STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345151	A. BUILDING _____ B. WING _____	C 01/06/2022

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WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET KINGS MOUNTAIN, NC 28086

(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 An unannounced Recertification survey was conducted on 1/3/22 through 1/6/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# Q8F211	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation survey was conducted on 1/3/22 through 1/6/22. 1 of 7 allegations was substantiated. Event ID# Q8F211.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		2/4/22

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

Electronically Signed | 01/25/2022

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to treat a resident in a dignified manner by not changing a soiled diarrhea brief after the resident rang her call light for incontinence assistance for 1 of 2 residents reviewed for dignity and respect (Resident #97). This made the resident feel like the staff did not care about her and was humiliating to her that she and Resident #107 had to smell the odor until she was cleaned and changed. The findings included: Resident #97 was admitted to the facility on 05/11/21. Review of Resident #97's quarterly Minimum Data Set (MDS) assessment dated 11/19/21 revealed she was cognitively intact for daily decision making and required extensive	F 550	White Oak Manor-Kings Mountain ensures residents are treated with respect and dignity which includes to treat residents in a dignified manner by providing timely incontinence care. Resident #97's report of call light being turned off and incontinence care not completed was further investigated. Resident #97 continues to have her call light answered and changed when needing care. Resident #97 was also followed up with Social Services on 1/24/2022 regarding dignity and respect to ensure resident does not feel humiliated and embarrassed. An Audit of current interviewable residents requiring incontinence care will be completed by 1/25/22 by the Social Services (SS) Department. The audit consist of interviews with residents requiring incontinence care with regards	

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F 550	Continued From page 2 assistance of 2 staff with toileting. The MDS also revealed Resident #97 was always incontinent of bowel. Review of Resident #97's care plan dated 11/22/21 revealed she had a plan of care for being incontinent of bladder and bowel due to decreased mobility and was at risk for the development of pressure areas and moisture associated skin issues. The interventions included answer call light promptly for assistance with incontinence care. Observation and interview on 01/03/22 at 1:28 PM with Resident #97 revealed her lying in bed dressed for the day and stated, "I have been better." Resident #97 explained that around 5:00 AM this morning she had a "bout of explosive diarrhea." The resident stated she put on her call light and Nurse Aide (NA) #5 came in and turned her light off and stated she would be back as soon as she was finished with another resident. Resident #97 further stated she waited for NA #5 to return and put her call light on again and NA #4 came in at 7:30 AM and changed her. Resident #97 indicated she knew the times because she had looked at the clock in her room when she put her call light on and when she was changed. Her roommate agreed Resident #97 had waited to be changed because she was awake and could smell her diarrhea and said she had looked at the clock also. Resident #97 stated it made her feel like the staff did not care about her when NA #5 never came back to change her and stated it was humiliating to her that her roommate and she had to smell the diarrhea until she was changed. Interview on 01/03/22 at 1:45 PM with Resident #107 who was the roommate of Resident #97	F 550	to call lights being answered and not turned off until care is completed, and feeling dignified by being provided timely incontinence care. An audit including the other residents that cannot be interviewed will be randomly observed to ensure no odors of bowel movement and resident appearance to determine comfort and cleanliness. This audit will be completed on 1/26/22 by Nursing Supervisor. Current and new residents will be treated with dignity and respect, and call lights will continue to be answered and incontinence care will be provided in a timely manner. Facility staffing including Licensed Nurses and Nursing Assistants will receive re-education on treating residents with dignity and respect; call lights will be answered in a timely manner and it will not be turned off until the residents' needs are met; and particularly for the nursing staff regarding incontinence care including bowel movements will be completed in a timely manner to ensure residents are changed and clean, no lingering smell of bowel movements, ensuring residents feel that they are treated in a dignified manner. The re-education will be completed by the Staff Development (SDC) prior to 2/4/22. Newly hired facility staff will receive this education during their job specific orientation by the SDC. Nursing Administration (Director of Nursing (DON), SDC and Nursing Supervisor) will monitor by conducting observations over random shifts of residents being checked for incontinence care in a timely manner. Nursing	

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F 550	Continued From page 3 revealed she was cognitively intact and was also awake and remembered the resident putting on her light to be changed. Resident #107 stated NA #5 came in and turned off the resident's call light and told Resident #97 she would be back to assist her with incontinence care. Resident #107 stated NA #5 never came back and NA #4 came in around 7:30 AM and changed her. Resident #107 stated they both had to sit and smell the diarrhea until NA #4 came in to change Resident #97. Phone interview on 01/04/22 at 4:47 PM with NA #5 revealed she had been assigned to care for Resident #97 on the 7:00 PM to 7:00 AM shift on 01/03/22 to 01/04/22. NA #5 stated Resident #97 had diarrhea during her shift several times and stated she had changed her each time. NA #5 further stated she could not recall the time but stated the last time she had changed the resident she was just wet and had not had a bowel movement. NA #5 indicated she did not recall going in the room and turning off the resident's call light around 5:00 AM. Interview on 01/03/22 at 3:48 PM with NA#4 revealed she was taking care of Resident #97 during the 7:00 AM to 7:00 PM shift on 01/03/22. NA #4 stated she had been late this morning arriving at 7:30 AM and noticed Resident #97's call light was on, so she went straight into her room. According to NA #4, Resident #97 had had a diarrhea accident in her brief, so NA #4 stated she went ahead and changed her. She said the resident had not messed up her draw sheet or bed, so she got her cleaned up and changed her brief. NA #4 stated Resident #97 had told her she had put her light on at 5:00 AM this morning to be changed and NA #5 had turned her light off	F 550	Administration will complete 10 observations weekly for 4 weeks, then 5 observations for 4 weeks, then 3 observations for 4 weeks, and as needed thereafter. The SS Department will monitor by conducting observations during random shifts of call lights turned on by the residents and timeliness of incontinent care being completed. Observations will also include any indication of incontinent bowel odors. The SS Department will complete 10 observations weekly for 12 weeks. The SS Department will also monitor by conducting interviews with residents that require incontinence care regarding timeliness of call lights being answered and feeling dignified when provided with incontinence care. The SS Department will complete 5 resident interviews weekly for 12 weeks. Results from the monitoring will be discussed during monthly Quality Assurance (QA)meeting with team and recommendations made as indicated. The Administrator, DON, SS Director are responsible for the ongoing compliance of F550. The completion date for compliance is 2-4-2022.	

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F 550	Continued From page 4 and never came back to change her. NA #4 stated the resident had told her it made her feel like the staff didn't care about her and embarrassed the resident that she and her roommate had to smell the diarrhea until she was changed. Interview on 01/06/22 at 3:33 PM with the Director of Nursing (DON) revealed the administrative staff held meetings with the Nurses and the NAs at least monthly and as needed. The DON stated they had high expectations for their Nurses and NAs providing care to the residents. The DON further stated he expected the NAs or Nurses to meet the needs of the residents prior to turning off their call light. Interview on 01/06/22 at 4:14 PM with the Administrator revealed she expected residents with a smell of bowel movement to be changed by staff. The Administrator stated she expected the staff to monitor call lights and answer them in a timely manner. She further stated they had done sensitivity training for the NAs and their expectation was for residents who were incontinent to be checked on every 2 hours or as needed. The Administrator indicated there may be residents that require even more frequent monitoring and she expected them to change residents as needed, prior to going to activities and especially prior to going out for an appointment.	F 550		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the	F 638		2/4/22

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F 638	Continued From page 5 quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews with staff, the facility failed to complete two Elopement Risk Tool assessments for a resident with a history of exit seeking and wandering behaviors for 1 of 5 residents reviewed for accidents (Resident #38). The findings included: Resident #38 was admitted to the facility on 04/30/21 with multiple diagnosis which included non- Alzheimer's dementia and anxiety. Resident #38's Elopement Risk Tool assessment completed on 05/04/21 indicated Resident #38 had a history of wandering at home. The assessment revealed Resident #38 had recent exit-seeking/wandering behaviors. Resident #38's assessment summary included an order for an alarm bracelet and placement in a secured unit. Further review of the medical record revealed there no Elopement Risk Tool Assessments completed after 05/04/21. A nursing progress note dated 07/31/21 revealed Resident #38 was noted to be wandering in the corridor and into other residents' rooms. Resident #38's quarterly Minimum Data Set (MDS) dated 08/04/21 revealed Resident #38 was severely cognitive impaired requiring extensive assistance with activities of daily living (ADL). Resident #38 was not coded for any wandering behaviors in the facility during the	F 638	White Oak Manor- Kings Mountain ensures quarterly assessments are completed at least every 3 months. The Social Services (SS) staff are convinced they completed the assessments but the 2 assessments were missing. An updated Elopement Risk Tool assessment for resident #38 was completed on 1/5/2022 by the Social Service Director (SSD). Resident #38 Minimum Data Set (MDS) dated 8/4/21 and 11/4/21 was reopened, modified and corrected to reflect the wandering and pacing behaviors on 1/5/2022 by the Resident Assessment Coordinator. An audit was completed on 1/5/2022 of current residents with a history of exit seeking and wandering behaviors to ensure the Elopement Risk Tool Assessment was done. Audit was done by the Social Service Director (SSD). Newly admitted residents will continue to have an Elopement Risk Tool assessment completed to determine and identify residents at risk for exit seeking and wandering behaviors. The re-education also includes MDS accuracy for wandering and pacing behaviors. This re-education was completed by the Social Service Director (SSD) on 1/11/2022. Newly hired SS staff will receive this education during their job specific	

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F 638	Continued From page 6 assessment period. A nursing progress note dated 10/31/21 revealed Resident #38 was pacing up and down the resident halls Resident #38's quarterly MDS dated 11/04/21 revealed she was not coded for any wandering behaviors. An interview conducted with the Social Services Director (SSD) on 01/05/21 at 11:31 AM revealed the elopement risk tool was to be completed quarterly along with the MDS. She stated Resident #38's last elopement risk tool was completed on 05/04/21. The interview revealed the elopement risk tool was not completed timely and should have been with the quarterly MDS on 08/04/21 and 11/04/21. She stated she felt like she had entered it, but it must have not saved in the computer system. An interview with the Director of Nursing on 1/6/22 at 2:42 PM revealed he wasn't sure how often the elopement risk tool was supposed to be completed. He stated the reason for Resident #38's elopement risk tool assessment not being updated was probably an oversight. An interview with the Administrator on 01/06/22 at 4:04 PM revealed the elopement risk tool should be completed quarterly. She stated she had called the corporate office to ensure the assessment had not been completed and it hadn't. The interview revealed the SSD thought she might have entered the information and did not save it in the computer system.	F 638	orientation with the Corporate SS Consultant or SSD. The SSD will monitor by reviewing 3 residents weekly for 12 weeks for completion of Elopement Risk Tool assessment and accuracy of MDS coding for wandering and pacing behaviors. Identified trends will be discussed in Morning Quality Improvement (QI) meeting for 12 weeks and as needed thereafter. Any identified issues will be further discussed during monthly Quality Assurance (QA) meeting with team and recommendations made as indicated. The SSD is responsible for the ongoing compliance of F638. The completion Date for Compliance will be 2/4/2022.	
F 641 SS=E	Accuracy of Assessments	F 641		2/4/22

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F 641	Continued From page 7 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to ensure the Minimum Data Set (MDS) was accurate for 2 of 3 residents reviewed for wandering (Resident # 38 and Resident #13), 1 of 2 residents reviewed for pacing (Resident #38), 1 of 1 resident reviewed for range of motion (Resident #79) and 1 of 1 resident reviewed for Hospice (Resident #110). The findings included: 1.a. Resident #38 was admitted to the facility on 04/30/21 with multiple diagnosis which included non- Alzheimer's dementia and anxiety. A nursing progress note dated 07/31/21 revealed Resident #38 was noted to be wandering in the corridor and into other residents' rooms. Resident #38's quarterly Minimum Data Set (MDS) dated 08/04/21 revealed Resident #38 was severely cognitive impaired requiring extensive assistance with activities of daily living (ADL). Resident #38 was not coded for any wandering behaviors in the facility during the assessment period. b. A nursing progress note dated 10/31/21 revealed Resident #38 was pacing up and down the resident halls.	F 641	White Oak Manor- Kings Mountain ensures the accuracy of assessments. The Social Services (SS) Department and Resident Assessment Coordinator (RAC) inaccurately coded for wandering, pacing. Range of Motion (ROM), and Hospice. The inaccuracy was made in error or due to an oversight. Resident #38's Minimum Data Set (MDS)dated 8/4/2021 and 11/4/2021 was reopened, modified and corrected to reflect the wandering and pacing behaviors on 1/5/2022 by the resident Assessment Coordinator (RAC). Resident #13's MDS dated 10/7/21 was reopened, modified and corrected to reflect wandering behavior on 1/24/2022 by the RAC. Resident #79 MDS dated 11/21/21 was reopened, modified and corrected to reflect proper coding for ROM on 1/24/2022 by the RAC. Resident #110's MDS dated 12/14/21 was reopened, modified and corrected to reflect proper coding for Hospice 'while a resident and while not a resident.' on 1/5/2022 by the RAC. An audit of the most recent MDS was completed of current residents with wandering and pacing behaviors, ROM and Hospice. This audit was completed on 1/25 to 1/26/2022 by the RAC and	

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F 641	Continued From page 8 Resident #38's quarterly MDS dated 11/04/21 revealed she was not coded for any pacing behaviors. An interview conducted with the Social Services Assistant (SSA) #1 on 01/05/22 at 12:00 PM revealed she was responsible for completing the behavior section of the MDS for Resident #38. She stated she was new at completing the MDS assessment's and had only been completing them since June 2021. The interview revealed she did not interview staff prior to completing the resident's assessments but tried to look at the progress notes during the look back period. She stated she must have just missed the progress note regarding Resident #38 wandering and pacing. SSA #1 stated she must have just missed coding the behavior on the assessment. An interview conducted with the Director of Nursing (DON) on 01/06/22 at 2:42 PM revealed Resident #38's MDS should be accurately coded for wandering and pacing. An interview conducted with the Administrator on 01/06/22 at 4:04 PM revealed the MDS should be coded accordingly. She stated Resident #38 was always pacing and wandering the resident halls on the memory care unit and her MDS should reflect her behaviors. 2. Resident # 13 was admitted to the facility on 10/1/21 with multiple diagnosis which included dementia and anxiety disorder. An elopement risk tool was completed dated 10/1/21 revealed Resident #13 was coded yes for the resident had a pattern on wandering throughout the facility including wandering into	F 641	SSD. Newly admitted residents will continue to be coded accurately for wandering and pacing behaviors, ROM and Hospice. The SS staff were re-educated on accurate coding of the MDS assessments, particularly for wandering and pacing behaviors on 1/11/2022 by the Social Service Director. The Resident Assessment Coordinators (RAC's) were re-educated on accurate coding of the MDS assessments particularly for ROM and Hospice. This re-education was completed by the corporate consultant 1/26/22. Newly hired SS and RAC staff will receive this education during their job specific orientation with the Corporate Consultant. The SSD will monitor by reviewing 3 residents weekly for 12 weeks for accuracy of MDS coding for wandering and pacing behaviors, ROM and Hospice. Identified trends will be discussed in Morning Quality Improvement (QI) meeting for 12 weeks and as needed thereafter. Any identified issues will be further discussed during monthly Quality Assurance (QA) meeting with team and recommendations made as indicated. The SSD and RAC are responsible for the ongoing compliance of F641. The completion date for compliance 2/4/2022.	

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F 641	Continued From page 9	F 641		

other resident's room.

Resident #13's admission Minimum Data Set dated 10/7/21 revealed Resident #13 was severely cognitive impaired requiring extensive assistance with majority of activities of daily living (ADL). Resident #13 was not coded for any wandering behaviors in the facility during the assessment period.

An interview conducted with the Social Service Assistant (SSA) #1 on 1/5/21 at 12:00 PM revealed she was responsible for completing the behavior section of the MDS for Resident #13. She further revealed she had not interviewed staff prior to completing Resident #13's admission MDS. SSA #1 indicated Resident #13 should had been coded for wandering as indicated in the elopement risk tool completed on 10/1/21.

An interview conducted with the Director of Nursing (DON) on 1/6/21 at 2:42 PM revealed he would expect the coding on the MDS to be accurate of the resident's behaviors. The DON further revealed the elopement risk dated 10/1/21 indicated Resident #13 was a wanderer and should had been coded for wandering on the MDS.

An interview with the Administrator on 1/6/21 at 3:50 PM revealed the MDS should be coded accordingly, and Resident #13 should had been coded for wandering due to her behaviors of wandering.

3. Resident #79 was admitted to the facility on 6/25/21 with diagnoses that included cerebrovascular accident (stroke), right-sided hemiplegia (paralysis of the right side of the body)

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F 641	Continued From page 10	F 641		

and contracture of the right hand.

Resident #79's Functional Range of Motion assessment was completed on 6/25/21, 7/23/21 and 8/17/21 and indicated Resident #79 was able to flex and extend her right wrist and right fingers to 25% of the full range of motion.

The most recent quarterly Minimum Data Set (MDS) assessment dated 11/21/21 indicated Resident #79 was cognitively intact and required extensive physical assistance with most activities of daily living (ADL) but did not have any impairment in range of motion.

An observation and interview were conducted with Resident #79 on 1/3/22 at 10:34 AM. Resident #79 was lying down with her right arm resting on the bed and her right hand in a closed-fist position. Resident #79 stated that she could not move her right arm and right hand because she had a stroke.

An interview with Nurse Aide (NA) #2 on 1/5/22 at 3:02 PM revealed she was familiar with Resident #79 and had taken care of her before. NA #2 stated Resident #79 could not move her right arm.

An interview with NA #3 on 1/5/22 at 3:11 PM revealed she had worked with Resident #79 as a restorative aide, and she reported that Resident #79 could not move her right arm. NA #3 stated Resident #79 was only able to move her right arm if she picked it up with her left arm or if NA #3 lifted it up for her. NA #3 also stated Resident #79 had been unable to move her right arm and right hand since she was admitted to the facility.

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	345151	A. BUILDING _____ B. WING _____	C 01/06/2022

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F 641	Continued From page 11	F 641		

An interview with the Resident Assessment Coordinator (RAC) on 1/5/22 at 9:06 AM revealed Resident #79's 11/21/21 quarterly MDS assessment had been completed by the previous MDS Nurse who no longer worked at the facility. The RAC stated coding for functional limitation in range of motion would depend on the functional range of motion assessment tool. If the assessment revealed less than 50% range of motion, then she would code it as an impairment in range of motion.

An interview with the Director of Nursing on 1/6/22 at 2:42 PM revealed he wasn't sure how Resident #79's quarterly MDS on 11/21/21 should have been coded for functional limitation in range of motion as he was not familiar how Resident #79 did during that time. He stated if the previous MDS Nurse made an error in coding her MDS, it was probably an oversight and wasn't intentional.

An interview with the Administrator on 1/6/22 at 3:52 PM revealed the MDS Nurse should have coded Resident #79's MDS to reflect her condition at the time the assessment was completed.

4. Resident #110 was admitted to the facility on 12/07/21. Her diagnoses included chronic obstructive pulmonary disease (COPD).

Resident #110 had a Hospice revocation document which revealed Hospice services were revoked on 12/07/21.

A progress note written by the Social Services Assistant #2 dated 12/07/21 revealed Resident #110 was admitted to the facility for short-term skilled therapy services from the Hospice house.

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F 641	Continued From page 12 Hospice services were discontinued at admission to the facility on 12/07/21. The admission minimum data set (MDS) dated 12/14/21 indicated Resident #110 was severely cognitively impaired. She was coded for receiving Hospice services both "while a resident" and "while not a resident". An interview with the Social Services Assistant #2 on 01/04/22 at 2:36 PM revealed Resident #110 came from the Hospice house and services were discontinued when the resident admitted to the facility on 12/07/21. An interview with the Resident Assessment Coordinator (RAC) on 01/04/22 at 4:04 PM revealed the previous RAC who completed the admission MDS was no longer employed at the facility. The Resident Assessment Coordinator verbalized Hospice did not provide services to Resident #110 while they were at the nursing home. The Resident Assessment Coordinator stated this was an oversight and a correction would need to be made. The Director of Nursing (DON) was interviewed on 01/04/22 at 4:31 PM who revealed Resident #110 was receiving Hospice services prior to coming to the facility. The services were discontinued on admission. The DON explained the coding for the MDS should be correct and accurate. An interview with the Administrator on 01/06/22 at 9:50 AM stated the process would be for the MDS to reflect orders and to be accurate.	F 641		
F 679 SS=E	Activities Meet Interest/Needs Each Resident	F 679		2/4/22

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F 679	Continued From page 13 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide an ongoing resident centered activities program based on identified resident's individual interests for 1 of 1 sampled cognitively impaired resident in the memory care unit (Resident #13). The findings included: Resident # 13 was admitted to the facility on 10/1/21 with multiple diagnoses which included dementia and anxiety disorder. Resident #13's admission Minimum Data Set (MDS) dated 10/7/21 revealed Resident #13 was severely cognitively impaired. The MDS further revealed Resident #13 activity preferences included music, keeping up with news, religious gatherings, and group activities. Review of Resident #13's care plan dated 10/11/21 revealed Resident #13 had a preference to walk and be respected in balance with staff efforts to increase participation in activities. The	F 679	White Oak Manor- Kings Mountain ensures to provide activities that meet the interest and needs of the residents. Resident #13 will be provided with activities of interest that includes one-on-one and group activities. The activities will be documented on the Activity Participation record. The Activities Department and Nursing Assistants will be providing the activities on the memory care . The Activities Department will also provide current and newly admitted residents in the memory care unit with activities of interest, and document participation. An Activity Schedule was posted in the memory care unit on 1/7/2022 by the Activities Director (AD). The Activities Department was re-educated on the importance to provide the residents in memory care unit with activities that meet the interest and needs of the residents. The re-education was completed on 2/1/2022 by the Activities	

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F 679	Continued From page 14	F 679		

care plans goal further revealed Resident #13 will continue to be able to walk within the care center and will appear to enjoy socialization with staff and peers daily. Interventions included to invite Resident #13 and direct guide to group programs of interest.

Residents #13's Activity Participation record for October revealed Resident #13 was not documented for activities dated 10/4/21 to 10/8/21 and 10/13/21 to 10/17/21, and 10/19/21 to 10/28/21.

Resident #13's Activity Participation record for November revealed Resident #13 was not documented for activities dated 11/2/21 to 11/8/21 and 11/15/21 to 11/22/21, and 11/24/21 to 11/29/21.

Resident #13's Activity Participation record for December revealed Resident #13 was not documented for activities dated 12/14/21 to 12/23/21 and 12/25/21 to 12/31/21.

An observation was conducted on 1/5/22 at 9:50 AM that no activity schedule was posted in the memory care unit.

An interview conducted with Nurse #4 on 1/5/22 at 9:57 AM revealed the memory care unit had lost their activity unit coordinator about 6 months ago, and there had been very little activities since then. Nurse #4 further revealed staff complained to the Administrator that nursing staff was unable to lead activities because they were busy giving care. Nurse #4 stated the Activities Director and Activities Assistant visited a couple days a week for a few minutes, but there was no one-on-one interaction with the residents. Nurse #4 indicated

Director.
Newly Hired staff for the Activities Department and Nursing Assistants will receive this education during their job specific orientation with the Activities Director (AD) and the Staff Development Coordinator (SDC).
The Administration (Administrator, Director of Nursing or Staff Development Coordinator) will monitor by conducting observations weekly for 12 weeks.
The Administration will also monitor the documentation on the Activities Participation record for 3 residents weekly for 12 weeks.
Results from the monitoring will be discussed Monday-Friday during the Quality Improvement (QI) morning meetings. Any identified issues or trends will be further discussed at the monthly Quality Assurance meeting with team and recommendations made as indicated.
The Activity Director is responsible for ongoing compliance of F679.
The completion date for compliance is 2/4/2022.

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F 679	Continued From page 15	F 679		

there had been no activity schedule posted in several months for the residents in the memory care unit.

An interview conducted with Nurse #5 on 1/5/21 at 10:06 AM revealed staff had complained to upper management that the residents in the memory care unit needed someone to help with activities. Nurse #5 revealed Resident #13 wandered the hall and in and out of residents' rooms and would benefit from one-on-one activities.

An interview conducted with the Activity Director (AD) on 1/5/21 at 10:43 AM revealed he worked Monday through Friday and tried to go back to the memory care unit daily and do an activity like coloring or television. The AD further revealed he had no activity schedule for the memory care unit but was familiar with Resident #13. The AD indicated Resident #13 paced the halls, but he would try to color or turn on the television with Resident #13 and other residents.

An interview conducted with the Activity Assistant (AA) on 1/6/21 at 10:45 AM revealed there was not a schedule for activities in the memory care unit. The AA further revealed she was not able to complete activities daily with those residents on the memory care unit but would try to go and complete a quick activity in between activities that were not held for the memory care unit residents.

An interview conducted with the Director of Nursing (DON) on 1/6/21 at 2:42 PM revealed the facility was in the process of looking for a staff member to do more resident specific activities with residents in the memory care unit. The DON stated he expected residents to have activities

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	345151	A. BUILDING _____ B. WING _____	C 01/06/2022

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F 679	Continued From page 16 that they enjoyed. An interview with the Administrator on 1/6/21 at 3:50 PM revealed the facility had lost an activity member who worked on the memory unit care that had not been replaced. The Administrator further revealed she had asked the AD to go back to the unit as much as possible. The Administrator stated the facility could do better with activities and expected residents to have activities they preferred.	F 679		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to administer supplemental oxygen as ordered for 1 of 2 residents reviewed for respiratory care (Resident #110). The findings included: Resident #110 was admitted to the facility on 12/07/21. Her diagnoses included chronic obstructive pulmonary disease (COPD). Resident #110's physician's orders dated	F 695	White Oak Manor- Kings Mountain ensures oxygen is administered as ordered. Resident #110's oxygen was reassessed by physician and clarified physician's order on 1/4/2022 to titrate oxygen up to 3L nasal cannula (NC) to keep oxygen saturation levels above 89%. An audit of current residents on oxygen was reviewed for accurate settings of oxygen liter flow. This audit was completed on 1/24/2022 by the Quality Information Manager (QIM).	2/4/22

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F 695	Continued From page 17 12/07/21 revealed an order for oxygen to be administered at 2 L (liters) via nasal cannula (NC) continuously. Resident #110 quarterly Minimum Data Set (MDS) dated 12/14/21 revealed Resident #110 was severely cognitively impaired and received oxygen therapy. Resident #110 was care planned for shortness of breath dated 12/14/21. The interventions included administer oxygen therapy as ordered. An observation was completed of Resident #110 on 01/03/22 at 10:49 AM which revealed the oxygen setting on 1.5 L per minute. Resident #110 was resting in bed and showed no signs or symptoms of distress. An observation was completed of Resident #110 on 01/03/22 at 12:49 PM which revealed the oxygen setting on 1.5 L per minute. Resident #110 was resting in bed and showed no signs or symptoms of distress. An observation was completed of Resident #110 on 01/03/22 at 3:19 PM which revealed the oxygen setting on 1.5 L per minute. Resident #110 was sitting up in bed and showed no signs or symptoms of distress. An observation made on 01/04/22 at 9:00 AM revealed Resident #110 's in-room oxygen concentrator set to 1.5 L per minute. Resident #110 was observed in her bed resting. She had her oxygen applied to her nares via NC. She did not show any signs or symptoms of distress. An observation made on 01/04/22 at 2:42 PM	F 695	New residents on oxygen and newly ordered oxygen for current residents will be administered as ordered. Licensed Nurses and Nursing Assistants will be re-educated on ensuring residents on oxygen are administered as ordered. This re-education will be completed by Staff Development Coordinator (SDC) prior to 2/4/2022. Newly hired nursing staff will receive this education during their job specific orientation with the SDC. Nursing Administration (Director of Nursing (DON), SDC or Nursing Administration) will monitor by conducting observations of current residents on oxygen to ensure the oxygen liter flow is set as ordered. Observations will be completed weekly for 12 weeks. Results from the monitoring will be discussed during Quality Improvement (QI) morning meeting Monday through Friday. Identified issues or trends will be further discussed at monthly Quality Assurance (QA) meeting with the team and recommendations made as indicated. The DON is responsible for the ongoing compliance of F695. The Completion date for compliance is 2/4/2022.	

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F 695	Continued From page 18	F 695		

revealed Resident #110 's in-room oxygen concentrator set to 1.5 L per minute. Resident #110 was observed in her bed resting. She had her oxygen applied to her nares via NC. She did not show any signs or symptoms of distress.

An interview was completed with nurse aide (NA) #1 on 01/04/22 at 2:57 PM regarding oxygen therapy for Resident #110. She understood Resident #110 received 2 L of oxygen continuously. NA #1 verbalized she was trained not to administer oxygen or adjust the oxygen setting. NA #1 stated she could adjust the nasal cannula when needed. NA #1 last checked on Resident #110 at lunch but did not recall the oxygen setting.

An observation and interview were completed on 01/04/22 at 3:12 PM with Nurse #1. Nurse #1 revealed Resident #110 had been on supplemental oxygen since admission. Nurse #1 believed Resident #110's oxygen order was 3 L continuously, but she would have to verify in the chart. Nurse #1 explained Resident #110 was known for adjusting her nasal cannula but no history of adjusting her oxygen setting on the in-room concentrator. Nurse #1 did not recall when she last verified Resident #110's oxygen setting. An observation with Nurse #1 revealed Resident #110 sitting up in her bed with her nasal cannula applied to her nares. The in-room oxygen concentrator was set at 1.5 L continuously. Resident #110 did not show signs or symptoms of distress. Nurse #1 obtained a pulse oximetry (reading of the oxygen level in the blood) which read 94%. Nurse #1 verbalized she would notify the physician to determine if Resident #110 was a candidate for her oxygen to be titrated.

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F 695	Continued From page 19 An interview was completed with the Director of Nursing (DON) on 01/04/22 at 3:37 PM regarding oxygen therapy for Resident #110. He was aware Resident #110 received oxygen but not familiar with the order. He revealed orders for oxygen therapy were located in the medical record and should be followed by staff. Nurses were trained and responsible for making sure oxygen settings were correct throughout the shift. The DON communicated the facility would take an all-staff approach to make sure the proper oxygen settings were applied for those residents receiving supplemental oxygen. An interview with the Administrator on 01/06/22 at 09:39 AM revealed that staff should follow the physician's orders related to oxygen therapy.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		2/4/22

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F 812	Continued From page 20 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store, label, and date opened food stored ready for use in 1 of 1 walk-in cooler and 1 of 1 walk-in freezer. This practice had the potential to affect the food served to residents. The findings included: During the initial tour of the kitchen on 01/03/22 from 9:39 AM to 10:15 AM an observation of the walk-in cooler revealed the following: · 1 open, used box of pork sausage patties in a clear plastic bag open to air with no date · 1 open, used bag of French toast with no date · 1 clear storage bag with 1 half-used cucumber and 1 half-used onion with no date and clear, white matter in bag. The cook was observed on 01/03/22 at 9:45 AM open boxes of food with no dates. She revealed the process for food storage was to seal the bag and date it. She verbalized the food in cooler was good for 7 days. The cook further verbalized vegetables and cooked foods were supposed to be dated and were good for 3 days. She indicated she would discard the items. An observation of the walk-in freezer at 9:55 AM revealed the following problem: · 1 icing piping bag with no date An interview with the Registered Dietician (RD) completed 01/03/22 at 10:15 AM revealed all open containers of food should be sealed, labeled, and dated. She immediately removed and discarded all open containers of food not	F 812	White Oak Manor- Kings Mountain ensures used food is properly sealed, labeled and dated. The items located in walk-cooler (used box of pork sausage patties, used bag of French toast, 1 clear storage bag with 1 half used cucumber and 1 half used onion with clear matter) were discarded immediately during survey. The item located in walk-in freezer (1 icing piping bag) was discarded immediately when noted by surveyor. All food items in the walk-in cooler and freezer were checked for being properly sealed, labeled and dated by the Registered Dietician on 1/3/2022. Dietary staff were re-educated on food items being properly sealed, labeled and dated. This re-education will be completed prior to 2/4/2022 by the Registered Dietitian (RD). Newly hired dietary staff will receive their education during their job specific orientation by the Certified Dietary Manager (CDM) or RD. The RD, CDM or dietary supervisor will monitor food items in the walk-cooler and freezer daily for 2 weeks, then 3 days a week for 4 weeks, and then once a week for 6 weeks. Results from monitoring will be discussed during the morning Quality Improvement (QI) meeting Monday through Friday. Identified issues or trends will be further discussed at the monthly Quality Assurance (QA) meeting with the team	

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F 812	Continued From page 21 sealed, labeled, and dated. An interview with the Corporate RD on 01/05/22 at 11:36 AM revealed staff should make sure all open food containers were labeled, sealed, and dated. An interview with the Administrator on 01/06/22 at 9:44 AM revealed all open food containers should be labeled, sealed, and dated.	F 812	and recommendations made as indicated. The RD and CDM are responsible for the ongoing compliance of F812 The completion date for compliance is 2/4/2022.	