| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345127 | A. BUILDING _____ B. WING _____ | C 03/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WHITE OAK MANOR - TRYON** | **70 OAK STREET TRYON, NC 28782** |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 3/13/23 through 3/17/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1QS011. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 3/13/23 through 3/17/23. Event ID # 1QS011. The following intake was investigated: NC00195068. 3 of 3 complaint allegations did not result in a deficiency. | F 000 | | |
| F 550 SS=E | 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 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 | F 550 | | 4/14/23 |

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

Electronically Signed | 04/03/2023

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| F 550 | Continued From page 1<br>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 review, observations and staff interviews, the facility failed to treat residents in a dignified manner by standing over them while assisting with eating and/or referring to residents as "feeders". This practice affected 5 of 5 residents reviewed for dignity (Residents #206, #21, #31, #16, and #42). The reasonable person concept was applied to this deficiency as individuals have the expectation of being treated with dignity while dining.<br><br>The findings included:<br><br>1. Resident #206 was admitted to the facility on 3/7/23.<br><br>The admission Minimum Data Set (MDS) assessment dated 3/13/23 indicated Resident #206 was moderately cognitively impaired and | F 550 | White Oak Manor - Tryon will treat each resident with respect, 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 will protect and promote the rights of our residents.<br><br>On 3/17/23 the Social Services Director interviewed interviewable residents in the facility including resident #21. Residents were asked if they had heard any staff use the term "feeder" in the past week and if the residents had any concerns with any of the staff or residents to which all residents responded "no" to both questions. | |

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| F 550 | Continued From page 2<br>required extensive assistance with eating.<br><br>During a lunch observation in the resident dining room on 3/13/23 at 12:05 PM, the Quality Improvement Manager was observed standing over Resident #206 while providing feeding assistance for the duration of the meal from 12:05 PM to 12:26 PM. There were empty chairs in the dining room that were available for use.<br><br>An interview was conducted with the Quality Improvement Manager on 3/14/23 at 11:04 AM. The Quality Improvement Manager stated that she usually assisted with meals whenever asked. She explained that she normally asked staff about which residents needed assistance with eating. The Quality Improvement Manager stated that she watched a training video on feeding assistance and that it did not include whether to sit or stand while providing assistance. She stated that whether to stand or sit beside the resident depended on whatever the staff assisting with the meal preferred. The Quality Improvement Manager stated she was supposed to sit beside the resident but that there was not enough room at the table on 3/13/23. She revealed that she typically assisted residents while standing over them.<br><br>An interview with the Director of Nursing (DON) was conducted on 3/16/23 at 4:26 PM. The DON stated that the Quality Improvement Manager was new and that she had already spoken to her regarding feeding assistance.<br><br>2. During a dinner meal observation on the 200 hall on 3/15/23 at 6:07 PM, Nurse Aide (NA) #3 was observed telling the other nurse aides on the 200 hall that "the rest are feeders," as he was | F 550 | On 4/13/23, the Social Services Director used the same interview questions above to interview residents #206, #42, and #31. Residents #206 and #31 stated no that they had not heard the term "feeder" used and had no concerns with any staff or residents. Resident #42 was unable to answer the questions due to cognitive deficits.<br><br>On 4/13/23, the Social Services Director interviewed residents #206, #16, and #42 asking if staff have been interacting and sitting with them while providing assistance with their meals. Residents #206 and #16 answered "yes" to staff interacting and sitting with them while assisting with meals. Resident #42 was unable to provide an answer due to cognitive deficits. The Social Services Director also interviewed interviewable residents requiring assistance with meals if staff had been interacting and sitting with them while assisting to which all residents responded "yes".<br><br>On 3/16/23, the Director Of Nursing individually re-educated the Quality Information Manager and Restorative CNA on the proper technique of assisting residents with their meals while sitting down with each resident.<br><br>The Staff Development Coordinator in-serviced all nursing staff and trained feeding assistants on 3/23/23 for the proper technique of assisting residents with their meals and to make sure they | |

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| F 550 | Continued From page 3<br>assisting with passing out dinner trays. The doors to residents' rooms were open to the hallway and Residents #206, #21, #42, and #31 were all in their rooms and within hearing distance of NA #3.<br><br>An interview with NA #3 on 3/15/23 at 6:08 PM revealed he did not typically call the residents "feeders" and that he only meant to say it to the other nurse aides.<br><br>An interview with the Director of Nursing (DON) was conducted on 3/16/23 at 4:26 PM. The DON stated that it was inappropriate to refer to residents as "feeders" and that they should be referred to as residents who require feeding assistance.<br><br>An interview was conducted with the Administrator on 3/17/23 at 4:15 PM. The Administrator stated that he never wanted to hear the word "feeder" used to describe residents. He stated he talked to some staff individually and that an in-service email had been sent out to all staff.<br><br>3a. Resident #16 was admitted to the facility on 01/04/17.<br><br>The most recent quarterly Minimum Data Set (MDS) dated 12/13/22 revealed Resident #16 had severe cognitive impairment and required supervision with eating.<br><br>3b. Resident #42 was admitted to the facility on 09/01/21.<br><br>The most recent quarterly MDS dated 01/05/23 showed that Resident #42 had severe cognitive | F 550 | are sitting down with each resident.<br><br>On 3/16/23, the Administrator re-educated the Nursing Assistant noted using the term "feeder" on the importance of dignity and identifying each resident individually by their preferred name.<br><br>The Staff Development Coordinator in-serviced all staff on 3/16/23 that the term "feeder" should never be used for any resident including those needing assistance with their meals.<br><br>The dining rooms and hallways will be monitored 3 times a week by the Administrator and/or Administrative Nursing staff to ensure the appropriate technique is being used by staff while assisting residents with their meals which includes: sitting with the resident, passing out meal trays, and ensuring the appropriate language is being used for 4 weeks. The same monitoring will be continued 2 times a week for 4 weeks and 1 time a week for 4 weeks.<br><br>The Social Services Director, Social Services Assistant, and/or the Administrator will monitor meal intake and behavior monitoring data collected by CNA's for residents #206, #16, #21, #42, and #31. This will be reviewed 3 times a week for 4 weeks, 2 times a week for 4 weeks, and 1 time a week for 4 weeks.<br><br>The identified trends are discussed during morning QI meeting Monday-Friday and discussed with the QA Committee for any | |

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| F 550 | Continued From page 4<br>impairment and required extensive assistance with eating.<br><br>During an observation of lunch in the facility dining room on 03/13/23 from 12:18 PM to 12:25 PM, Nurse Aide (NA) #2 was observed standing at a table assisting Resident #16 and Resident #42 with eating while standing over them for about 5 minutes. There were empty chairs in the dining room that were available for use.<br><br>During a phone interview on 03/13/23 at 4:13 PM with NA #2, she described how a resident who needed assistance should be helped with meals. NA #2 said she would position herself seated, in a chair to assist and would face the resident while feeding. She said she was standing next to Resident #16 and Resident #42 to assist with feeding during lunch because there were too many residents at the table. NA #2 further stated the nurse aides typically sat between two residents and did not stand when assisting with feeding. If the table was too crowded with residents needing assistance and there was no room to put a chair between two residents, NA #2 said she would normally move a resident to a separate table to assist.<br><br>During an interview on 03/16/23 at 4:26 PM with the Director of Nursing (DON), she stated that staff had been educated to sit next to the residents while assisting them to eat and not stand over them. The DON reported that she had spoken with staff about feeding assistance. The DON stated that standing over a resident when assisting with eating was not appropriate.<br><br>During an interview on 03/17/23 at 4:22 PM with the Administrator, he reported standing over | F 550 | recommendations if needed.<br><br>The Administrator is responsible for the ongoing compliance of F550.<br><br>The completion date for this plan of correction is 4/14/23. | |

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| F 550 | Continued From page 5<br>residents while assisting them to eat was not acceptable. | F 550 | | |