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 _____	08/04/2011

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
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interviews and record reviews the facility failed to provide one (1) of thirteen (13) sampled residents with assistance to maintain their ability to eat. (Resident #8). The findings are: Resident #8 has diagnoses including; cancer, chronic airway obstruction and esophageal reflux. The resident was included on the facility's listing of interviewable residents. Review of Resident #8's most recent Minimum Data Set (MDS) assessment of 07/15/11 revealed she required supervision and one person physical assistance with eating. Resident #8's current plan of care, which was initiated on 06/17/11, contained a "Problem/Need" which addressed a need for assistance with Activities of Daily Living (ADLs) related to her weakness and shortness of breath. The care plan's goal specified that Resident #8 would continue to feed herself. An approach specified that staff were to encourage Resident #8 to be as independent as able and to monitor for a decline in her ability to participate with ADLs. On 08/03/11 at 9:22 a.m. Resident #8 was	F 311	F 311 Dietary Services was immediately notified that resident required small diameter juice glasses with meals and provided them on tray. Small plastic disposable cups were already available in the room and also being used by nurses administering meds and by some nursing assistants. DON immediately counseled Nursing Assistant that if the resident declines a temperature sensitive snack, that it is to be removed from room or put in the refrigerator. The nursing assistant was also counseled about the need to open a container before offering and providing appropriate utensils for eating. The Resident Care Guide was immediately updated to reflect the currents needs and desires of this resident. The staff tries very hard to respect the wishes of residents and especially those of Hospice residents about their eating. This resident had repeatedly told staff she did not want to be fed. Staff Development Nurse will inservice nursing assistants about recognizing changes in residents' needs and communicating this to their nurses. She will also inservice nurses to report this change to the Resident Assessment nurse and other involved disciplines to make sure that needed documentation for good communication is in place, ie. Care Plans, Resident Care Guide, Nursing Assistant Communication Board, Dietary tray cards.	9/3/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary J Lance — TITLE: Administrator — (X6) DATE: 9/25/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 311	Continued From page 1 observed in bed as staff served her breakfast meal. Staff provided the resident with set up assistance with her meal tray and encouraged her to eat her breakfast. At 9:25 a.m. staff was observed to leave the resident's room. Observations of Resident #8 from 9:25 a.m. to 9:47 a.m. revealed that she became easily fatigued as she attempted to feed herself and drink milk from a regular sized cup. As she attempted to feed herself independently Resident #8 was observed to have difficulty getting foods and fluids from her meal tray to her mouth due to her hands shaking. The resident was observed to spill foods and milk onto herself while feeding herself. During this observation staff was observed to enter the resident's room at 9:37 a.m. and 9:47 a.m. to encourage her to eat, but offered no physical assistance. At 9:48 a.m. staff was observed to remove Resident #8's breakfast meal tray from her room and to leave her milk on her over bed table which was positioned to the resident's left side. Observations of the resident's finished breakfast tray revealed that she ate less than twenty-five (25) percent of the meal. On 08/03/11 at 9:50 a.m. Resident #8 stated that she becomes very tired when feeding herself and that it is difficult to eat very much. The resident also stated that she did not consume very much of the milk that was served on her breakfast tray because she became weak and that it was difficult for her to drink from a regular sized cup. The resident stated that she now needed to use smaller cups to be able to drink fluids with spillage. The resident explained that she had previously made staff aware of this need, but continued to be served fluids in regular sized cups. The resident specified that she did not want	F 311	Staff Development Coodinator will instruct nursing assistants to ask at-risk residents who have indicated that they do not want help each time that the nursing assistant provides services if they may provide assistance. Staff Development will instruct how to structure the question for best reception and will also inservice nursing staff about how to maintain the fine line between respecting a resident's wishes and meeting needs, especially with Hospice residents. To monitor residents at risk and more susceptible to rapid decline, SWIPE Committee (continuous quality improvement) will review Hospice residents in the weekly meeting and residents who have sustained a weight loss as evidenced by weekly or monthly weights to determine if additional assistance is needed during meals and with snacks. SWIPE committee will communicate to the nurses for that neighborhood of potential or identified increased resident need for assistance so that the nurse can make sure the nursing assistants are aware and providing for these needs. This will be a weekly ongoing process and results will be reviewed at the monthly Quality Assurance meeting to assess effectiveness.	9/1/11

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F 311	Continued From page 2 to be fed, but in order for her to be as independent as possible with eating she now required beverages to be served in smaller cups and more staff assistance. On 08/03/11 at 10:05 a.m. a staff member was observed to enter Resident #8's room and provided her with a four (4) ounce yogurt. Staff set the unopened yogurt on the resident's over bed table and exited the room. Staff did not provide Resident #8 with a eating utensil or open the container prior to leaving the resident's room. On 08/03/11 at 10:50 a.m. Resident #8 was observed in bed with the unopened four ounce yogurt still on her over bed table. The resident stated that she would like to try the yogurt, but needed assistance. The resident specified that she needed someone to open the container of yogurt and needed a spoon to be able to eat the yogurt. On 08/03/11 at 11:15 a.m. Nursing Assistant (NA) #2 was observed to enter Resident #8's room. The resident stated that she had not eaten her yogurt because she could not open it and was not provided with a spoon. Resident #8 said she did not want to eat the yogurt now because it was too warm. Interview with NA #2, at this time, revealed that Resident #8 required assistance with eating and that her fluids needed be served in small cups to allow her to drink beverages without difficulty. NA #2 provided Resident #8 with a small cup that contained thickened water and the resident consumed it without difficulty. Interview with administrative staff on 08/03/11 at 11:25 a.m. revealed that Resident #8 should be	F 311		

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F 311	Continued From page 3 assisted by staff to eat her meals and snacks. Staff also stated that Resident #8's beverages should be served in small cups and that all of her foods needed to be opened to allow her to be as independent as possible with eating.	F 311	F 312 Resident's nails have been cleaned and trimmed. Nails will be checked daily and cleaned as necessary by nursing assistants. Resident acceptance will be encouraged by use of a reward sticker each day that will also serve as a monitoring tool that the nursing assistants will initial as having inspected/ cleaned the nails. Nurse will check nails weekly, monitoring for length and cleanliness and will trim as needed, again rewarding resident for his cooperation. Staff Development Coordinator will inserivce all nursing staff regarding the program for this resident and for proper nail care for all residents and what to do if the resident refuses. Nurses will check nails once a week randomly to assure compliance and will document on the ADL monitoring sheet. The DON will review and present at the weekly SWIPE (continuous quality improvement committee) meeting for two months. At the monthly Quality Assurance meeting , the committee will review the ongoing effectiveness of this plan and direct adjustment if needed for the two months of supervised monitoring.	9/1/11
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to keep fingernails clean for one (1) of nine (9) sampled residents who were dependent on staff to maintain their personal hygiene.(Resident #9). The findings are: Resident # 9 was admitted to the facility on 05/13/87 with diagnoses of cerebral palsy, convulsions, cataracts, diabetes mellitus, and mental retardation. The most recent Minimum Data Set (MDS) dated 05/31/11 revealed the resident required extensive assistance from staff for activities of daily living (ADL) including personal hygiene. A review of the Care Area Assessment (CAA) Summary dated 04/01/11 revealed ADL to be addressed in a care plan due to nutritional problems, mental errors: sequencing problems,	F 312		

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F 312	Continued From page 4	F 312		

incomplete performance, anxiety limitations, and physical limitations such as weakness, limited range of motion, poor coordination, poor balance, visual impairment and pain. Resident #9's current care plan, dated 06/07/11, specified that that she required extensive to total assist with ADLs due to cerebral palsy with limited range of motion. An approach included: provide assist with all ADLs as needed.

On 08/02/11 at 10:25 a.m. Resident #9 was observed in his room lying in bed. His fingernails on both hands were long and had brown debris underneath them. The resident was asked when he gets his nails cut and he said he did not want his nails cut because he opens soda cans with them.

On 08/02/11 at 4:15 p.m., 08/03/11 at 9:30 a.m., 08/04/11 at 12 noon and on 08/04/11 at 2:40 p.m. Resident #9's nails were observed with brown debris underneath the nails on both hands.

On 08/04/11 at 2:40 p.m. Nursing Assistant (NA) #1 who was caring for Resident #9 was interviewed. NA #1 stated that NAs usually trim and clean nails during shower days. The NA said Resident #9 is bed bound and he has to keep an eye on his nails to make sure they are cleaned during his bed baths or as needed. The NA observed the resident's nails and confirmed they should have been cleaned.

On 08/04/11 at 3:00 p.m. The Director of Nursing (DON) was interviewed. The DON stated resident's nails should be cleaned daily. She said NAs need to check resident's nails for length on bath days and trim them if needed and if the

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F 312	Continued From page 5 resident chooses to have them trimmed.	F 312		