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 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - KINGS MOUNTAIN	716 SIPES STREET KINGS MOUNTAIN, NC 28086

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E 000	Initial Comments An unannounced Recertification survey was conducted on 04/29/24 through 05/02/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 3SZ311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/29/24 through 05/02/24. Event ID# 3SZ311. The following intakes were investigated: NC00210079, NC00212188, NC00213563, and NC00214869. 8 of the 8 complaint allegations did not result in a deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §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 assessment. The comprehensive care plan must describe the following - (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 (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).	F 656		6/14/24

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

Electronically Signed | 05/23/2024

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F 656	Continued From page 1 (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, and staff interviews, the facility failed to develop an individualized person-centered comprehensive care plan in the areas of urinary catheter use and opioid (pain medication) use (Resident #89). This deficient practice was for 1 of 5 residents whose comprehensive care plans were reviewed. Findings included: Resident #89 was admitted to the facility on 11/27/2023 with diagnoses including diabetes mellitus (DM), chronic pain, peripheral vascular	F 656	White Oak Manor- Kings Mountain ensures the development and implementation of individualized person-centered comprehensive care plans for each resident, including the areas of urinary catheter use and pain medication use. Resident #89's comprehensive care plan was updated with the areas of urinary catheter and pain medication usage on 5/1/24 by the Corporate Consultant.	

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F 656	Continued From page 2 disease, and obstructive uropathy. a. A review of Resident #89's physician orders revealed an order dated 11/29/2023 for the placement of a urinary catheter due to urinary retention. b. A review of Resident #89's medication orders revealed: 1. Tramadol (an opioid) 50 milligrams (mg) twice a day for pain; start date: 11/27/2023. 2. Tramadol 50 mg three times a day for pain; start date: 12/21/2023 3. Tramadol 100 mg every 8 hours for pain; start date: 04/29/2024 A review of Resident #89's quarterly Minimum Data Set (MDS) dated 02/17/2024 revealed Resident #89 was cognitively intact. The MDS also revealed Resident #89 had an indwelling urinary catheter and received scheduled pain medications. Review of Resident #89's comprehensive care plan dated 02/01/2024 revealed no care plan was developed related to opioid use or a urinary catheter. An observation and interview was conducted with Resident #89 on 04/29/2024 at 3:43 PM. Resident #89 was lying in bed watching television. Resident #89 appeared comfortable and did not verbalize any complaints of pain or discomfort. Resident #89 had an indwelling urinary catheter with a privacy bag attached to his bed frame. The catheter bag was off of the floor and draining without difficulties. Resident #89 stated he has had issues with pain for a very long	F 656	An audit was completed by the Corporate Consultant on current residents' care plans for urinary catheter and pain medication usage. This audit was completed on 5/1/24. The Resident Assessment Coordinator (RAC) Nurses and the Interdisciplinary Care Team (IDT) were re-educated by the Corporate Consultant on 5/27/24 regarding the development of resident-centered care plans for urinary catheter and pain medication usage. Newly hired RAC nurses and IDT will receive this education during their job specific orientation with their Corporate Consultant. The DON will monitor current and newly admitted residents or residents with newly ordered urinary catheter and pain medication usage to ensure their comprehensive care plans are developed for urinary catheter and pain management usage. The monitoring will be completed weekly for 12 weeks to assure compliance. The identified trends will be discussed weekly during the Morning Quality Improvement (QI) meetings for 12 weeks. The identified issues or trends will further be discussed at the monthly Quality Assurance (QA) meetings with the care team for recommendations as indicated. The DON is responsible for the ongoing compliance of F656.	

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F 656	Continued From page 3 time because he had chronic back pain and bad circulation in his legs. He also stated that he had been working with his doctor who had adjusted his pain medications. Interviews were conducted with the MDS Nurse #1 and MDS Nurse #2 on 05/01/2024 at 2:30 PM. MDS Nurse #1 stated Resident #89's MDS dated 02/17/2024 noted he had a urinary catheter and received opioids (pain medication). MDS Nurse #2 indicated Resident #89 should have been care planned for the use of an indwelling urinary catheter and opioid use. MDS Nurse #1 further stated that she was not sure how the care plans for opioid use and the urinary catheter were overlooked. An interview was conducted with the Regional MDS Coordinator on 05/01/2024 at 2:51PM. The Regional MDS Coordinator stated that the quarterly MDS was accurate, and the Care Area Assessment (CAA) was triggered to proceed to care plan. She further stated that the MDS nurses were relatively new to their roles. She further stated Resident #89's care plan would be updated, and she would work on a process to capture an accurate and correct clinical picture of residents relating to the care plan process. An interview was conducted with the Administrator on 05/01/2024 at 3:10 PM. The Administrator stated she expected the care plan to reflect the resident's clinical condition and care needs.	F 656	Compliance date 6/14/24.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		6/14/24

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F 880	Continued From page 4	F 880		

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.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§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;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 5 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to follow their Hand Hygiene policy and procedure when Nurse #1 failed to sanitize her hands after doffing gloves used to clean stool smears from a resident's rectum and before donning clean gloves to apply treatment to the resident's rectum and then failed to doff her gloves, sanitize her hands and don clean gloves before refastening the resident's brief for 1 of 3 residents (Resident #21) reviewed for incontinence care. The findings included:	F 880	White Oak Manor-Kings Mountain 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 diseases, which includes the hand hygiene policy and procedures. When the observation of Nurse #1 failing to sanitize her hands after doffing gloves that were used to clean stool smears from	

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F 880	Continued From page 6 Review of the facility's Hand Hygiene Policy and Procedure with no date revealed the following statement: "Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: " Before and after assisting a resident with toileting; " After contact with a resident's mucous membranes and body fluids or excretions; " After removing gloves or aprons; An observation on 04/30/24 at 12:40 PM revealed Nurse #1 came into Resident #21's room to apply hemorrhoid cream to the resident. The resident turned onto her left side, Nurse #1 unfastened her brief and the resident had smears of stool on her rectum. Nurse #1 cleaned the stool from Resident #21's rectal area, doffed her gloves and without sanitizing her hands donned a clean pair of gloves and applied the hemorrhoid cream to Resident #21's rectal area. Nurse #1 without doffing her gloves, sanitizing her hands, and donning new gloves, proceeded to refasten the residents brief and the resident turned back on her back. Nurse #1 then doffed her gloves, sanitized her hands and left the room. An interview on 05/01/24 at 4:38 PM with Nurse #1 was conducted. Nurse #1 stated she should have sanitized her hands after doffing her gloves and before donning clean gloves to apply the hemorrhoid cream to Resident #21. She further stated she should have doffed her gloves, sanitized her hands, and donned clean gloves after applying the treatment and before fastening the resident's brief and positioning her in the bed. Nurse #1 indicated she knew she was supposed	F 880	the resident's rectum and before donning clean gloves to apply treatment to resident's rectum, and then failed to doff gloves, sanitize hands and don clean gloves before refastening the resident's brief, the facility immediately re-educated Nurse #1 on 5/6/24. The re-education was provided by the DON on properly sanitizing hands between doffing gloves that were used to provide incontinence care or cleaning of a soiled resident and donning clean gloves to apply any treatments, and then doffing the gloves, sanitize hands again and don clean gloves before refastening a resident's brief. The licensed nurses were re-educated on the hand hygiene policy and procedures, including properly sanitizing hands between doffing gloves that were used to provide incontinence care or cleaning of a soiled resident and donning clean gloves to apply any treatments, and then doffing the gloves, sanitize hands again and don clean gloves before refastening a resident's brief. The DON and/or Infection Control Preventionist will complete this re-education by 6/14/24. Newly hired licensed nursing staff will receive this education during their job specific orientation by the DON or Staff Development Coordinator (SDC). Licensed Nurses treating residents with topical treatments will be randomly monitored by observing the 3 resident treatments weekly for 12 weeks regards	

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F 880	Continued From page 7 to sanitize her hands after doffing her gloves and when moving from a dirty to clean procedure but was nervous and just forgot to do so. An interview on 05/02/24 at 10:52 AM with the Infection Preventionist was conducted. The Infection Preventionist stated Nurse #1 should have doffed her gloves after cleaning the resident, sanitized her hands and donned clean gloves prior to applying hemorrhoidal cream to the resident. She further stated Nurse #1 should have doffed her gloves, sanitized her hands, and donned clean gloves prior to refastening the resident's brief and positioning her for comfort in the bed. The Infection Preventionist indicated this should happen anytime when moving from a dirty to clean procedure and anytime you change your gloves. An interview on 05/02/24 at 10:58 AM with the Director of Nursing (DON) revealed it was her expectation that Nurse #1 sanitized her hands after doffing her dirty gloves and before donning clean gloves to proceed with resident treatment. She stated she also expected Nurse #1 to doff her gloves after applying treatment, sanitize her hands and don clean gloves prior to refastening her brief and positioning Resident #21in bed. The DON indicated she expected Nurse #1 to sanitize her hands anytime she doffed her gloves and when moving from a dirty to clean procedure with residents.	F 880	to following the hand hygiene policy and procedures. The monitoring will include newly admitted residents with topical treatments and newly hired and trained Licenses Nurses. The monitoring will be completed by the DON and/or Infection Control Preventionist. Results from the monitoring will be discussed weekly during QI meetings, and any identified issues or trends will be further discussed at the QA meetings with the care team and recommendations made as indicated. The DON and/or Infection Control Preventionist will be responsible for bringing audit results to weekly QI meetings. The DON is responsible for ongoing compliance of F880. Compliance date is 6/14/24.	
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident;	F 914		6/14/24

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F 914	Continued From page 8 §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews, the facility failed to provide a privacy curtain for 1 of 14 rooms on the memory care unit reviewed for privacy (Room 316). The findings included: Resident #48 was admitted to the facility on 03/29/21. The quarterly Minimum Data Set (MDS) dated 03/14/24 revealed Resident #48 was severely cognitively impaired. An observation of room 316 was conducted on 04/29/24 at 10:00 AM and revealed a semi-private room with and the bed next to the door had no privacy curtain hanging. An observation and interview were conducted with Nurse #3 on 04/30/24 at 10:15 AM revealed room 316 did not have a privacy curtain hanging. Nurse #3 further revealed housekeeping was responsible for cleaning and changing out curtains in residents' rooms. Nurse #3 indicated she was unable to recall how long room 316 had gone without a privacy curtain. An observation and interview conducted with Nurse Aide (NA) #3 on 04/30/24 at 10:20 AM revealed the privacy curtain for the bed next to	F 914	White Oak Manor- Kings Mountain ensures the residents' bedrooms are equipped to assure full visual privacy, which includes providing privacy curtains in all bedrooms. Resident Room 316's privacy curtain was installed immediately when observation was shared with the facility by Housekeeping Director on 5/2/24. An audit was completed by the Housekeeping Director on 5/3/24 of all resident's bedrooms, including the memory care unit to ensure privacy curtains were installed and provided. The facility staff will be re-educated on the importance that all resident bedrooms have privacy curtains and to contact the Housekeeping or Maintenance Department to install a new privacy curtain when not available, soiled or in disrepair. The Housekeeping Director will complete this re-education by 6/14/24. The Housekeeping Department will be re-educated on monitoring for the privacy curtains that may be missing, soiled or in disrepair during their daily rounds in the facility. The Housekeeping Director will	

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F 914	Continued From page 9 the door had been torn down by a resident about two to three weeks ago. NA #3 further revealed she had not completed a work order and was going to do it now. NA #3 indicated a work order was completed by entering on the computer and it was sent straight to the Maintenance Director. An interview conducted with Housekeeping Aide #1 on 04/30/24 at 11:35 AM revealed she was aware the privacy curtain in room 316 had been torn down. It was further revealed she thought maintenance was aware and was going to fix Resident #48's privacy curtain and had not completed a work order. An interview conducted with the Director of Maintenance on 05/01/24 at 2:30 PM revealed he was not aware the privacy curtain in room 316 had been torn down because no staff had completed a work order. It was further revealed a work order can be completed by any staff and should have been completed and the curtain would have been put back up immediately. An interview conducted with the Administrator on 05/01/24 at 11:15 AM revealed she expected residents to have privacy and privacy curtains to be in place. It was further revealed a work order should have been completed and the privacy curtain should have been put back up in a timely manner.	F 914	complete this re-education by 6/14/24. Newly hired facility staff members including Housekeeping staff will receive this education during their job specific orientation by their Department Directors or SDC. The Housekeeping Director will monitor 5 resident bedrooms on each unit for privacy curtains weekly for 12 weeks to assure compliance. The identified trends will be discussed weekly during the Morning QI meetings for 12 weeks. The identified issues or trends will further be discussed at the monthly QA meetings with the care team for recommendations as indicated. The Housekeeping Director will be responsible for bringing audit results to weekly QI meetings. The Housekeeping Director is responsible for the ongoing compliance of F914. Compliance date is 6/14/24.	