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 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 01/09/23 through 01/12/23. The facility was found in compliance with the requirements CFR 483.73, Emergency Preparedness. Event ID #IH8J11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/09/23 through 01/12/23. Event ID #IH8J11. 1 of 11 complaint allegations was substantiated resulting in a deficiency. Intakes NC00192523, NC00192694, NC00194319, NC00196217 and NC00196446 were investigated.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		2/8/23

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

Electronically Signed | 02/06/2023

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 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 580	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, responsible party and Nurse Practitioner the facility failed to notify the physician when a resident (Resident #142) experienced a second change in condition when the resident's wrist started to swell following an unwitnessed fall. This failure was for 1 of 3 residents reviewed for notification of changes (Resident #142).	F 580	White Oak Manor- Kings Mountain ensures the Resident Representative and Healthcare Practitioner/Physician are notified of residents' change in condition including another change in condition after an initial change. The Nurse Practitioner for Resident #142 was notified of resident's unwitnessed fall	

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 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 580	Continued From page 2 The findings included: Resident #142 was admitted to the facility on 10/13/22 with diagnosis which included fracture of the carpal bone in the left wrist. An initial nursing assessment dated 10/13/22 at 8:33 PM revealed Resident #142 was alert and oriented. A nursing progress note dated 10/15/22 at 3:40 PM written by Nurse #1 revealed Resident #142 was noted to be on the floor at 8:32 AM. Nurse #1 completed an assessment and contacted Nurse Practitioner #1 at 8:47 AM and obtained orders for a 2-view x-ray of right wrist STAT (urgent, right away). The note revealed due to the resident having pain the orders were put in right away. The note revealed while waiting for x-ray Resident #142's wrist began to swell. The resident's Responsible Party (RP) was contacted at 11:20 AM. The note revealed the RP contacted Emergency Medical Services (EMS) A fall occurrence report dated 10/15/22 at 8:32 AM revealed Resident #142 experienced an unwitnessed fall in her room. The presence of pain/discomfort was documented at her right wrist. Nurse #1 documented she contacted Nurse Practitioner #1 at 8:47 AM and contacted the residents Responsible Party (RP) at 11:20 AM. Resident #142 was documented to have been sent to the hospital at 1:45 PM. Resident #142 was documented to have swelling at her right wrist and a possible fracture. An interview was conducted on 1/10/22 at 3:01 PM with the residents Responsible Party (RP). The RP stated he received a phone call at 11:22	F 580	and positioning of right wrist on 10/15/22 at 8:32AM and the Resident Representative was notified at 11:20AM. Resident #142 was then noted with swelling to the right wrist without notifying the Nurse Practitioner. The resident's Resident Representative contacted Emergency Medical Services when noted the resident's swelling of right wrist. Resident #142 was evaluated and treated at the hospital for a fractured right wrist. An audit was completed by the Administration team on 2/2/23 of current residents that had changes in condition for the last 30 days to ensure notification of change was completed and any additional changes in condition that required further notification. Current and newly admitted residents having a change in condition will have notifications to the Resident Representative and Health Practitioner/Physician along with notifications of any further changes in the residents' condition. The licensed nursing staff were re-educated on notifying the Healthcare Practitioner/Physician and Resident Representatives regarding a resident's change in condition, and to complete additional notification and any further changes in condition without waiting for the initial notification's tasks to be completed. This re-education was given by the Director of Nursing and Assistant Director of Nursing/Staff Development	

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 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 580	Continued From page 3 AM from Nurse #1 who told him Resident #142 had experienced a fall. The interview revealed he immediately went to the facility and saw Resident #142's wrist was swollen. He stated he told Nurse #1 he wanted the resident sent to the hospital and began to dial Emergency Medical Services (EMS). On 1/11/23 at 9:18 AM an interview was conducted with Nurse #1. She stated Resident #142 had experienced an unwitnessed fall on 10/15/22 around 8:30 AM and was observed lying in the floor of her room with her head at the doorway. Nurse #1 stated she assessed Resident #142 while she was lying on her left side and noted the resident's right wrist was underneath her. She stated at that point the resident's wrist was not swollen. Nurse #1 stated she contacted the Nurse Practitioner and obtained an order for a STAT (urgent, right away) x-ray. The interview revealed within the hour of the incident Resident #142's wrist began to swell but remained in no pain. Nurse #1 stated she did not contact the NP again when the resident's wrist began to swell because she knew the x-ray was ordered and thought she had to wait for them to arrive. On 1/12/23 at 10:36 AM an interview was conducted with the Director of Nursing (DON). The DON stated if the resident had a change of condition such as swelling the nurse should have contacted the Nurse Practitioner and let her know there had been a change. On 1/12/23 at 11:24 AM an interview was conducted with Nurse Practitioner #1. She stated Nurse #1 had contacted her stating the resident had experienced an unwitnessed fall and she had given orders for a STAT (urgent, right away)	F 580	Coordinator and will be completed by 2/7/23. Newly hired licensed nursing staff will receive this education during their job specific orientation by the Staff Development Coordinator. The Director of Nursing and/or Nursing Administration will monitor for notification including additional changes of condition of residents for 10 residents weekly for 4 weeks, then 5 residents weekly for 4 weeks, and then 2 residents weekly for 4 weeks. Identified trends or issues from the monitoring tool will be discussed during the morning QI meetings, weekly for 12 weeks in addition to reviewing the facility's occurrences, and then discussions with the Quality Assurance Committee meetings for further recommendations as needed. The DON is responsible for the ongoing compliance of F580. Compliance date is 2/8/2023.	

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 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 580	Continued From page 4 x-ray. She stated STAT in the long term care facility did not mean urgent or immediate she stated she expected the x-ray within 24-48 hours. Nurse Practitioner #1 stated if Resident #142 had a second change of condition such as swelling or pain she would have wanted to be alerted and would have sent the resident to the hospital for an evaluation.	F 580		