eyes but stated she should have acknowledged Resident #79 and not ignored her when apologizing for needing assistance.<br><br>An interview conducted with the Director of Nursing (DON) on 06/18/21 at 5:00 PM revealed Resident #79 should have not been ignored and should have been acknowledged by NA #7. The DON further revealed all residents should be spoken to with respect and NA #7 would be completing sensitivity training.<br><br>An interview was conducted with the Administrator on 06/18/21 at 6:15 PM revealed | F 550 | 3 months, and periodically thereafter, with the committee making recommendations for system changes as indicated.<br><br>The DON is responsible for onging compliance to F550.<br><br>The completion date of 8/1/21. | |

| 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 07/02/2021 |

| 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 550 | Continued From page 5 | F 550 | | |

NA #7 should have acknowledged Resident #79, and residents were expected to be treated with dignity and respect by all facility staff.

3. Resident #55 was admitted to the facility on 05/10/21 with diagnoses which included stage III decubitus ulcer of sacral region, chronic obstructive pulmonary disease (COPD), atherosclerotic heart disease and low back pain.

Review of her admission Minimum Data Set (MDS) dated 05/14/21 revealed Resident #55 had adequate hearing, was cognitively intact, required limited assistance of 2 staff with toileting and was frequently incontinent of urine and occasionally incontinent of bowel and wore briefs.

Review of Resident #55's care plan dated 06/07/21 revealed she had a care plan in place for assistance with activities of daily living (ADL). The interventions included assist with bathing, dressing, personal hygiene, and incontinence care on rounds and as needed.

An observation and interview on 06/14/21 at 1:23 PM with Resident #55 revealed she had waited last evening on 06/13/21 for an hour and 32 minutes (which she timed by the clock in her room) for assistance in getting her brief changed. Resident #55 stated when the Nurse Aide (NA) came in to change her she told the resident it was 8:00 PM and she had not sat down since coming on shift and she was taking her dinner break and the resident would have to wait to be changed until she was back from her break. Resident #55's roommate (Resident #73) agreed the NA said that to Resident #55. Resident #55 further stated the NA had been in 2 times while her light was on and turned it off and told Resident #55

| 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 07/02/2021 |

| 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 550 | Continued From page 6 | F 550 | | |

she would be back when she finished with other residents she was assisting. Resident #55 said she could not recall the NA's name but stated she frequently worked on their hall.

On 06/15/21 at 4:39 PM during a follow-up interview with Resident #55 and Resident #73, they identified the NA from 6/13/21 as NA#7. Resident #55 stated she was not only wet but had a bowel movement and it really upset her and made her feel dirty and like she didn't matter when the NA told her she was going to take a break before changing her brief. Resident #55 stated she was also concerned about the bowel movement getting into or on her sacral wound.

On 06/15/21 at 5:00 PM an interview with NA #7 revealed she had been assigned to care for Resident #55 and Resident #73 on 06/13/21, 06/14/21 and 06/15/21 during the 3:00 PM to 11:00 PM shift. NA #7 said she did not recall telling Resident #55 she was going to take a break before providing her incontinence care. She stated she always took care of her residents and provided incontinence care when requested. NA #7 indicated she would never treat a resident disrespectfully.

On 06/16/21 at 9:37 AM an interview with the Social Services Director (SSD) revealed she had spoken with Resident #55 and Resident #73 and they both had requested that NA #7 not be assigned to take care of them again because of the way she treated them. The SSD stated the residents did not feel like they had been abused by NA #7 but did not feel as though she cared about them and their needs.

On 06/18/21 at 4:24 PM an interview with the

| 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 07/02/2021 |

| 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 550 | Continued From page 7 | F 550 | | |

Director of Nursing (DON) revealed she had not received any complaints about NA #7 and her not taking care of residents prior to this week. She stated NA #7 was usually soft spoken and quiet and did not complain. The DON further stated she expected NA #7 and all the NAs to provide care to residents requesting care prior to going on breaks and expected them to treat all the residents with dignity and respect.

On 06/18/21 at 7:13 PM an interview with the Administrator revealed she expected all residents in the facility to be treated with dignity and respect by all the staff.

4. Resident #73 was readmitted to the facility on 07/10/18 with diagnoses which included osteoarthritis, overactive bladder, major depressive disorder, anxiety disorder and dementia.

Review of her quarterly Minimum Data Set (MDS) dated 05/21/21 revealed Resident #73 had adequate hearing, was cognitively intact, and required extensive assistance of 1 staff member with bed mobility, transfers, walking in room, and toileting and required total assistance of 1 staff person for bathing. The MDS further revealed Resident #73 was always incontinent of urine and frequently incontinent of bowel and wore briefs.

Review of Resident #73's care plan dated 05/25/21 revealed she had a care plan in place for assistance with activities of daily living (ADL) related to decreased mobility secondary to weakness. The interventions included assist with bathing, hygiene, dressing, grooming, turning, and repositioning, assist with toileting and incontinence care with rounds and as needed.

| 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 07/02/2021 |

| 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 550 | Continued From page 8 | F 550 | | |

The care plan indicated the resident's ADL participation and need for assistance fluctuates from day to day and time of day and per resident desire to participate.

An observation and interview on 06/14/21 at 1:23 PM with Resident #73 revealed she had been yelled at by an NA for requesting assistance and stated the NA had told her "you can just get up and do it yourself." The resident stated she did everything she could for herself but sometimes she needed assistance and when she asked the NA, she told her to do it herself. Resident #73 further stated the NA used a loud tone and acted like the resident was bothering her by her asking for assistance. Resident #73 expressed it made her feel like a child that was being scolded and like her needs were not important. Resident #73 indicated that was not the first time the NA had yelled at her and stated she yelled at her last evening when she was yelling for assistance for her roommate (Resident #55) who needed her brief changed. Resident #73 further indicated the NA came in the room and yelled at her and told her to stop yelling for help that the NAs were helping other residents and they would get to them when they got to them. Resident #73 disclosed her saying that made her feel like they were not important and that the NAs didn't care when they got to them.

On 06/15/21 at 4:39 PM while in the room talking with Resident #73, NA #7 and NA #8 came in to provide incontinence care to Resident #55. After they left the room Resident #73 identified NA #7 as the NA who had yelled at her and told her to get up and do for herself. Resident #73 stated she would prefer NA #7 not take care of her anymore after today because of the way she had

| 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 07/02/2021 |

| 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 550 | Continued From page 9<br>talked to her and treated Resident #55.<br><br>On 06/15/21 at 5:00 PM an interview with NA #7 revealed she had been assigned to care for Resident #73 on 06/13/21, 06/14/21 and 06/15/21 on the 3:00 PM to 11:00 PM shift. NA #7 said she did not recall yelling at Resident #73 or telling her to do care for herself. She stated she always took care of her residents and would never yell at a resident. NA #7 indicated she would never treat a resident disrespectfully.<br><br>On 06/18/21 at 4:24 PM an interview with the Director of Nursing (DON) revealed she had not received any complaints about NA #7 and her not taking care of residents prior to this week. She stated NA #7 was usually soft spoken and quiet and did not complain. The DON further stated she expected NA #7 and all the NAs to provide care to residents requesting care, not yell at residents and expected them to treat all the residents with dignity and respect.<br><br>On 06/18/21 at 7:13 PM an interview with the Administrator revealed she expected all residents in the facility to be treated with dignity and respect by all the staff. | F 550 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by: | F 558 | | 8/1/21 |

| 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 07/02/2021 |

| 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 558 | Continued From page 10<br>Based on observation, resident and staff interviews, and record review, the facility failed to ensure a lift sling was available to transfer a dependent resident out of bed when requested for 1 of 1 resident (Resident #30) requiring transfers with mechanical lifts and provide a mattress without lumps and dips in it for 1 of 3 residents reviewed for choices (Resident #53).<br><br>The findings included:<br><br>Resident # 30 was admitted to the facility on 1/1/2021 with diagnoses of progressive neurological condition, heart failure, and Parkinson's disease. Review of Resident #30's quarterly Minimum Data Set (MDS) dated 4/15/2021 revealed the resident required extensive assistance of two persons for bed mobility, transfers, and toilet use.<br><br>Observation of Resident #30 on 6/17/2021 at 12:30 PM revealed the resident lying in bed on her back, looking at a cell phone. An interview with Resident #30 on 6/17/2021 at 12:40 PM revealed she was hesitant to ask to be out of bed. She stated there were not enough lift slings to get her out of bed every day. Resident #30 stated she did not ask to be transferred to her wheelchair because it might take too long to find a lift sling to get put back in bed. Resident #30 stated lying in bed could cause her to have pressure ulcers but sitting up in the chair too long would cause her pain. She felt like her transfers were limited.<br><br>A joint interview with Nurse Aides (NA) #1 and #4 on 6/17/2021 at 12:45 PM revealed they did not have a lift sling to use for Resident #30 on 6/17/21. They stated there were often not | F 558 | White Oak of Shelby Residents have the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br><br>Resident #30 will be able to get out of bed upon request using the correct sling size.<br><br>Resident #53 received a new mattress that was placed on their bed on 6/17/21.<br><br>Staff will have ample supply of sized slings to accommodate residents who require the mechanical lift to transfer. Safety Nurse will check for adequate supply of slings during the week days and the Nurse in Charge during the weekends.<br><br>All residents will have a mattress that is free of lumps and dips.<br><br>The CSM (central supply manager)has placed an order for more slings, to have an ample supply for the NA to utilize for the mechanical lifts. The slings will be stored in the shower rooms with extra stored in central supply. This will be completed by 7/12/21.<br><br>The Housekeeping Supervisor completed an audit of all resident mattresses to assure the mattresses are free of lumps and dips. This will be completed by 7/12/21.<br><br>The Nursing staff will be re-educated on | |

| 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 07/02/2021 |

| 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 558 | Continued From page 11<br>enough slings to get all residents out of bed. NA #1 and #4 stated they had to search the facility on a regular basis to locate slings. Both indicated the slings are color coded to size. The NAs stated residents who went to dialysis had to go with their lift sling under them so they could be transferred at the dialysis center. There were other residents whose body size and fit in their wheelchair prohibited removal of the sling. These residents were care-planned for the lift to remain under the resident while up in the chair. With the dialysis residents and the residents whose slings were left under them, the number of available slings for other residents was reduced. NAs # 1 and # 4 stated they had both made nurses aware of the shortage of lift slings. The NAs indicated clean slings were placed in the shower rooms after laundry had washed them.<br><br>An interview with Nurse #4 on 6/17/2021 at 3:00 PM revealed she was aware of the shortage of lift slings. She stated she did alert the DON but could not recall a date or time.<br><br>An interview with Nurse #6 on 6/17/2021 at 3:08 PM revealed she too was aware of the shortage of slings. She stated, "we have been in need of lift slings for a long time."<br><br>Observation of lift storage on 6/17/2021 at 3:45 PM revealed a size legend on the mechanical lift which indicated the size and color options of the slings. The sling legend was as follows: XS slings (55-77 pound capacity) are brown, small slings (77-132 pound capacity) are red, medium slings (121-165 pound capacity) are yellow, large slings (154-264 pound capacity) are green, LL slings (220-350 pound capacity) are light purple, and XL slings (308-440 pound capacity) are dark | F 558 | reporting to CSM or SDC (Staff Development Coordinator) if they are in need of a sling and what size is needed. And also to report if any resident has complained about their mattress to report this to SS (Social Services) or Housekeeping for replacement. This education will be given by the Nurse Management and completed prior to 8/1/21. Newly hired nursing staff receive this education during their job specific training with the SDC or Nurse Management.<br><br>The Social Workers will be monitoring by interviewing 5 residents a week for 4 weeks, then 3 residents for 4 weeks, then 2 residents for 4 weeks and periodically thereafter to assure compliance to F558.<br><br>Results of the interviews will be discussed during their morning QI meeting weekly for 3 months and periodically thereafter, with the committee making recommendations for system changes as indicated.<br><br>The DON is responsible for ongoing compliance to F558.<br><br>The completion date of 8/1/21. | |

| 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 07/02/2021 |

| 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 558 | Continued From page 12 | F 558 | | |

blue. Weight capacities were verified with the manufacturer. A tour of the shower rooms revealed 7 red lift slings, 1 light blue lift sling, 2 green lift slings, and 4 yellow lift slings.

A review of the facility's list of residents requiring use of a lift revealed there were a total of 34 residents who required use of a total mechanical lift for transfers. There was a total of 15 total mechanical lift slings visualized in the facility. Resident #30 required use of a size LL (light purple sling) for transfers

A joint interview with the Central Supply Manager (CSM #12) and the DON was conducted on 6/18/2021 at 3:00 PM. The DON stated the laundry department was responsible for counting slings and monitoring for damage. CSM #12 indicated that 1 blue and 1 green sling had been recently discarded due to damage. The CSM # 12 was asked if she kept a par level of slings. She stated she had only been responsible for lift slings for a couple of weeks and had not yet established a par level. She stated she had ordered more slings yesterday. The DON produced a list which she stated showed the facility should have had at least 70 lift slings. The DON was asked to interpret the information contained in the list. She reviewed the list again and stated, "they were supposed to put a number on each sling and document when it was cleaned, but I can see they did not put a number on the slings. It appears they have been recounting the same slings over and over." The DON later provided a "lift sling inventory" (no date) which showed there were 18 slings in the facility and 4 shower slings. The DON stated she expected NAs and Nurses to alert her when lift sling inventory was low. The DON also stated she

| 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 07/02/2021 |

| 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 558 | Continued From page 13 | F 558 | | |

expected staff to transfer residents at their request. She could not provide an answer for how staff were to transfer residents when lift slings were not available.

2. Resident #53 was admitted to the facility on 10/22/20 with diagnoses which included chronic obstructive pulmonary disease (COPD), sleep apnea, low vision in the right eye, blindness in the left eye, spinal stenosis with chronic pain and vascular dementia.

The most recent quarterly Minimum Data Set (MDS) dated 05/06/21 indicated Resident #53 was cognitively intact for daily decision making and received scheduled and as needed pain medication for almost constant pain at a level of 8.

An interview conducted with Resident #53 on 06/14/21 at 10:00 AM revealed he had requested a new mattress for 5 months and had not gotten one yet. He stated he had asked different staff (could not remember who) for a new mattress because his had "bumps and valleys" in it and really caused him pain in his back and hips. Resident #53 indicated he had spoken with the Social Services Director (SSD) on 06/11/21 about getting a new mattress and said he had not heard back from her on whether he was getting a new one.

An interview on 06/17/21 at 10:33 AM with the Housekeeping Supervisor (HS) and the Social Services Director (SSD) revealed the SSD was made aware of Resident #53's request for a new mattress on 06/11/21. She stated the resident had called her and asked her the process for getting a new mattress and she said she had told

| 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 07/02/2021 |

| 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 558 | Continued From page 14<br>him she would request one for him. She further stated he told her that he had been requesting one for 5 months and had not received one. She explained she had made a note and placed in the HS's mailbox about the request for a new mattress. The HS stated she had not gotten the note but stated there were new mattresses that were going to be delivered to the facility today (06/17/21) and she would make sure Resident #53 received one of the new mattresses. The HS further stated the mattresses were due to be delivered by 12:00 PM. The SSD indicated the resident probably should be placed on the list of residents to get a new mattress every 8 months and she would make sure his name was included on the list.<br><br>An interview on 06/18/21 at 7:14 PM with the Administrator revealed she would have expected staff to provide a new mattress for Resident #53 when he asked and would have expected it to happen timelier than 5 months. | F 558 | | |
| F 561 SS=E | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. | F 561 | | 8/1/21 |

| 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 07/02/2021 |

| 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 561 | Continued From page 15<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, the facility failed to provide a resident with her preferred number of showers a week and failed to get her up out of bed to her wheelchair (Resident #47), failed to provide a resident his preference of using his machine (cleaner and sanitizer) to clean his Continuous Positive Airway Pressure (CPAP) mask, tubing, humidifier and water chamber instead of staff cleaning the equipment (Resident #53) and failed to honor a resident's wish to get up out of bed and into her wheelchair every morning after breakfast (Resident #71) for 3 of 3 residents reviewed for choices.<br><br>The findings included:<br><br>1. Resident #47 was admitted to the facility on 11/06/20 with diagnoses which included major depressive disorder and dementia.<br><br>The most recent quarterly Minimum Data Set | F 561 | White Oak of Shelby allow residents to have the right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>Resident #47 will be transferred out of bed to their wheelchair when requested and will be given their routinely scheduled showers 2 times each week.<br><br>Resident #71 will be transferred into their wheelchair after breakfast as preferred.<br><br>Resident #53 will be able to have his personal cleaning/sanitizing machine for his CPAP equipment. The cleaning/sanitizing machine is currently with the RR (Resident Representative)who will return the machine to the facility the week of 7/12/21, per a phone call with the RR and the SW(Social Worker). | |

| 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 07/02/2021 |

| 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 561 | Continued From page 16<br>(MDS) dated 04/28/21 indicated Resident #47 was severely cognitively impaired and displayed no behaviors for rejection of care. Further review of the MDS revealed Resident #47 was totally dependent on one staff member with bathing.<br><br>An interview was conducted with Resident #47's family member who resided in the same room with the resident. The family member stated Resident #47 was supposed to get two showers each week but had not been getting her showers as scheduled but instead getting "washed up in bed." The family member stated the resident was scheduled for showers on 1st shift (7:00 AM to 3:00 PM) on Wednesday and Saturday but had not been getting them as scheduled because the facility was often short-staffed and the Nurse Aides just did not have enough help to give showers. The family member also stated Resident #47 had not been up out of bed in the wheelchair or recliner in months due to the facility being short-staffed and the NAs not having time to get her up to the recliner or wheelchair.<br><br>Review of Resident #47's Activities of Daily Living (ADL) care plan, with a recent review date of 05/03/21, addressed her need for staff assistance with all ADL related to dementia. Interventions included for staff to assist with bathing, grooming, dressing, feeding, incontinence care and oral care and assist out of bed to wheelchair.<br><br>Review of the facilities shower schedule book revealed a sheet that listed the day of the week as well as the shift that resident room numbers were scheduled to receive showers. It was noted Resident #47 resided in a room and bed that was scheduled to receive showers on Wednesday and Saturday during the hours of 7:00 AM to 3:00 PM. | F 561 | Residents who choose to get out of bed or take their regularly scheduled shower will be given that opportunity. Residents who have CPAP equipment and choose to bring their own cleaning/sanitizing machine into the facility will be given that chance to do so.<br><br>The Nursing staff were re-educated on resident choices, i.e. getting them up into wheelchairs when requested, getting their regularly scheduled showers or to use their personal cleaning/sanitizing machine for their CPAP equipment to assure compliance to F561. This education was provided by the Nurse Management Team and was completed prior to 8/1/21. Newly hired nursing staff receive this education during their job specific orientation with the SDC or Nurse Management.<br><br>The Social Workers will interview residents with questions that include providing their preferred number of showers a week, does the staff transfer them out of bed when requested and during preferred times such as after breakfast, and if the resident has a CPAP (Continuous Positive Airway Pressure) to see if they had a cleaning machine at home that they would like to bring to the facility for use. The monitoring of the questions will consist of 5 residents and 3 family/RR a week for 4 weeks, then 3 residents and 2 family/RR a week for 4 weeks, then 2 residents and 1 family/RR a week for 4 weeks and periodically | |

| 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 07/02/2021 |

| 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 561 | Continued From page 17<br><br>Review of Resident #47's bathing activity report provided by the facility for the period of 04/01/21 through 06/17/21 revealed the resident had 8 showers documented in that time period and should have received 21 showers during that same time frame.<br><br>An interview was conducted on 06/16/21 at 10:58 PM with Nurse Aide (NA) #4 who typically has Resident #47 during the hours of 7:00 AM to 3:00 PM confirmed she had given Resident #47 a shower that morning after breakfast. NA #4 stated they had been short-staffed and when the NAs were assigned 18 to 20 residents on shift, they could not even get incontinence rounds done every 2 hours. She further stated it was difficult to get any showers done and care had to be prioritized with feeding residents and incontinence care being the main priorities and showers could not be provided.<br><br>An interview was conducted on 06/18/21 at 4:30 PM with the Director of Nursing (DON) and the DON confirmed the facility was having staffing challenges. She stated they had brought in Agency staff to try to augment the staff and assist with care but stated there were times when they called the Agency and they did not have staff to send to the facility. The DON acknowledged Resident #47 had not received showers as scheduled but explained she had been given bed baths. She added residents should receive a minimum of two showers per week or per their preference.<br><br>An interview was conducted on 06/18/21 at 6:23 PM with the Administrator who stated staffing challenges was most likely the cause of Resident | F 561 | thereafter to assure compliance to F561.<br><br>Results of the interviews will be discussed during their morning QI meeting weekly for 3 months and periodically thereafter; with the committee making recommendations for system changes as necessary.<br><br>The DON is responsible for ongoing compliance to F561.<br><br>The completion date of 8/1/21. | |

| 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 07/02/2021 |

| 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 561 | Continued From page 18 | F 561 | | |

#47 not getting her showers two times a week as scheduled. She added it was her expectation that residents would receive their scheduled showers each week.

2. Resident #53 was admitted to the facility on 10/22/20 with diagnoses which included chronic obstructive pulmonary disease (COPD), and sleep apnea.

The most recent quarterly Minimum Data Set (MDS) dated 05/06/21 indicated Resident #53 was cognitively intact for daily decision making and required supervision to limited assistance of one staff member with all activities of daily living (ADL).

An interview conducted with Resident #53 on 06/14/21 at 10:00 AM revealed he had been told by someone (could not remember who) at the facility that "corporate had told the facility it was illegal for him to have his CPAP cleaning machine in the room." Resident #53 stated he would like to have the machine because he was blind and could not see how the staff were cleaning his equipment and would prefer it be cleaned and sanitized by the machine. The Resident stated the machine had been removed from his room and was in storage and said he had been told the facility was going to give to his family member who was his responsible party (RP) on his next visit to the facility. Resident #53 indicated he had talked with the facility Social Worker about it but had not heard back from her about whether he could keep the machine.

An interview was conducted on 06/15/21 at 2:32 PM with Nurse #9 who typically cared for Resident #47 during the 7:00 AM to 7:00 PM

| 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 07/02/2021 |

| 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 561 | Continued From page 19 | F 561 | | |

shift. She confirmed that Resident #47 had a CPAP that he used at night for his sleep apnea. Nurse #9 stated she was not aware of a machine to clean and sanitize his CPAP but said the staff had instructions for cleaning the CPAP.

An interview conducted on 06/16/21 at 9:37 AM with the facility Social Services Director (SSD) revealed she was aware Resident #53 had requested his machine to clean and sanitize his CPAP. The SSD stated she had spoken with the Director of Nursing (DON) who had reached out to the Corporate Nurse Consultant who informed her he could not have the machine because there was no policy and procedure in place for the machine. The SSD further stated she had given the information to Resident #53 but said he still wanted to use the machine so that he knew the CPAP was being cleaned and sanitized every day before he used it at night. The SSD explained she understood Resident #53's concern since he was blind and could not see the staff cleaning his equipment but said the clinical staff had the final say about the machine.

An interview conducted on 06/18/21 at 4:35 PM with the Director of Nursing revealed she was aware Resident #53 wanted to use his machine to clean and sanitize his CPAP. She stated she had reached out to the Corporate Nurse Consultant and she had been the one who had said the resident could not use the machine because there was not a policy and procedure in place for the machine. The DON indicated she had spoken with other facilities who had residents with this type of machine and stated they should be able to develop a policy and procedure that would allow the resident to use the machine so he is assured his equipment is cleaned and

| 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 07/02/2021 |

| 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 561 | Continued From page 20 | F 561 | | |

sanitized daily.

An interview was conducted on 06/18/21 at 7:10 PM with the Administrator revealed she would speak with the Corporate Nurse Consultant about developing a policy and procedure that would allow Resident #53 to utilize his machine to clean and sanitize his CPAP equipment.

3. Resident #71 was originally admitted on 04/23/21 and was readmitted on 05/04/21.

A review of the admission Minimum Data Set (MDS) dated 05/20/21 indicated Resident #71 was cognitively intact and required extensive assistance with activities of daily living (ADL).

An observation was conducted on 06/15/21 at 11:30 AM revealed Resident #71 speaking to staff requesting to get out of bed.

An interview and observation was conducted with Resident #71 on 06/15/21 at 2:15 PM which revealed the resident was still in bed and appeared to be upset and frustrated. The resident stated she had asked multiple times since breakfast to get out of bed, but staff still hadn't assisted her. Resident #71 stated she didn't understand why staff didn't care about her and just left her laying in the bed all the time.

An interview was conducted with Nurse Aide (NA) #9 on 06/15/21 at 2:55 PM revealed which Resident #71 had requested to get out of bed this morning and NA #9 thought NA #14 had assisted the resident. NA #9 further revealed Resident #71 liked to get out of bed after breakfast most days. NA #9 indicated it was impossible to assist all residents with their request and needs.

| 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 07/02/2021 |

| 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 561 | Continued From page 21<br><br>An interview was conducted with NA #14 on 06/15/21 at 3:15 PM which revealed Resident #71 requested to get up in her wheelchair after her bath this morning around 9:30 AM. The NA further revealed she never had time to get her up in her wheelchair today due to staying busy. NA #14 stated she should have requested assistance to assure that Resident #71 got out of bed as requested.<br><br>An interview was conducted with the Director of Nursing (DON) on 06/18/21 at 5:00 PM which revealed Resident #71 did prefer to be out of bed in the mornings. It was further revealed if Resident #71 requested to get out of bed then it was expected for staff to assist the resident out of bed.<br><br>An interview conducted with the Administrator on 06/18/21 at 6:15 PM which revealed it was expected for nursing staff to assist residents if they were requesting to get out of bed. The Administrator further revealed Resident #71 should have been assisted out of bed in a timely manner. | F 561 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive | F 656 | | 8/1/21 |

| 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 07/02/2021 |

| 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 656 | Continued From page 22<br>assessment. The comprehensive care plan must describe the following -<br>(i) 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 §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop a care plan for left hand contracture management for 1 of 1 resident (Resident #35) reviewed for positioning and failed to implement care plan interventions to prevent falls for 1 of 1 resident (Resident #74) reviewed | F 656 | White Oak of Shelby does develop and implement a comprehensive person-centered care plan for each resident.<br><br>Resident #35's care plan has been | |

| 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 07/02/2021 |

| 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 656 | Continued From page 23<br>for accidents.<br><br>The findings included:<br><br>1. Resident #35 was last re-admitted to the facility on 5/4/20 with diagnoses that included hemiplegia (paralysis of one side of the body) following cerebral infarction affecting left non-dominant side.<br><br>A Physician Order dated 3/28/21 indicated Resident #35 to tolerate grip WHFO (wrist finger hand orthosis) splint to left hand for 6 hours daily for contracture management; monitor for signs and symptoms of skin breakdown.<br><br>The Annual Minimum Data Set (MDS) assessment dated 4/23/21 indicated Resident #35 was moderately cognitively impaired, exhibited no rejection of care behaviors, required extensive physical assistance with all activities of daily living (ADL) including personal hygiene and had impairment to both upper and lower extremities on the left side. The ADL Care Area Assessment indicated Resident #35 required extensive assistance with all ADL, had left-sided hemiplegia and required a WFHO (wrist finger hand orthosis) splint to the left hand.<br><br>Resident #35's care plan which was last reviewed on 5/7/21 did not address Resident #35's limited mobility and use of left-hand splint for contracture management.<br><br>An interview with the Resident Assessment Coordinator (RAC) on 6/17/21 at 5:50 PM revealed she did not know anything about Resident #35's left-hand splint and did not know why this information was not included in her care | F 656 | reviewed and revised to include the contracture management and the Lt. Hand Splint.<br><br>Resident #74's care plan has been reviewed and revised to accurately address their needs, i.e. that he throws away urinals when he is given them and that he moves his walker to where he chooses to move it around in his room.<br><br>Care plans for residents with splints will be audited by the Restorative Nurse to assure all splints are being care planned. This audit will be completed by 7/16/21.<br><br>Care plans for residents who have had a fall in the past 30 days will be audited and updated to accurately reflect the resident and the fall interventions put into place, this will be completed by the Restorative Nurse and/or the RAC nurse (Resident Assessment Coordinator)and will be completed prior to 8/1/21.<br><br>The Restorative Nurse and the RAC nurses were re-educated by the Corporate RAC Nurse on 7/7/21 on care planning contracture management and on assuring the care plan accurately reflects the resident.<br>Newly hired Restorative Nurses and RAC Nurses receive this education during their job specific orientation with the Corporate Consultant.<br><br>Over the next 90 days during the Care Plan review meetings the care plans will be reviewed and revised for all residents | |

| 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 07/02/2021 |

| 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 656 | Continued From page 24<br>plan. The RAC stated she probably recently reviewed Resident #35's care plan and forgot to include Resident #35's impaired mobility and contracture management to her care plan. She admitted that the facility had been without a restorative nurse for a while which might have been why Resident #35's left-hand splint was not included in her care plan.<br><br>An interview with the Director of Nursing (DON) on 6/18/21 at 5:30 PM revealed the RAC was responsible for updating care plans and should have added Resident #35's left-hand splint to it. The DON shared they hired a restorative nurse the week before, but she was currently on leave. She would be trained to update the care plans as well to include any splinting or positioning devices used by the residents.<br><br>An interview with the Administrator on 6/18/21 at 6:10 PM revealed Resident #35's left-hand splint should have been reflected in her care plan.<br><br>2. Resident #74 was admitted to the facility on 02/18/20 with diagnoses which included dizziness and Parkinson's disease.<br><br>Review of Resident #74's quarterly Minimum Data Set (MDS) dated 05/21/21 revealed the resident was cognitively impaired requiring limited assistance with one person assist for all transfers and toilet use. The MDS further revealed Resident #74 was coded for a walker and was incontinent frequently.<br><br>Review of Resident #74's care plan revised on 06/09/21 indicated the resident had a history of falls due to weakness, deconditioning, and | F 656 | who have had a fall or are at risk for a fall to assure interventions are appropriate and individualized for that resident.<br><br>The Restorative Nurse will monitor 5 care plans a week for 4 weeks, then 3 care plans a week for 4 weeks, then 2 care plans a week for 4 weeks and periodically thereafter to assure compliance to F656 for fall interventions and contracture management.<br><br>Results of the audits will be discussed during their morning QI meeting weekly for 3 months and periodically thereafter, with the committee making recommendations for system changes as needed.<br><br>The DON is responsible for ongoing compliance to F656.<br><br>The completion date of 8/1/21 | |

| 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 07/02/2021 |

| 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 656 | Continued From page 25 | F 656 | | |

Parkinson's disease. The goal for Resident #74 was no major injury should fall occur through the review date. Intervention in place included Resident #74's walker would be in reach at all times.

Review of Resident #74's care plan revised on 06/11/21 indicted the resident had activities of daily living (ADL) deficits. The goal for Resident #74 was to improve in bathing, dressing, toileting, grooming, and functional transfers. Interventions in place included Resident #74 needing a urinal and keeping it within reach.

An observation was conducted on 06/15/21 at 2:20 PM revealed Resident #74 asleep in the bed with no urinal in the room. The observation further revealed Resident #74's walker on the foot side of the bed against the wall folded behind a side table.

An observation was conducted on 06/15/21 at 4:00 PM revealed Resident #74 coming out of his restroom without a walker or any assistance. Resident #74's walker was still against the wall behind side table folded. It was further observed Resident #74 walking unsteady back to his bed tripping over his oxygen tubing. Interview with Resident #74 on 06/15/21 at 4:00 PM revealed he did not have a urinal in the room.

An observation was conducted on 06/16/21 at 8:09 AM revealed no urinal in Resident #74 room. The walker was observed in the same place as prior observation against the bed folded and tucked behind a side table.

An interview conducted with Nurse Aide #4 on 06/16/21 at 10:45 am revealed she could not

| 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 07/02/2021 |

| 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 656 | Continued From page 26 | F 656 | | |

recall what Resident #74 was care planned for. Nurse Aide #4 further revealed Resident #74 did not have a urinal in the resident's room and the Resident #74's walker was not in reach of the resident.

An interview and observation was conducted with Nurse #6 on 06/16/21 at 10:35 AM. It revealed Resident #74 did not have a urinal in the resident's room and the resident's wheelchair was against the wall near the bottom of the bed. The nurse further revealed the walker was not in reach of Resident #74 and should be unfolded and moved closer to his bedside. Nurse #6 indicated she did not know Resident #74 was care planned for a urinal and walker in reach of the resident.

An interview and observation was conducted with the Resident Assessment Coordinator on 06/16/21 at 11:55 AM revealed Resident #74s walker was against the wall in the same place as prior observations. The Resident Assessment Coordinator further revealed the walker was not in reach of the resident as it was documented in the care plan. It was observed a new urinal was placed in Resident #74's restroom but was not in reach of the resident.

An interview was conducted with the Director of Nursing (DON) on 06/18/21 at 5:00 PM. It revealed Resident #74's interventions should be followed and the walker and urinal to be in reach of the resident to help prevent any future falls.

An interview was conducted with the Administrator on 06/18/21 at 6:15 PM. It revealed Resident #74's care is expected to be followed as documented in the care plan.

| 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 07/02/2021 |

| 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 677 SS=E | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, resident and staff interviews, the facility failed to provide nail care to 6 of 10 residents (Resident #35, Resident #78, Resident #70, Resident #39, Resident #40 and Resident #294) reviewed for assistance with activities of daily living.<br><br>The findings included:<br><br>1. Resident #35 was last re-admitted to the facility on 5/4/20 with diagnoses that included polyneuropathy and hemiplegia (paralysis of one side of the body) following cerebral infarction affecting left non-dominant side.<br><br>The annual Minimum Data Set (MDS) assessment dated 4/23/21 indicated Resident #35 was moderately cognitively impaired, exhibited no rejection of care behaviors, required extensive physical assistance with all activities of daily living (ADL) including personal hygiene and had impairment to both upper and lower extremities on the left side.<br><br>Resident #35's care plan last reviewed on 5/7/21 indicated Resident #35 had self-care deficit and required assistance with her ADL due to some cognitive loss and decreased mobility. Interventions included assisting Resident #5 with her ADL as needed while encouraging her to participate as able. | F 677 | White Oak of Shelby assures any resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene.<br><br>Residents #35, #78, #70, #39, #40 and #294 have been provided with nail care, i.e. fingernails and toenails, completed on 7/8/21 by the nursing staff.<br><br>An audit was completed of all the residents fingernails and toenails by the Admissions Director and/or Staff Nurse to identify any resident in need of nail care. The audit was completed on 7/7/21. Any resident identified as needing Podiatry care will be scheduled to see the Podiatrist on their next facility visit scheduled for 8/3/21. Residents in need of toenail care will either be referred to the Podiatrist or a Nurse will provide this care.<br><br>Any resident in need of fingernail care will be referred to the Activity Director for a manicure. All nail care will be completed prior to 8/1/21 with the exception of those referred to the Podiatrist.<br><br>CSM (central supply manager) will stock | 8/1/21 |

| 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 07/02/2021 |

| 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 677 | Continued From page 28<br><br>An observation and interview of Resident #35 was made on 6/14/21 at 9:40 AM. Resident #35's fingernails were observed being at least a half inch longer than the tips of her fingers and there was brown matter underneath her fingernails. Resident #35's left hand was contracted into a closed-fist position with her long nails almost digging into her palm. Resident #35 stated it had been a while since her fingernails last got trimmed and wanted her fingernails to be checked and cut by the staff.<br><br>Further observations were made on 6/15/21 at 9:00 AM, 6/15/21 at 2:06 PM and 6/16/21 at 10:20 AM of Resident #35's fingernails being long and dirty with each observation. On 6/15/21 at 2:06 PM, Resident #35 stated she just had a sponge bath but wanted her fingernails trimmed.<br><br>An interview with Nurse Aide (NA) #3 on 6/15/21 at 11:10 PM revealed she had not recently done nail care on Resident #5. NA #3 disclosed she had to work by herself on the hall from 7:00 PM to 11:00 PM and needed a lot of help especially when working with residents who required 2-staff assistance. NA #3 stated she wasted a lot of time looking for another staff member from other halls to help her provide basic ADL care to the residents.<br><br>An interview conducted with NA #1 on 6/16/21 at 2:09 PM revealed she had observed Resident #35's long and dirty nails but she didn't have time to trim them on 6/15/21 on day shift because she didn't have enough help on the floor. NA #1 stated a staff member from another shift could have trimmed Resident #35's fingernails but this task always ended up for her to complete every | F 677 | all nail supplies on each unit and will check and restock the supply weekly going forward. This was started the week of 6/28/21 and each week thereafter.<br><br>The nursing staff, activity staff and social service staff were re-educated on nail care by the Nursing Administrative Team. The re-education includes identifying nails that need to be trimmed and report it to the licensed nurse; nail care to be provided on shower days and as needed; nails should be clean and free from debris; nursing staff to trim nails and smooth with an emery board as needed; if license nurse is unable to trim the nails, resident will be added to the podiatry list in order to be seen by the Podiatrist. This education will be completed prior to 8/1/21.<br><br>The Treatment Nurse will monitor by observing both fingernails and toenails of 10 residents a week for 4 weeks, then 6 residents a week for 4 weeks, then 3 residents a week for 4 weeks and randomly thereafter. If a resident is identified to need nail care, it will be provided at that time by the Nurse and/or Activity Department; if in need of podiatry care the Social Services will be contacted and the resident added to the list for the Podiatrist to see on their next facility visit, any emergent need will be communicated to the Podiatrist by the Social Service department.<br><br>Results of the observations will be discussed during their morning QI | |

| 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 07/02/2021 |

| 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 677 | Continued From page 29 | F 677 | | |

time. NA #1 admitted that she hadn't trimmed Resident #35's fingernails in a while due to always being busy with other tasks and not having enough staff members to help her.

An interview with NA #4 on 6/16/21 at 11:10 AM revealed she was usually assigned to another hall on day shift but had to help NA #1 most of the time when working with 2-staff assist residents. NA #4 stated they didn't have time to do nail care because there was not enough staff to provide ADL care to the residents.

An interview with NA #2 on 6/16/21 at 2:52 PM revealed she had to work on the evening shift on 6/14/21 by herself on the hall where Resident #5 resided. NA #2 stated it was difficult to get her tasks done because most of the residents on the hall needed assistance of at least 2 staff members so she spent a lot of time trying to find another staff member to help her. NA #2 disclosed she had seen Resident #35's fingernails being long and dirty, but she did not have enough time to stop and trim them on 6/14/21.

An interview with Nurse #4 on 6/16/21 at 3:23 PM revealed she tried to do nail care on her hall whenever she had the time to do it during the day shift. Nurse #4 disclosed it had been a while since she had trimmed Resident #35's fingernails.

An interview with the Director of Nursing (DON) on 6/18/21 at 5:30 PM revealed she expected the nurses to observe when nails were long and for the nurses to instruct their nurse aides when fingernails needed to be trimmed.

An interview with the Administrator on 6/18/21 at

meeting weekly for 3 months, and periodically thereafter, with the committee making recommendations for system changes when necessary.

The DON is responsible for ongoing compliance to F677.

The completion date of 8/1/21.

| 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 07/02/2021 |

| 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 677 | Continued From page 30 | F 677 | | |

6:10 PM revealed nurses and nurse aides should provide nail care to residents as needed. The Administrator stated they used to have their activities staff members help with nail care, but the nursing staff should always assess the residents' nails if they needed to be trimmed.

2. Resident #78 was admitted to the facility on 5/21/21 with diagnoses that included hemiplegia (paralysis of one side of the body).

The admission Minimum Data Set (MDS) assessment dated 5/27/21 indicated Resident #78 was severely cognitively impaired, had no rejection of care behaviors, required extensive physical assistance with all activities of daily living (ADL) including personal hygiene and had impairment to both upper and lower extremities on the left side.

Resident #78's care plan dated 6/3/21 indicated Resident #78 had ADL deficits related to generalized weakness and cognitive loss. Interventions included for staff to assist with bathing and dressing, encourage to do as much as possible and to assist in completing activity as needed.

An observation and interview of Resident #78 was made on 6/14/21 at 10:06 AM. Resident #78's fingernails were observed being at least a half inch longer than the tips of his fingers and there was brown matter underneath his fingernails. Resident #78 stated he wanted his fingernails trimmed.

Further observations were made on 6/15/21 at 2:10 PM and 6/16/21 at 10:25 AM of Resident #78's fingernails being long and dirty with each

| 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 07/02/2021 |

| 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 677 | Continued From page 31 | F 677 | | |

observation. On 6/16/21 at 10:29 AM, Resident #78 stated he wanted his fingernails trimmed and that the staff provided him with a sponge bath on 6/15/21 but had not cut his fingernails.

An interview conducted with NA #1 on 6/16/21 at 2:09 PM revealed she had observed Resident #78's long and dirty nails but she didn't have time to trim them on 6/15/21 on day shift because she didn't have enough help on the floor. NA #1 stated a staff member from another shift could have trimmed Resident #78's fingernails but this task always ended up for her to complete every time. NA #1 admitted that she hadn't trimmed Resident #78's fingernails ever since he had been transferred to his current room due to her always being busy with other tasks and not having enough staff members to help her.

An interview with NA #4 on 6/16/21 at 11:10 AM revealed she was usually assigned to another hall on day shift but had to help NA #1 most of the time when working with 2-staff assist residents. NA #4 stated they didn't have time to do nail care because there was not enough staff to provide ADL care to the residents.

An interview with NA #2 on 6/16/21 at 2:52 PM revealed she had to work on the evening shift on 6/14/21 by herself on the hall where Resident #78 resided. NA #2 stated it was difficult to get her tasks done because most of the residents on the hall needed assistance of at least 2 staff members so she spent a lot of time trying to find another staff member to help her. NA #2 disclosed she had seen Resident #78's fingernails being long and dirty, but she did not have enough time to stop and trim them on 6/14/21.

| 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 07/02/2021 |

| 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 677 | Continued From page 32 | F 677 | | |

An interview with Nurse #4 on 6/16/21 at 3:23 PM revealed she tried to do nail care on her hall whenever she had the time to do it on day shift. Nurse #4 disclosed she had not trimmed Resident #78's fingernails and thought that NA #1 had been taking care of them. Nurse #4 admitted it was hard to pay attention to nails on her hall because she was always focused on trying to get her medications administered within the allotted time.

An interview with the Director of Nursing (DON) on 6/18/21 at 5:30 PM revealed she expected the nurses to observe when nails were long and for the nurses to instruct their nurse aides when fingernails needed to be trimmed.

An interview with the Administrator on 6/18/21 at 6:10 PM revealed nurses and nurse aides should provide nail care to residents as needed. The Administrator stated they used to have their activities staff members help with nail care, but the nursing staff should always assess the residents' nails if they needed to be trimmed.

3. Resident #70 was admitted to the facility on 2/1/19 with diagnoses that included dementia and osteoporosis.

The quarterly Minimum Data Set (MDS) assessment dated 5/20/21 indicated Resident #70 was severely cognitively impaired, had no rejection of care behaviors and required extensive physical assistance with all activities of daily living (ADL) including personal hygiene.

Resident #70's care plan last reviewed on 5/14/21 indicated Resident #70 had self-care deficit and

| 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 07/02/2021 |

| 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 677 | Continued From page 33 | F 677 | | |

required assistance with her ADL. Interventions included for staff to assist with grooming and dressing while encouraging her to participate as able.

An observation and interview of Resident #70 was made on 6/14/21 at 10:37 AM. Resident #70's fingernails were observed extending about a centimeter longer than the tips of her fingers and there was brown matter underneath her fingernails. The left middle fingernail was jagged and cracked in the middle. Resident #70 stated it had been a long time since she had her fingernails trimmed and they needed to be shaped and cleaned.

Further observations were made on 6/15/21 at 9:17 AM, 6/15/21 at 2:41 PM and 6/16/21 at 10:23 AM of Resident #70's fingernails being long and dirty with each observation. On 6/16/21 at 10:23 AM, Resident #70 stated she wanted her fingernails trimmed and that they needed shaping. Resident #70 also stated that she would not refuse nail care if it was offered to her.

An interview with Nurse Aide (NA) #5 on 6/16/21 at 2:38 PM revealed she had not noticed Resident #70's fingernails being long and dirty. NA #5 stated it had been a while since she had provided nail care to Resident #70 because she usually did not have time to do it on day shift. NA #5 also stated she was responsible for trimming and cleaning Resident #70's nails if she had time to do it but she often did not have time and sometimes did not even get to go on break.

An interview conducted with NA #1 on 6/16/21 at 2:09 PM revealed she was not responsible for Resident #70 but always had to help NA #5 with

| 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 07/02/2021 |

| 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 677 | Continued From page 34 | F 677 | | |

Resident #70's care on day shift. NA #1 had observed Resident #70's long and dirty nails but she didn't have time to trim them because she didn't have enough help on the floor.

An interview with NA #2 on 6/16/21 at 2:52 PM revealed she had to work on the evening shift on 6/14/21 by herself on the hall where Resident #70 resided. NA #2 stated it was difficult to get her tasks done because most of the residents on the hall needed assistance of at least 2 staff members so she spent a lot of time trying to find another staff member to help her. NA #2 disclosed she had seen Resident #70's fingernails being long and dirty, but she did not have enough time to stop and trim them on 6/14/21.

An interview with Nurse #4 on 6/16/21 at 3:23 PM revealed she tried to do nail care on her hall whenever she had the time to do it on day shift. Nurse #4 disclosed she had not trimmed Resident #70's fingernails. Nurse #4 admitted it was hard to pay attention to nails on her hall because she was always focused on trying to get her medications administered within the allotted time.

An interview with the Director of Nursing (DON) on 6/18/21 at 5:30 PM revealed she expected the nurses to observe when nails were long and for the nurses to instruct their nurse aides when fingernails needed to be trimmed.

An interview with the Administrator on 6/18/21 at 6:10 PM revealed nurses and nurse aides should provide nail care to residents as needed. The Administrator stated they used to have their activities staff members help with nail care, but

| 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 07/02/2021 |

| 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 677 | Continued From page 35 | F 677 | | |

the nursing staff should always assess the residents' nails if they needed to be trimmed.

4. Resident #39 was admitted to the facility on 10/28/2020 with diagnoses of non-Alzheimer's dementia, dysphagia, and polyneuropathy. Her quarterly Minimum Data Set (MDS) dated 4/22/2021 revealed she was moderately cognitively impaired. Resident #39 required extensive assistance of one person for personal hygiene. Resident #39 was totally dependent on one person for bathing.

Observation of Resident #39 on 6/16/2021 at 8:50 AM revealed her receiving a bed bath by Nurse Aide (NA) #13. Resident #39's fingernails were ¾ inches long beyond the end of the finger. The nails were uneven and dark yellowish brown. Bilateral great toenails were thickened, yellow and crumbly. The remainder of the toenails were dark grayish brown, jagged and approximately ¼ inch long beyond the end of the toe. Resident #39 did not respond appropriately to questions regarding her nail care.

An interview with NA #13 at the time of the bed bath revealed nurses in the facility were responsible for nail care.

An interview with NA #4 on 6/16/2021 at 11:10 AM revealed she was not able to complete nail care for residents because there was not enough staff. NA #4 stated she had informed the nurse of the inability to complete her tasks.

Observation of Resident #39 on 6/16/2021 at 11:40 AM revealed her sitting on the side of her bed without socks on. Her toenails and fingernails remained untrimmed.

| 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 07/02/2021 |

| 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 677 | Continued From page 36 | F 677 | | |

Observation of supply rooms on the 400 hall, 200 hall and the 300-hall on 6/16/21 at 3:26 PM revealed no nail clippers or emery boards.

Observation of Resident #39 on 6/16/2021 at 3:40 PM revealed her fingernails and toenails remained untrimmed.

Observation of Resident #39 on 3/17/2021 at 11:01 AM revealed her fingernails and toenails remained untrimmed.

An interview with Nurse # 14 on 6/18/2021 at 10:15 AM revealed nail care supplies were kept in clean supply. Nurse #14 provided a tour of the clean supply closet on the 400-hall. At this observation, a caddy was present with labels for nail clippers, emery boards and nail brushes. Nurse # 14 was asked to open the caddy. There were no nail clippers. Emery boards were present. Nurse # 14 was asked how she obtained nail care supplies when they were out. She stated nurses on the 400-hall usually went to the supply closet on the 200-hall if they needed more supplies.

A second tour of the 200-hall supply closet on 6/18/2021 at 10:30 AM revealed a caddy without labels that contained emery boards and one pair of nail clippers. The nail clippers available were not designed for use with thickened nails.

An interview with the Director of Nursing on 6/18/2021 at 5:30 PM revealed she expected nail care to take place during bathing or at any time nails needed attention. She stated the facility had plenty of nail clippers in the main central supply. This supply was validated by another surveyor.

| 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 07/02/2021 |

| 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 677 | Continued From page 37 | F 677 | | |

She indicated nails that were thicker could be trimmed by the treatment nurse with a specialty type of clippers. She stated she had directed staff to check all nails in the building 2 days ago. She stated she did not confirm the task was completed.

An interview with the Administrator on 6/18/2021 at 6:10 PM revealed she expected nurses and nurse aides to provide nail care to residents as needed.

5. Resident #294 was admitted to the facility on 6/4/2021 with diagnoses of aphasia, stroke with resulting hemiplegia. Resident #294's entry Minimum Data Set (MDS) dated 6/4/2021 revealed she was she required limited assistance of one person for personal hygiene and was totally dependent on one person for bathing.

An observation of Resident #294 on 6/14/2021 at 2:41 PM revealed her sitting in bed, clothed with a top and matching pair of pants. Her toenails were approximately ½ inches long past the end of the toe. The nails were dark brownish yellow and crumbly. Resident #294 did not respond appropriately to questions.

An interview with Nurse Aide (NA) #15 on 6/16/2021 at 8:45 AM revealed nail care was provided by the nurses. She stated she was responsible for notifying nurses of the need for nail care. She stated nail care should be noted on the shower sheets. NA #15 did not recall informing the nurse of the need for nail care.

An interview with Nurse #15 on 6/16/2021 at 9:00 AM revealed she expected NAs to inform her if nail care was needed. She stated she did not

| 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 07/02/2021 |

| 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 677 | Continued From page 38 | F 677 | | |

recall any report regarding the need for nail care for Resident #294.

Observation of supply rooms on the 400 hall, 200 hall and the 300-hall on 6/16/21 at 3:26 PM revealed no nail clippers or emery boards.

A review of shower sheets on 6/17/2021 at 10:10 AM revealed no note regarding the need for nail care for Resident #294.

An interview with Nurse #14 on 6/18/2021 at 10:15 AM revealed nail care supplies were kept in clean supply. Nurse #14 provided a tour of the clean supply closet on the 400-hall. At this observation, a caddy was present with labels for nail clippers, emery boards and nail brushes. Nurse #14 was asked to open the caddy. There were no nail clippers. Emery boards were present. Nurse #14 was asked how she obtained nail care supplies when out. She stated nurses on the 400-hall usually went to the supply closet on the 200-hall if they needed more supplies.

Observation of Resident #294 on 6/18/2021 at 10:20 AM during therapy session revealed the same long, dark, brownish yellow, crumbly nails.

An interview with Nurse #14 on 6/18/2021 at 10:15 AM revealed nails care supplies for her hall (400 hall) were kept in clean supply. Nurse #14 provided a tour of the clean supply closet on the 400-hall. At this observation, a caddy was present with labels for nail clippers, emery boards and nail brushes. Nurse # 14 was asked to open the caddy. There were no nail clippers. Emery boards were present. Nurse #14 was asked how she obtained nail care supplies when they were out. She stated nurses on the 400-hall usually

| 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 07/02/2021 |

| 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 677 | Continued From page 39 | F 677 | | |

went to the supply closet on the 200-hall if they needed more supplies.

A second tour of the 200-hall supply closet on 6/18/2021 at 10:30 AM revealed a caddy without labels that contained emery boards and one pair of nail clippers. The nail clippers available were not designed for use with thickened nails.

An interview with the Director of Nursing on 6/18/2021 at 5:30 PM revealed she expected nail care to take place during bathing or at any time nails needed attention. She stated the facility had plenty of nail clippers in the main central supply. This supply was validated by another surveyor. She indicated nails that were thicker could be trimmed by the treatment nurse with a specialty type of clippers. She stated she had directed staff to check all nails in the building 2 days ago. She stated she did not confirm the task was completed.

An interview with the Administrator on 6/18/2021 at 6:10 PM revealed she expected nurses and nurse aides to provide nail care to residents as needed.

6. Resident #40 was recently re-admitted to the facility on 4/7/2021 with diagnoses of non-Alzheimer's dementia and Parkinson's disease. His quarterly Minimum Data Set (MDS) dated 3/23/2021 revealed he was cognitively intact. He required limited assistance of one person for personal hygiene. He was totally dependent on one person for bathing. His vision was impaired.

Observation of supply rooms on the 400 hall, 200 hall and the 300-hall on 6/16/21 at 3:26 PM

| 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 07/02/2021 |

| 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 677 | Continued From page 40 | F 677 | | |

revealed no nail clippers or emery boards.

An observation of Resident #40 on 6/17/2021 at 3:00 PM revealed jagged fingernails approximately ¼ inch beyond the end of the fingers. A dark colored substance was visible under the nails.

An interview with NA #4 on 6/17/2021 at 11:00 AM revealed she was not able to complete nail care for residents because there was not enough staff. She stated Resident # 40 could not see well enough to cut his own nails. NA #4 did not recall informing the nurse of the need for resident nail care.

An interview with Resident #40 on 6/17/2021 at 3:00 PM revealed he preferred his fingernails to be shorter and cleaner, but he could not see well enough to tell if the nails were dirty. He stated he preferred his fingernails to be cut weekly, but it had been 3 to 4 weeks since someone cut or cleaned his nails.

A second tour of the nail supplies in the 200-hall supply closet on 6/18/2021 at 10:30 AM revealed a caddy without labels that contained emery boards and one pair of nail clippers. The nail clippers available were not designed for use with thickened nails.

An interview with the Director of Nursing on 6/18/2021 at 5:30 PM revealed she expected nail care to take place during bathing or at any time nails needed attention. She stated the facility had plenty of nail clippers in the main central supply. This supply was validated by another surveyor. She indicated nails that were thicker could be trimmed by the treatment nurse with a specialty

| 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 07/02/2021 |

| 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 677 | Continued From page 41<br>type of clippers. She stated she had directed staff to check all nails in the building 2 days ago. She stated she did not confirm the task was completed.<br><br>An interview with the Administrator on 6/18/2021 at 6:10 PM revealed she expected nurses and nurse aides to provide nail care to residents as needed. | F 677 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, resident and staff interviews, the facility failed to apply a left-hand splint for 1 of 1 resident (Resident #35) reviewed for positioning.<br><br>The findings included: | F 688 | White Oak of Shelby ensures that residents with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in | 8/1/21 |

| 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 07/02/2021 |

| 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 688 | Continued From page 42<br><br>Resident #35 was last re-admitted to the facility on 5/4/20 with diagnoses that included hemiplegia (paralysis of one side of the body) following cerebral infarction affecting left non-dominant side.<br><br>A Physician Order dated 3/28/21 indicated Resident #35 to tolerate grip WHFO (wrist finger hand orthosis) splint to left hand for 6 hours daily for contracture management; monitor for signs and symptoms of skin breakdown.<br><br>Resident #35's Medication Administration Record (MAR) for June 2021 revealed an order for: Patient will tolerate grip WHFO to left hand for 6 hours daily for contracture management. Monitor for signs/symptoms of skin breakdown. It was documented as being applied every shift at 6:30 AM, 2:30 PM and 10:30 PM.<br><br>The Annual Minimum Data Set (MDS) assessment dated 4/23/21 indicated Resident #35 was moderately cognitively impaired, exhibited no rejection of care behaviors, required extensive physical assistance with all activities of daily living (ADL) including personal hygiene and had impairment to both upper and lower extremities on the left side. The ADL Care Area Assessment indicated Resident #35 required extensive assistance with all ADL, had left-sided hemiplegia and required a WFHO (wrist finger hand orthosis) splint to the left hand.<br><br>Resident #35's care plan which was last reviewed on 5/7/21 did not address Resident #35's limited mobility and use of left-hand splint for contracture management. | F 688 | mobility is demonstrably unavoidable.<br><br>Resident #35 had their Lt. hand splint applied per Doctor's order. Resident #35's care plan has been updated to include the Lt. hand splint for contracture management.<br><br>The Restorative Nurse will make a round in the facility to check that residents who need or have a doctor's order for a splint, have the splint and it is being applied as ordered; this will be completed by 7/16/21.<br><br>The nursing staff will be re-educated on assuring residents, who have a splint/s, are applied per doctor's order. The re-education consist of following the physician's order for applying a splint; and the licensed nurse is responsible for applying the splint as indicated on the EMAR (electronic medication administration record). The other staff are aware and educated to review the resident's care guide for residents that require a splint. The education was conducted by the DON/SDC and/or the Nurse Management Team and will be completed prior to 8/1/21.<br><br>Newly hired nursing staff receive this education during their job specific orientation with the SDC or Nurse Management.<br><br>The Restorative Nurse will monitor by checking residents who have an order for a splint weekly for 12 weeks and randomly thereafter to assure compliance to F688. | |

| 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 07/02/2021 |

| 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 688 | Continued From page 43<br>During an initial observation and interview with Resident #35 on 6/14/21 at 9:40 AM, Resident #35 was noted to have left-sided weakness with her left hand contracted in a closed-fist position. Resident #35 stated she was unable to move her left arm and that the staff was not doing anything for her left-hand contracture.<br><br>Follow-up observations and interviews with Resident #35 were made on:<br>6/14/21 at 3:50 PM - Resident #35 did not have a hand splint to her left hand. A blue hand splint was visible on top of her bedside table.<br>6/15/21 at 9:00 AM - Resident #35 did not have a hand splint to her left hand. Her left hand was positioned on top of a pillow. Resident #35 stated her hand splint hadn't been applied for a few days and she preferred to have it on because her left hand felt better with her splint on.<br>6/15/21 at 2:06 PM - Resident #35 did not have a hand splint to her left hand. A blue hand splint was on top of her bedside table.<br>6/15/21 at 6:35 PM - Resident #35 did not have a hand splint to her left hand.<br>6/15/21 at 9:35 PM - Resident #35 was observed lying in bed. No splint was observed to her left hand. A blue hand splint was on top of her bedside table.<br>6/16/21 at 10:20 AM - Resident #35 did not have a hand splint to her left hand.<br><br>An interview with Nurse Aide (NA) #3 on 6/15/21 at 11:10 PM revealed she had applied Resident #35's left-hand splint on her before but not on 6/15/21. NA #3 stated she did not have time to put Resident #35's left-hand splint on because she had to work on the hall by herself from 7:00 PM to 11:00 PM. NA #3 stated it was hard to provide care to most of her residents who | F 688 | Results of the splint checks will be discussed during their morning QI meeting weekly for 3 months, and periodically thereafter, with the committee making recommendations for system changes as indicated.<br><br>The DON is responsible for ongoing compliance to F688.<br><br>The completion date of 8/1/21. | |

| 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 07/02/2021 |

| 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 688 | Continued From page 44 | F 688 | | |

required 2-staff assistance because she had to find other nurse aides on the other halls to help her.

An interview with NA #1 on 6/16/21 at 2:09 PM revealed she was mainly assigned to the hall where Resident #35 resided and had provided care to Resident #35 on day shift but was not sure who was responsible for applying her left-hand splint. NA #1 thought therapy staff members were supposed to apply the splint to Resident #35's left hand.

An interview with Nurse #4 on 6/16/21 at 3:23 PM revealed the nurses were responsible for applying Resident #35's left-hand splint. Nurse #4 remembered offering to apply Resident #35's splint to her left hand on 6/15/21 but Resident #35 stated to her that she wanted to rest and requested her to come back afterwards. Nurse #4 admitted she forgot to come back and apply Resident #35's left-hand splint as had been ordered because she got busy with some other tasks.

A phone interview with Nurse #2 on 6/17/21 at 7:00 PM revealed she could not remember if she had applied Resident #35's splint to her left hand on 6/14/21. Nurse #2 stated she did not usually work on the hall and was not very familiar with the residents on the hall.

An interview with the Rehabilitation Manager (RM) on 6/17/21 at 3:25 PM revealed therapy had recommended a splint to be worn on Resident #35's left hand for contracture management. Occupational Therapy (OT) last worked with Resident #35 from 3/22/21 to 3/26/21 to address the splint application. Resident #35 was

| 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 07/02/2021 |

| 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 688 | Continued From page 45<br>discharged from OT services on 3/26/21 when she was able to tolerate wearing her left-hand splint for 6 hours. The RM stated they had educated the nursing staff on how to apply her left-hand splint before discharging her from therapy services. The RM further stated that therapy services was not aware that nursing had been unable to apply Resident #35's left-hand splint as ordered. He added that the nurses were always welcome to ask for help from therapy if they needed help with the application of Resident #35's left-hand splint.<br><br>An interview with the Director of Nursing (DON) on 6/18/21 at 5:30 PM revealed the nurses were supposed to apply Resident #35's splint to her left hand and that it was supposed to be applied in the mornings for up to 6 hours as tolerated by Resident #35. The DON added she had to revise the order for Resident #35's splint in her MAR because it was only supposed to be applied on day shift and not on all shifts.<br><br>An interview with the Administrator on 6/18/21 at 6:10 PM revealed the nurses were responsible for the application of Resident #35's left-hand splint. The Administrator added that she recently hired a restorative nurse to oversee the restorative program, but she was currently on leave. | F 688 | | |
| F 693 SS=D | Tube Feeding Mgmt/Restore Eating Skills<br>CFR(s): 483.25(g)(4)(5)<br><br>§483.25(g)(4)-(5) Enteral Nutrition<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must | F 693 | | 8/1/21 |

| 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 07/02/2021 |

| 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 693 | Continued From page 46<br>ensure that a resident-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, resident and staff interviews, the facility failed to discard an enteral tube feeding formula per manufacturer's guidelines and continued to administer an expired enteral tube feeding to 1 of 1 resident (Resident #5) reviewed for tube feeding.<br><br>The findings included:<br><br>A review of the manufacturer's guidelines for Osmolite 1.5 cal (calorie) updated on 4/7/21 indicated the following statement regarding use of ready-to-hang container with enteral feeding pumps:<br>*Unless a shorter hang time is specified by the set manufacturer, hang product for up to 48 hours after initial connection when clean technique and only one new set are used. Otherwise hang for no more than 24 hours. | F 693 | White Oak of Shelby assures residents who receive enteral feedings, will have the feeding discarded per the manufacturer's guidelines.<br><br>Resident #5 will receive their enteral feedings following manufacturer's recommendations on when to discard the formula, i.e. after 48 hours any unused formula will be discarded.<br><br>Other residents who receive enteral feedings have been audited and reviewed by the RD (Registered Dietician) to assure the enteral feeding formula is being discarded per the manufacturer's recommendations and completed by 7/16/21.<br><br>The licensed nursing staff were re-educated by the Nurse Management | |

| 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 07/02/2021 |

| 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 693 | Continued From page 47<br>Resident #5 was admitted to the facility on 7/5/16 with diagnoses that included dysphagia (difficulty swallowing) and esophagitis (inflammation of the esophagus which is a muscular tube that connects the mouth and the stomach).<br><br>A Physician's Order in Resident #5's medical record revealed an active order which started on 5/14/19 for Osmolite 1.5 cal (calorie) at 45 cc (cubic centimeters)/hour to provide 270 kcal (kilocalories) or 180 ml (milliliters) in 24 hours, feeding to run from 8 PM to 12 AM.<br><br>The Quarterly Minimum Data Set (MDS) assessment dated 6/3/21 indicated Resident #5 was cognitively intact, required extensive assistance with eating, had a feeding tube and received 25% or less of her total calories through tube feeding and 500 cc (cubic centimeters)/day or less of average fluid intake by tube feeding.<br><br>During an initial observation and interview with Resident #5 on 6/14/21 at 10:49 AM, a bottle of Osmolite 1.5 cal with 400 ml left on the bottle was left hanging on the feeding pump, available for use but was not running and was not connected to Resident #5. The bottle of Osmolite was dated as opened on 6/11/21 at 8:00 PM. An interview with Resident #5 revealed she only received the tube feeding at night when the nurse hooked her up to the feeding pump. She was able to eat regular food at all three meals but did not usually eat much because she didn't like what they served her.<br><br>The same bottle of Osmolite 1.5 cal was observed on 6/14/21 at 12:46 PM and 3:53 PM still hanging on the feeding pump in Resident #5's room. The bottle was dated as opened on | F 693 | on discarding enteral feedings per manufacturer's recommendations, this was completed prior to 8/1/21.<br>Newly hired licensed nurses receive this education during their job specific orientation with Nurse Management or SDC.<br><br>The RD will monitor by checking residents with enteral feedings weekly for 12 weeks and randomly thereafter to assure all enteral feeding formulas are discarded per manufacturer's recommendations.<br><br>Results of the enteral feeding checks will be discussed during their morning QI meeting weekly for 3 months, and periodically thereafter, with the committee making recommendations for system changes as indicated.<br><br>The DON is responsible for ongoing compliance to F693.<br><br>The completion date of 8/1/21 | |

| 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 07/02/2021 |

| 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 693 | Continued From page 48 | F 693 | | |

6/11/21 at 8:00 PM.

A phone interview with Nurse #1 on 6/14/21 at 3:35 PM revealed she worked with Resident #5 on 6/13/21 and had started the Osmolite 1.5 cal that was hanging on the feeding pump. Nurse #1 remembered having started the tube feeding at 8 PM and let it run until 12 AM because it only ran for 4 hours per night. She stated she did not hang a new tube feeding bottle on the night of 6/13/21 but could not remember what the date was on the bottle. Nurse #1 further stated she usually let Resident #5's tube feeding bottle last for 3 days before she discarded the formula.

An interview with Nurse #2 on 6/14/21 at 4:06 PM revealed she had just discarded Resident #5's Osmolite bottle that had been hanging on her feeding pump because she noticed that it was over the 48-hour limit. Nurse #2 disclosed that she had not noticed the opened date on the Osmolite bottle earlier but decided to check it after she was handed a written in-service material by the Director of Nursing (DON) on enteral feedings.

An interview with the Director of Nursing (DON) at 6/14/21 at 4:23 PM revealed she had walked by Resident #5's room and noticed that the tube feeding of Osmolite that was hanging on the feeding pump was dated as having been opened on 6/11/21 and that it was expired and was over 48 hours since it had been opened. The DON stated the Osmolite bottle should have been discarded after 48 hours of being opened and not left available for use on the feeding pump. The DON decided to start education on all nurses regarding enteral feedings.

| 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 07/02/2021 |

| 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 693 | Continued From page 49<br>Further observation of Resident #5 on 6/16/21 at 8:25 PM revealed a bottle of Osmolite 1.5 cal with about 600 ml left on the bottle infusing via feeding pump at 45 cc/hour. The bottle was dated as opened on 6/14/21 at 8 PM.<br><br>On 6/17/21 at 8:36 AM, an opened full bottle of Osmolite 1.5 cal was observed hanging on Resident #5's feeding pump and labeled as opened on 6/16/21 at 11:45 PM.<br><br>A phone interview with Nurse #3 on 6/17/21 at 11:52 AM revealed she worked on the night of 6/16/21 and remembered starting the Osmolite bottle at 8 PM even though the opened date on the bottle was 6/14/21. Nurse #3 let the Osmolite bottle dated 6/14/21 run for 4 hours, discarded it and decided to hang a new bottle for Resident #5 at 11:45 PM. Nurse #3 stated she did not know if Resident #5 was going to need her Osmolite feeding in the morning, so she went ahead and started a new bottle.<br><br>An interview with the DON on 6/17/21 at 2:58 PM revealed she did not realize Resident #5's Osmolite feeding which was opened on 6/14/21 had been expired on 6/16/21 before Nurse #3 decided to let it run for 4 hours and administer it to Resident #5. She was also not aware that the nurses had been running Resident #5's enteral feeding for at least 3 days before discarding it. The DON stated Osmolite enteral feeding should be discarded after 48 hours of being hung on a feeding pump. She shared that they had tried before to do bolus feeding instead of using a feeding pump but Resident #5 did not want to change her feeding set-up. | F 693 | | |
| F 725 SS=H | Sufficient Nursing Staff | F 725 | | 8/1/21 |

| 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 07/02/2021 |

| 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 725 | Continued From page 50<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, the facility failed to provide sufficient nursing staff, resulting in missed showers for dependent residents, partial baths or bed baths being provided instead of preferred showers, nail care not being provided for dependent residents, residents not being assisted up out of bed as requested and incontinence care | F 725 | White Oak of Shelby will provide sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being or each resident, as determined by resident assessments | |

| 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 07/02/2021 |

| 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 725 | Continued From page 51<br>not being provided for 13 of 17 residents reviewed for dignity and respect, choices and activities of daily living (Residents #16, #79, #55, #73, #47, #53, #71, #35, #78, #70, #39, #40 and #294).<br><br>The findings included:<br><br>This tag is cross referred to:<br><br>1. F550: Resident Rights: Based on record reviews, observations, staff interviews, and resident interviews the facility failed to treat residents in a dignified manor when staff did not provide incontinence care and the resident heard staff talking about her being difficult to change (Resident #16), when staff rolled their eyes when a resident asked to be put to bed (Resident #79), when staff told a resident they were going on break before providing incontinence care (Resident #55) and when staff yelled at a resident for trying to get assistance with care and trying to get assistance with incontinence care for her roommate (Resident #73). The residents expressed feelings of being upset, uncomfortable, unclean, and felt the nursing home did not care about them. This affected 4 of 4 residents reviewed for dignity and respect (#16, #79, #55, and #73).<br><br>2. F561: Self Determination: Based on observations, record reviews, resident and staff interviews, the facility failed to provide a resident with her preferred number of showers a week and failed to get her up out of bed to her wheelchair (Resident #47), failed to provide a resident his preference of using his machine (cleaner and sanitizer) to clean his Continuous Positive Airway Pressure (CPAP) mask, tubing, humidifier and | F 725 | and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment.<br><br>The facility's nursing staff positions and assignments were evaluated and additional systems will be put in place. The facility has contracted with additional nursing staff agencies with contracts for a more permanent extended timeframe.<br><br>The facility also posted a job ad for multiple Resident Assistants (RA) to assist the nurse aides on the floor while caring for the residents. The RAs can assist with tasks such as changing linen. The facility is hiring nurse aides to focus primarily on resident showers. Hiring Medication Aides will also be attempted again. Other disciplines to assist as well, such as activities to assist with nail care and social services to assist in identifying the need for nail care. Nursing Administration to cover when call outs occur.<br>The facility will continue to provide bonuses for staff starting employment and picking up additional shifts.<br><br>With current and new systems put into place and as new positions are hired, sufficient nursing staff will be able to provide showers for dependent residents, provide showers for residents that prefer showers, provide nail care for dependent residents, assist residents up out of bed as requested and provide incontinence care. | |

| 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 07/02/2021 |

| 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 725 | Continued From page 52<br>water chamber instead of staff cleaning the equipment and honor his wish for a new mattress without lumps and dips in it (Resident #53) and failed to honor a resident 's wish to get up out of bed and into her wheelchair every morning after breakfast (Resident #71) for 3 of 3 residents reviewed for choices.<br><br>3. F677: Activities of Daily Living for Dependent Residents: Based on record review, observations, resident and staff interviews, the facility failed to provide nail care to 6 of 10 residents (Resident #35, Resident #78, Resident #70, Resident #39, Resident #40 and Resident #294) reviewed for assistance with activities of daily living.<br><br>On 06/15/21 at 4:41 PM an interview was conducted with NA #8. The NA stated she and the other NA working with her had to work together to get all the residents changed and put to bed because a lot of them required 2 staff assistance with care.<br><br>On 06/15/21 at 5:08 PM an interview was conducted with NA #7. NA #7 stated she and the NA working with her were only able to complete 2 incontinence rounds on with the current staffing.<br><br>On 06/15/21 at 10:54 PM an interview was conducted with Nurse #12. The Nurse stated there were 3 Nurses and 6 NAs in the building at present for 91 residents. Nurse #12 further stated from 11:00 PM to 7:00 AM there would only be 4 NAs in the building and said it was difficult especially on the back halls due to residents that required 2 staff for care. | F 725 | Audit tools have been put in place to track new employees and when their start day is scheduled to begin, which will be completed by the Human Resources Director. The Administrator and Nurse Administration will be given the updated nursing schedule daily Monday - Friday (M-F)with Friday including a review of the weekend schedule , by the Staffing Secretary to review staffing prior to the day occurring and then the Nursing Secretary will turn in the staffing for each day the day after.<br><br>Sufficient nursing staff will be monitored by a daily check of the number of nursing staff to the number of residents to care for, by the Director of Nursing / Nurse Management. A monitoring tool has been developed that will be completed by the staffing secretary and reviewed by the Director Of Nursing / Nurse Management.<br><br>Results from the monitoring tools and nursing schedule review will be discussed weekly for 3 months and as needed thereafter during the morning QI meeting with identified issues or trends discussed further at the QA (Quality Assurance) meeting with the team and recommendations made as indicated.<br><br>The Administrator and DON are responsible for ongoing compliance to F725.<br><br>The completion date of 8/1/21. | |

| 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 07/02/2021 |

| 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 725 | Continued From page 53 | F 725 | | |

On 06/15/21 at 11:03 PM an interview was conducted with NA #10 and NA #11. NA #10 stated staffing was not good on her shift which was 11:00 PM to 7:00 AM. The NA stated she had residents on North, South and skilled and spent her time running from one hall to another and stated it was difficult to get care done for the residents when you were assigned to 22 residents. NA #10 and NA #11 explained they worked together to get at least 2 rounds of incontinence care done on the residents they were assigned and said it was not possible to do rounds every 2 hours as expected.

On 06/16/21 at 10:27 AM an interview was conducted with NA #12. The NA stated although she had other duties, she had been working on the floor lately due to so many open positions for NAs and not being able to secure help through Agencies. NA #12 described staffing as being good some days and bad some days. She stated on days when there were only 5 NAs they would have 14 to 15 residents and were not able to get all the showers done, were not able to get incontinence care done every 2 hours and could not get all the linens changed for the residents. NA #12 further stated the residents that require 2 staff assistance were the most difficult to get done with bathing and incontinence care.

On 06/16/21 at 10:37 AM an interview was conducted wit Nurse #6. The Nurse described staff as "terrible especially at night." She stated some of the NAs leave at 5:00 AM and there was not enough NAs to provide care to the residents.

| 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 07/02/2021 |

| 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 725 | Continued From page 54 | F 725 | | |

On 06/16/21 at 10:58 AM an interview was conducted with NA #4. The NA stated staffing was not good and said when NAs were assigned 18 to 20 residents, they could not complete incontinence rounds every 2 hours, give showers as scheduled and get residents up. She further stated it was very frustrating for the NAs and was not fair to the residents. NA #4 described a day last week in which they had 16 residents each and it was all they could do to keep them clean and dry. NA #4 indicated they were constantly asked to work over shift to cover holes in the schedule from not enough help to care for the residents.

On 06/16/21 at 11:47 AM an interview was conducted with the Nurse Schedule Coordinator (NSC). The NSC stated she did schedule at least a week out with assistance from the Director of Nursing (DON). The NSC explained for 1st shift she tried to staff shifts with the following for the current census of 88:

· Day shift: (7:00 AM to 7:00 PM) 5 to 6 Nurses
· 1st shift: (7:00 AM to 3:00 PM) 9 to 10 NAs
· 2nd shift: (3:00 PM to 11:00 PM) 7 to 9 NAs
· Night shift: (7:00 PM to 7:00 AM) 3 to 4 Nurses
· 3rd shift: (11:00 PM to 7:00 AM) 5 to 6 NAs

The NSC indicated there was usually a Nurse on call and said the Nurse usually had to come into work. She further indicated they were using one Agency to staff for Nurses and NAs and said they were using Agency daily. The NSC explained there was not enough staff employed by the facility to meet the staffing needs daily. She

| 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 07/02/2021 |

| 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 725 | Continued From page 55 | F 725 | | |

disclosed the facility was offering incentives to employees to work half and full shifts, weekends, weekdays and said they were getting a lot of participation with the incentives. According to the NSC, she has heard from the NAs they need more help and said 2nd shift was the most difficult shift to staff. The NSC advised staffing was based on the number of residents in the building, the acuity of the residents and the staffing pattern provided to her by administration.

On 06/16/21 at 2:09 PM an interview was conducted with NA #1. NA #1 stated she had not been able to do resident nails due to her "heavy load." NA #1 indicated there was not enough help on 1st shift to get showers done, get residents up and do incontinence care every 2 hours as expected and said it was not fair to the residents or the staff.

On 06/16/21 at 2:39PM an interview was conducted with NA #5. The NA stated there was not enough help or time in the day to get everything done for the residents when they were assigned 12 to 16 residents. NA #5 indicated the only way she could get showers done was to skip all her breaks and could only get 2 incontinence rounds done on the residents.

On 06/16/21 at 2:52 PM an interview was conducted with NA #2. The NA stated she had done a lot of double shifts at the facility. NA #2 further stated she could not do proper care when she had 18 to 20 residents. She indicated she was not able to get showers done and barely got 2 rounds of incontinence care done and said it

| 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 07/02/2021 |

| 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 725 | Continued From page 56 | F 725 | | |

was impossible to do incontinence rounds every 2 hours.

On 06/18/21 at 4:35 PM an interview was conducted with the Director of Nursing (DON). The DON described their staffing patterns as the following:

Nurse Aides: 7:00 AM to 3:00 PM - 1 NA for 10 residents
3:00 PM to 11:00 PM - 1 NA for 16 residents
11:00 PM to 7:00 AM - 1 NA for 22 residents

The DON indicated staffing patterns were based on census and acuity of residents and said she worked closely with the Nurse Staffing Coordinator (NSC) to ensure adequate staffing for the resident needs. She further indicated they were offering referral and sign-on bonuses, recruiting from colleges, advertise online with job sites, and are doing moral boosters for the current employees. According to the DON additional help did not always compute to more being done for the residents but stated her expectation was for residents to receive the care deserved and requested.

On 06/18/21 at 7:04 PM an interview was conducted with the Administrator. The Administrator stated they were trying to recruit Nurses and NAs and were offering sign on bonuses, incentives for working extra shifts, visiting colleges, and sending flyers to colleges. She further stated they had even tried to hire Medication Techs but stated they were competing

| 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 07/02/2021 |

| 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 725 | Continued From page 57<br>with salaries at the hospital and other facilities. The Administrator indicated they were trying to hire but the geographical area was difficult to find help and the salaries were challenging. She explained despite the difficulties with staffing, her expectation was for staff to provide the care requested and deserved to the residents and to request assistance from other staff as needed. | F 725 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and | F 755 | | 8/1/21 |

| 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 07/02/2021 |

| 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 755 | Continued From page 58<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations and interviews with staff and pharmacist, the facility failed to obtain an eye medication from the pharmacy for 1 of 4 residents (Resident #4) observed for medication administration.<br><br>The findings included:<br><br>Resident #4 was last re-admitted to the facility on 5/24/20 with diagnoses that included glaucoma.<br><br>The Physician's Order in Resident #4's medical record dated 6/3/21 indicated an active order for Latanoprost 0.005% eye drops - place 1 drop in each eye at bedtime for glaucoma.<br><br>An observation was made of Nurse #5 administering medications to Resident #4 on 6/15/21 at 10:10 PM. While Nurse #5 was pulling the medications off the medication cart, she stated that she could not find Resident #4's Latanoprost eye drops and would not be able to administer it as ordered for that time.<br><br>An interview with Nurse #5 on 6/15/21 at 10:25 PM revealed the nurse who worked the night before might not have ordered Resident #4's Latanoprost which could have been why it was not available. Nurse #5 stated she would fax a refill request to the pharmacy so it would be filled the next day.<br><br>A phone interview with Nurse #8 on 6/18/21 at | F 755 | White Oak of Shelby provides routine drugs for the residents as prescribed by the Physician.<br><br>Resident #4's eye drops are available and being administered per physician's order.<br><br>An audit of all residents with order for eye drops was completed to verify that the eye drops were available and in the medication cart. This audit was completed by the Corporate Nurse Consultant on 7/9/21.<br><br>The licensed nurse staff were re-educated on how to order/refill eye drops from the pharmacy by Nurse Management or the Consultant Pharmacist and will be completed prior to 8/1/21.<br>Newly hired nurses will receive this education during their job specific orientation with the SDC or Nurse Management.<br><br>The Consultant Pharmacist / Nurse Consultant will monitor by checking the medication carts for availability of eye drops for 5 residents with eye drop orders weekly for 4 weeks, then 4 residents with eye drop orders weekly for 4 weeks, then 3 residents with eye drop orders weekly for 4 weeks and randomly thereafter to assure compliance to F755. | |

| 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 07/02/2021 |

| 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 755 | Continued From page 59<br>2:44 PM revealed she worked with Resident #4 on 6/16/21 and 6/17/21 but did not remember being able to administer Latanoprost to Resident #4 because it was not available. Nurse #8 stated she might have but could not remember for sure if she re-ordered the eye medication. She added she did not use the back-up pharmacy because they had a cut-off time of 6:00 PM. If a medication was needed after 6:00 PM, any request would have been brought in with the next delivery day.<br><br>To follow up on Resident #4's Latanoprost eye drop availability, an interview was made with Nurse #6 who worked day shift on 6/18/21 at 9:40 AM. She stated she could not find Resident #4's Latanoprost in the medication cart. She also looked for it in the medication refrigerator in case they had left it there after being delivered from the pharmacy but did not find any that belonged to Resident #4. Nurse #6 stated she was not aware that Resident #4's Latanoprost had not been available and nothing was relayed to her about it during report. Nurse #6 stated she was going to call pharmacy to find out if it was going to get delivered that day.<br><br>A phone interview with the pharmacist on 6/18/21 at 10:27 AM revealed they last sent a 25-day supply of Latanoprost eye drops for Resident #4 on 5/31/21 and she would have been close to running out as of 6/15/21. The pharmacist stated they received a refill request on 6/15/21 at 10:30 PM but they faxed a notice back to the facility on 6/16/21 at 9:31 PM that it was too soon to refill. The next refill date was set for 6/23/21 but they never received a phone call from the facility that they needed the Latanoprost eye drop for Resident #4 or that she was already out. The | F 755 | Results of the eye drop availability checks will be discussed during the morning QI meeting weekly for 3 months and periodically thereafter, with the committee making recommendations for system changes as indicated.<br><br>The DON is responsible for ongoing compliance to F755<br><br>The completion date of 8/1/21. | |

| 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 07/02/2021 |

| 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 755 | Continued From page 60<br>pharmacist stated if a nurse had called them to request a medication that was too soon to refill, they would have filled it anyway and just charged it to the facility if they needed the medication right away. The pharmacist added that she was going to call the facility to find out if they needed to send the medication with the routine delivery for the day.<br><br>An interview with the Director of Nursing (DON) on 6/18/21 at 5:21 PM revealed the facility used another local pharmacy for back-up for medications that were needed immediately, and the nurses should have ordered it right away so that Resident #4 would not miss a dose of her Latanoprost eye drops. The nurses should have followed-up with pharmacy if a medication that they ordered did not come on the next delivery day. The DON was also not aware that the pharmacy had faxed a notice to the facility that it was too soon to refill but the nurses should have seen this come through in the main fax machine.<br><br>An interview with the Administrator on 6/18/21 at 6:10 PM revealed the nurses should have re-ordered Resident #4's eye medication and followed up on the order to make sure it had been delivered from the pharmacy. | F 755 | | |
| F 759 SS=E | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by: | F 759 | | 8/1/21 |

| 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 07/02/2021 |

| 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 759 | Continued From page 61<br>Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by failure to administer 3 medications according to physician's orders, omission of 1 medication and wrong dose administered for 1 medication. These errors constituted 5 out of 32 opportunities, resulting in a medication error rate of 15.63% for 3 of 4 residents (Residents #6, Resident #4, and Resident #31) observed during medication administration.<br><br>The findings included:<br><br>1. Resident #6 was last re-admitted to the facility on 12/28/20 with diagnoses that included hypertension and congestive heart failure.<br><br>A Physician's Order in Resident #6's medical record dated 1/20/21 indicated an active order for Metoprolol 25 mg (milligrams) ½ tablet (12.5 mg) by mouth twice daily for hypertension; do not crush, hold if systolic blood pressure <100, record blood pressure.<br><br>An observation was made of Nurse #5 on 6/15/21 at 9:50 PM while she was administering medications to Resident #6. Nurse #5 was observed as she pulled Resident #6's pills and placed them on one medication cup. Included in the medications was his Metoprolol 12.5 mg pill. Nurse #5 entered Resident #6's room, woke him up and gave the medication cup to him. Resident #6 proceeded to place the pills in his mouth, took a sip of water and swallowed his medications. Nurse #5 then placed a blood pressure wrist cuff on Resident #6's right wrist and took his blood pressure. Nurse #5 stated that Resident #6's blood pressure was 140 systolic and 76 diastolic. | F 759 | White Oak of Shelby ensures that the Medication error rates are not 5 percent or greater.<br><br>Resident #6 will have their BP (blood pressure) checked prior to administering the Metoprolol, as per doctor's order. Resident #4 will receive the Latanoprost eye drops per doctor's order and are available on the medication cart. They will receive the correct dosage of Lactulose per doctor's order. And they will receive the Bacitracin-Polymyxin eye ointment in the eye that is ordered by the doctor. Resident #31 will receive the Dorzolamide-Timolol eye drops to their Rt. eye only per the doctor's order.<br><br>All residents who receive medications will receive their medications following physician's orders.<br><br>The licensed nurses were re-educated on following doctor's orders when administrating medications by the Consultant Pharmacist and/or Nurse Management. The re-education consist of the 6 medication rights which includes the right medication, right time, right dose, right resident, right route, and right documentation. The re-education also included using the EMAR (electronic medication to guide prep of medication and will be completed prior to 8/1/21. Newly hired nurses will receive this education during their job specific orientation with the SDC or Nurse Management. | |

| 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 07/02/2021 |

| 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 759 | Continued From page 62<br><br>An interview with Nurse #5 on 6/15/21 at 10:09 PM revealed she forgot to check Resident #6's blood pressure prior to giving him his Metoprolol pill. Nurse #5 stated she remembered she had to check his blood pressure right after Resident #6 placed all the pills in the medication cup into his mouth and it was too late by then. Nurse #5 further stated that if Resident #6's blood pressure was below 100 systolic, she would have monitored his blood pressure more frequently.<br><br>An interview with the Director of Nursing (DON) on 6/18/21 at 5:21 PM revealed Nurse #5 should have paid more attention to the directions in Resident #6's Metoprolol order and checked his blood pressure prior to administering his Metoprolol. She should have notified the physician of any medication errors especially if after administering Resident #6's Metoprolol dose, Nurse #5 found out that his blood pressure was lower than 100 systolic.<br><br>2. Resident #4 was last re-admitted to the facility on 5/24/20 with diagnoses that included corneal ulcer, glaucoma, and constipation.<br><br>The Physician's Orders in Resident #4's electronic medical record indicated the following active orders:<br>a. 5/27/20 - Bacitracin-Polymyxin eye ointment - apply ¼ inch ribbon to right eye every morning and at bedtime for corneal ulcer<br>b. 1/20/21 - Lactulose 10 gm (grams)/15 ml (milliliters) - take 2 tablespoonfuls (30 ml) by mouth three times a day for constipation<br>c. 6/3/21 - Latanoprost 0.005% eye drops - place 1 drop in each eye at bedtime for glaucoma | F 759 | The Consultant Pharmacist will observe and educate the 2 nurses who made the medication errors, Nurse #4 and Nurse #5, this will be completed by 7/12/21.<br><br>The Consultant Pharmacist and/or the Nurse Consultant will monitor by observing 5 nurses during medication administration weekly for 4 weeks, 3 nurses weekly for 4 weeks, then 2 nurses weekly for 4 weeks and randomly thereafter during routine visits, to assure ongoing compliance to F759.<br><br>Results of the medication administration observations will be discussed during the morning QI meeting weekly for 3 month and periodically thereafter, with the committee making recommendations for system changes as necessary.<br><br>The DON is responsible for ongoing compliance to F759.<br><br>The completion date of 8/1/21. | |

| 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 07/02/2021 |

| 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 759 | Continued From page 63 | F 759 | | |

An observation was made of Nurse #5 administering medications to Resident #4 on 6/15/21 at 10:10 PM. While Nurse #5 was pulling the medications off the medication cart, she stated that she could not find Resident #4's Latanoprost eye drops and would not be able to administer it as ordered for that time. Nurse #5 proceeded to pour Resident #4's Lactulose into a cup and measured 10 ml into a medication cup. Nurse #5 entered Resident #4's room while carrying her pills in a medication cup, Lactulose in a separate medication cup and Bacitracin eye ointment. Nurse #5 administered Resident #4's pills first in applesauce, then gave her the 10 ml Lactulose cup and gave her a cup of water to drink. Nurse #5 proceeded to administer Resident #4's Bacitracin eye ointment into her left lower eyelid and then into her right lower eyelid.

An interview with Nurse #5 on 6/15/21 at 10:25 PM revealed the nurse who worked the night before might not have ordered Resident #4's Latanoprost which might have been why it was not available. Nurse #5 stated she would fax a refill request to the pharmacy so it would be filled the next day. Nurse #5 also stated she placed Resident #4's Bacitracin ointment into both eyes because this was what Resident #4 wanted her to do. Nurse #5 also said she got confused regarding Resident #4's Lactulose order and should have read the label before she assumed what the dose was.

An interview with the Director of Nursing (DON) on 6/18/21 at 5:21 PM revealed Nurse #5 should have given Resident #4 the correct dose of Lactulose and followed the order for the Bacitracin ointment. The DON stated the facility used another local pharmacy for back-up for

| 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 07/02/2021 |

| 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 759 | Continued From page 64 | F 759 | | |

medications that were needed immediately, and the nurses should have ordered it right away so that Resident #4 would not miss a dose of her Latanoprost eye drops.

3. Resident #31 was last re-admitted to the facility on 4/9/18 with diagnoses that included glaucoma.

A Physician's Order dated 6/20/20 in Resident #31's medical record indicated an active order for Dorzolamide-Timolol eye drops - place 1 drop into right eye twice a day for glaucoma.

An observation was made of Nurse #4 administering medications to Resident #31 on 6/16/21 at 10:45 AM. Nurse #4 was observed administering Resident #31's Dorzolamide eye drops to both eyes instead of just the right eye.

An interview with Nurse #4 on 6/16/21 at 3:23 PM revealed she got nervous while being observed by the surveyor during medication administration and failed to read the order for Dorzolamide and note that it was just for the right eye. Nurse #4 stated she knew as soon as she dropped it into Resident #31's left eye that she just made a medication error.

An interview with the Director of Nursing (DON) at 6/18/21 at 5:21 PM revealed she was informed by Nurse #4 right after she made the medication error regarding Resident #31's Dorzolamide eye drops. The DON stated she expected the nurses to follow the medication orders as prescribed by the physician.

An interview with the Administrator on 6/18/21 at 6:10 PM revealed it was her expectation that

| 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 07/02/2021 |

| 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 759 | Continued From page 65<br>medications should be given by the nurses as ordered by the physician. | F 759 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported; | F 880 | | 8/1/21 |

| 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 07/02/2021 |

| 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 880 | Continued From page 66<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations and staff interviews, the facility failed to implement the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 2 staff members (Nurse #1) wore a surgical mask while in quarantine rooms, 1 of 2 staff members (Nurse | F 880 | White Oak of Shelby ensures to implement and maintain an infection prevention and control program and policies designed to provide safe, sanitary and comfortable environment and help prevent the development and transmission of communicable disease. | |

| 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 07/02/2021 |

| 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 880 | Continued From page 67<br>Aide (NA) #6) took her N95 mask off and placed it in her uniform pocket after exiting a quarantine room, 1 of 3 quarantine rooms had no signage on the door indicating the resident was on enhanced contact/droplet isolation and 2 of 3 isolation rooms had "Modified Precautions" signs on the door instead of enhanced droplet/contact precautions. These practices affected 3 of 3 residents (Resident #62, Resident #294, and Resident #295) reviewed for infection control. In addition, 1 of 1 staff member (Nurse #7) failed to disinfect a glucometer according to manufacturer's recommendations for 1 of 1 resident (Resident #55) observed for glucometer use. These failures occurred during a COVID-19 pandemic.<br><br>The findings included:<br><br>The Centers for Disease Control and Prevention (CDC) guideline entitled, "Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccinations," updated on 04/27/21 read under section 5. Use of Personal Protective Equipment: "Recommendations for use of personal protective equipment by health care personnel remain unchanged."<br>The Centers for Disease Control and Prevention (CDC) guideline entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/23/21 indicated, in part:<br>*The PPE (Personal Protective Equipment) recommended when caring for a patient with suspected or confirmed COVID-19 includes the following:<br>1. Respirator - Put on an N95 respirator (or | F 880 | Nurse #1 who was observed wearing a surgical mask while in the quarantine rooms was re-educated on the proper PPE to worn by the DON on 6/29/21.<br><br>Nurse Aide (NA) #6 who was observed taking off her N95 mask and placing it in her uniform pocket after exiting a quarantine room was an agency staff and only worked that evening of 6/15/21, and will not be returning to work at the facility.<br><br>When the observation of the missing Precaution signage and incorrect Precaution signage was reported to the facility on 6/18/21, the facility immediately posted the Enhanced Contact/Droplet Precaution signage on the 3 resident room doors.<br><br>The facility also audited and checked the other residents that were on contact precautions for proper signage to ensure the signs were posted on 6/18/21 by the Infection Preventionist.<br><br>Nurse #7 who did not disinfect a glucometer according to manufacturer's recommendation was re-educated on properly disinfecting glucometers by the DON on 6/18/21.<br><br>The current licensed nurses were re-educated on the implementation of the CDC guidelines for the use of PPE and signage which include the use of the N95 mask in the quarantine rooms, proper doffing of the N95 masks when exiting a | |

| 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 07/02/2021 |

| 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 880 | Continued From page 68<br>equivalent or higher-level respirator) before entry into the patient room or care area, if not already wearing one as part of extended use strategies to optimize PPE supply. Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or re-use. Perform hand hygiene after removing the respirator or facemask.<br>2. Eye Protection - Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. Remove eye protection after leaving the patient room or care area, unless implementing extended use. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or re-use.<br><br>A review of the facility's COVID-19 Plan revealed the following guidance:<br>COVID-19 Status:<br>Fully vaccinated (and no known exposure past 14 days) or positive including history of medically resolved COVID-19 in less than 90 days: green zone or general population<br><br>Negative or unknown or resolved positive longer than 90 days and NOT fully vaccinated: yellow zone to include private room on 14 day observation and *enhanced droplet/contact isolation.<br><br>Active diagnosis of COVID-19 symptomatic or NOT medically resolved: red zone to include | F 880 | quarantine room, displaying the proper Enhanced Contact/Droplet Precaution signage on resident room door when in quarantine, and following manufacturer's recommendation for properly disinfecting the glucometer.<br><br>The Nurse Aides (NAs) were also re-educated on the implementation of the CDC guidelines for the use of PPE and signage which include the use of the N95 mask in quarantine rooms and proper doffing of the N95 mask when exiting a quarantine room, and following the proper Enhanced Contact/Droplet Precaution signage when residents are in quarantine. The re-education will be completed by the DON prior to 8/1/21.<br><br>Newly hired nursing staff receive this education during their job specific orientation by Nurse Management.<br><br>Residents on Enhanced Contact/Droplet Precautions will be monitored for appropriate signage on door, and by observing 5 nursing staff donning and doffing proper PPE weekly for 4 weeks, then 3 nursing staff weekly for 4 weeks, then 2 nursing staff weekly for 4 weeks. The monitoring will include newly admitted residents on Enhanced Contact/ Droplet Precautions. The monitoring will be completed by the Nurse Management.<br><br>Residents that a glucometer is used for will be monitored by observing 5 opportunities for disinfecting the glucometer weekly for 4 weeks, then 3 | |

| 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 07/02/2021 |

| 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 880 | Continued From page 69<br>private room or cohort with another positive and *enhanced droplet/contact isolation.<br><br>*Enhanced droplet/contact isolation requires the following Personal Protective Equipment (PPE): gown, gloves, eye protection and N95 mask. Enhanced droplet/contact precautions signage is required on the room door.<br><br>Upon entry to the facility on 06/14/21 during the entrance conference the Administrator identified the 400 hall as the quarantine hall for new admissions/readmissions whose COVID-19 status was unknown (residents admitted who were not vaccinated).<br><br>1. A continuous observation was made of the quarantine hall for new admissions/readmissions on 06/15/21 from 8:45 PM to 9:20 PM. There were 8 residents on one side of the hall and 5 residents on the other side of the hall. Of the 8 residents, there were 3 residents whose COVID status was unknown according to their medical record. The unknown status was attributed to the residents not being vaccinated and they had been placed on "modified precautions." Nurse #1 and Nurse Aide (NA) #6 were assigned to care for all the residents on the quarantine hall for new admissions and readmissions. During the observation, a sign for "Modified Precautions" was on the door of 2 residents - Resident #294 and Resident #295. There were caddies on the resident doors with surgical masks, gloves and gowns in the caddies. There was also a sign on the door demonstrating the appropriate donning of Personal Protective Equipment (PPE). There was a sign on Resident #62's door stating an aerosolizing procedure had been done and anyone entering must be wearing an N95 mask. | F 880 | opportunities weekly for 4 weeks and then 2 opportunities weekly for 4 weeks. The monitoring will also include newly admitted residents that a glucometer is used for. The monitoring will be completed by the Nurse Management.<br><br>Results from the monitoring will be discussed weekly for 3 months during the morning QI meeting and identified issues and trends will further be discussed at the QA meeting with the team and recommendation made as indicated.<br><br>The DON is responsible for ongoing compliance to F880.<br><br>The completion date of 8/1/21. | |

| 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 07/02/2021 |

| 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 880 | Continued From page 70 | F 880 | | |

There was no other sign on Resident #62's door; however, there was a caddie on the door containing surgical masks, gowns and gloves. Nurse #1 was wearing a surgical mask at the time of the observation and NA #6 was wearing an N95 mask. Nurse #1 was observed going between "Modified Precautions" rooms (room 420 and room 422) and a room with a resident who was not on precautions (room 419) wearing the same surgical mask and did not change her mask when going into the "Modified Precautions" rooms. Nurse #1 did have a face shield on and cleaned the face shield with a sanitizing wipe in between resident rooms and placed the clean shield on a pole on her medication cart. At 9:08 PM NA #6 was observed going into Resident #62's room to deliver her some water and snacks with her N95 mask and face shield on. When NA #6 exited Resident #62's room at 9:20 PM she took off her face shield and cleaned it with a sanitizing wipe, and proceeded to take off her N95 mask and put the mask in the front pocket of her uniform top instead of discarding it in the trash can inside the resident's room. She then placed a surgical mask on her face and told Nurse #1 she was going to take her dinner break.

An interview conducted with Nurse #1 on 06/15/21 at 9:03 PM revealed she wore a surgical mask, face shield or goggles, gown and gloves into the "Modified Precautions" rooms and cleaned her goggles or face shield in between residents. She stated she had been instructed to wear just a surgical mask in the quarantine rooms because the residents were "just on modified precautions and not enhanced droplet/contact precautions."

An interview conducted with NA #6 on 06/15/21 at

| 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 07/02/2021 |

| 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 880 | Continued From page 71 | F 880 | | |

10:00 PM revealed she wore the same N95 mask into all the rooms on "modified precautions." She stated she removed the N95 mask and placed in the front pocket of her uniform and put on a surgical mask when going in the rooms that were not on precautions. NA #6 further stated there were additional N95 masks available at the nurse's station if she needed another mask.

An interview with the facility's Infection Preventionist (IP) and Director of Nursing on 6/18/21 at 5:40 PM revealed Nurse #1 should have worn an N95 into all resident rooms who were on modified precautions due to their unknown COVID status. The IP indicated "modified precautions" meant the staff had to wear a gown, gloves, goggles or face shield and N95 mask when entering the room. She further indicated prior to leaving the room, the staff were supposed to take the gloves, gown and mask off and discard them in the trash can inside the resident's room and sanitize their goggles or face shield with a sanitizing wipe once they have exited the resident's room. The IP explained the gloves, gown and mask were all one time use and should be discarded prior to leaving the patient's room on modified precautions. She further explained the staff could put on a surgical mask for source control provided they were going into a room where the resident was not on precautions. According to the IP and the DON there were adequate supplies of all PPE needed and the PPE should be discarded after each use except for the goggles or face shield which can be reused. The DON stated they were aware the modified precautions stated "medical surgical mask at a minimum" but said all staff had been trained to wear an N95 mask in resident rooms who were on precautions due to unknown

| 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 07/02/2021 |

| 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 880 | Continued From page 72 | F 880 | | |

COVID-19 status. The DON further stated the "Modified Precautions" signs had been provided to them by their corporate nurse consultant so that is what they had been using to designate residents on precautions for 14 days. The IP stated Nurse #1 and NA #6 should have discarded their N95 mask and surgical mask after exiting each resident's room and sanitized their goggles or face shield with sanitizing wipes after exiting each resident room.

An interview with the Administrator on 06/18/21 at 7:10 PM revealed she expected Nurse #1 and Nurse Aide #6 to follow the protocol for wearing appropriate PPE on the quarantine hall when caring for new admissions and readmissions whose COVID status was unknown. She stated she also expected the appropriate signage to be posted on the resident rooms under quarantine for 14 days.

2. A review of the facility's glucometer manufacturer's recommendations dated 12/2017 indicated the following cleaning and disinfecting guidelines:
* Cleaning and disinfecting can be completed by using a commercially available EPA (Environmental Protection Agency)-registered disinfectant detergent or germicide wipes.
* To use a wipe, remove from container and follow product label instructions to disinfect the meter. Take extreme care not to get liquid in the test strip and key code ports of the meter.
* Many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used; use one wipe to clean and a second wipe to disinfect.

| 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 07/02/2021 |

| 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 880 | Continued From page 73 | F 880 | | |

A review of the facility's disinfectant/bleach wipe product label instructions last updated on 2/29/20 included the following:
* Repeated use of the product may be required to ensure that the surface remains visibly wet for 3 minutes at room temperature. For use as a disinfectant: use a second disinfectant towelette to thoroughly wet the surface.
* Allow to air dry after wiping the surface and prior to using the meter again or storing it.

A review of the facility's policy entitled, "Fingerstick Blood Sugar," revised on 5/15/20 indicated the following information:
* Clean the glucometer with one wipe and discard.
* Cover glucometer with a clean wipe for 3 minutes and place on clean barrier.
* After 3 minutes, remove bleach wipe, place glucometer on a clean barrier (i.e., paper towel), and allow to dry prior to using again and/or storing in medication cart.

An observation was made of Nurse #7 checking Resident #55's blood sugar on 6/18/21 at 11:55 AM. Nurse #7 cleaned Resident #55's left third finger with an alcohol prep, punctured the fingertip with a lancet and placed a drop of blood on the glucometer strip that was inserted in the glucometer. Nurse #7 applied pressure to Resident #55's left third finger until it stopped bleeding and then proceeded to exit Resident #55's room while carrying the glucometer and other supplies she used to check Resident #55's blood sugar. Nurse #7 went back to her medication cart, placed the glucometer on top of the medication cart and discarded the test strip along with her gloves and the lancet into the sharps container. Nurse #7 used hand sanitizer

| 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 07/02/2021 |

| 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 880 | Continued From page 74 | F 880 | | |

to both hands and placed the glucometer back into its original box and into the third drawer in the medication cart. When Nurse #7 was asked if she was not going to disinfect the glucometer, Nurse #7 stated she forgot and got the glucometer out of the box and set it back on top of the medication cart. Nurse #7 put on gloves to both hands, pulled out a bleach wipe out of the product container and started to wipe the glucometer front and back. She placed the glucometer onto a clean paper towel, covered it with another clean paper towel and then started patting it to dry.

An interview with Nurse #7 on 6/18/21 at 12:11 PM revealed she covered the glucometer with a paper towel and started patting it to dry because the bleach wipe was too strong and the fumes from it were making her eyes water. When the product label was reviewed with Nurse #7, she found out that it was recommended to let it air dry after wiping the bleach wipe on the glucometer.

An interview with the Director of Nursing (DON) and the Infection Preventionist (IP) on 6/18/21 at 5:53 PM revealed Nurse #7 should have followed the manufacturer's recommendations for both the glucometer and the bleach wipes, and she should have let it air dry instead of patting it dry with a paper towel.