STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING _____ B. WING _____	07/15/2016

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WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

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F 000	INITIAL COMMENTS The statement of deficiencies was amended on 09/13/16 following the Informal Dispute Resolution results notice from the Centers for Medicare and Medicaid Services (CMS). CMS agreed to uphold the F309 at actual harm (G) and deleted example #2 and to delete F157 and F314. CMS also upheld F441 and F520 which were both cited at a scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D).	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on 2 of 2 meal observations, a resident interview, staff interviews and medical record review, the facility failed to honor the food preferences for 1 of 4 sampled residents observed during dining (Resident #1). The findings included: Resident #1 was re-admitted to the facility on 11/22/13. Diagnoses included intracranial injury, spastic hemiplegia affecting the dominant side, major depressive disorder and dysphagia.	F 242	White Oak Manor-Charlotte resident's have the right to choose activities, schedules and healthcare consistent with his or her interests, assessments, and plans of care; and make choices about aspects of his or his life in the facility that are significant to the resident. Resident#1 has been re-assessed by the ST (Speech Therapist) who recommended a diet upgrade. The order for a Mechanical Soft Diet was changed to a regular texture diet. The food preferences have been updated on the	8/28/16

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

Electronically Signed | 08/05/2016

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 242	Continued From page 1 A care plan dated 03/16/16 identified that Resident #1 had fluctuating meal intake, dysphagia, and received a mechanical soft diet. Interventions included to provide food preferences when possible. A quarterly Minimum Data Set dated 05/31/16, assessed Resident #1 as having modified independence with cognition, able to understand and be understood and requiring the assistance of 1 staff person with meals. Resident #1 was observed on 07/13/16 at 12:42 PM in the main dining room having lunch. Resident #1 received a hot dog with chili, mashed potatoes, coleslaw, cream corn, water, tea, coffee, iced cake, graham crackers, and ice cream. Resident #1 stated during the observation, "Do you want my hot dog? I did not touch it. I don't like hot dogs or coleslaw, I did not eat either one. I would rather have my chicken salad sandwich." Resident #1 ate a few bites of the cream corn and all of the iced cake, ice cream, and graham crackers and drank some water and coffee. He did not eat the hot dog or the coleslaw. Review of the tray card for Resident #1 revealed coleslaw was recorded as a food he disliked and a chicken salad sandwich was recorded as an item he preferred with his meals. Resident #1 was observed on 07/14/2016 at 1:06 PM in his room having lunch. Resident #1 received chopped Salisbury steak, rice, stewed tomatoes, congealed gelatin, vegetable soup, tea, coffee, water, and ice cream. He did not receive a chicken salad sandwich. Review of the tray card for Resident #1 revealed he preferred having a chicken salad sandwich with his meal.	F 242	tray card by the RD (Registered Dietician)by 8/1/16. The RD is interviewing residents to clarify their food preferences list, this will be completed by 8/5/16. The resident tray cards for preferences will be updated by 8/8/16. The dietary staff were re-educated on assuring they follow the food preferences on the resident's tray card each meal. The re-education was conducted by the RD/CDM (Certified Dietary Manager) and completed by 8/8/16. Newly hired Dietary Staff receive this education during their job specific orientation. The RD/CDM/Cook will monitor the tray line daily for 4 weeks assure food preferences are honored and as needed thereafter. The food preference list will be discussed with each resident during the MDS look back period to assure food preferences are up to date on their tray card and that food preferences are being followed, this will be completed on an ongoing basis. Food preferences will be discussed each month during the resident council meetings to assure food preferences are being honored on an ongoing basis to assure compliance to F 242. Trends or concerns identified during the tray line observation are discussed during morning QI meetings M-F for 4 weeks and as needed thereafter. With recommendations made as indicated. The RD is responsible for ongoing compliance to F 242.	

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F 242	Continued From page 2 An interview occurred on 07/15/16 at 11:12 AM with the registered dietitian (RD) and the certified dietary manager (CDM). During the interview, the RD stated that Resident #1 had multiple foods he disliked and at times it was difficult to keep up with them all. The RD stated that if Resident #1 did not like or eat his main meal, he would eat a chicken salad sandwich and it should be provided to him. The RD further stated "he eats that (chicken salad sandwich) pretty good." The CDM stated that he routinely monitored the lunch meal tray line, but failed to provide Resident #1 with the chicken salad sandwich and expected nursing staff to communicate to dietary when Resident #1's meal intake was poor so that dietary could make sure he received the chicken salad sandwich. The CDM stated providing the coleslaw to Resident #1 was an error and missed during the monitoring of the lunch meal tray line.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews, the facility failed to place a residents call light within reach as to inform staff of the need for assistance for 1 of 1 residents sampled for accommodation of resident	F 246	White Oak Manor-Charlotte residents have the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or	8/28/16

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F 246	Continued From page 3 needs (Resident #69). The findings included: Resident #69 was admitted to the facility on 10/25/10 with diagnoses which included kidney disease, heart failure, paralysis, and shingles. An annual Minimum Data Set (MDS) dated 06/01/16 indicated Resident #69 had no short or long term memory problem, was cognitively intact for daily decision making, and required extensive assistance from staff for most of her activities of daily living. Further review of the MDS indicated Resident #69 had no behaviors exhibited and no rejection of care. On 07/15/16 at 9:00 AM, Resident #69 was observed grimacing, rocking back and forth, and stated "Oh god, my arm is killing me!" She further stated "it is awful and I can't take it anymore, please go and get me a nurse?" The resident's call bell was observed to be in a chair, approximately 2 arm lengths away from the resident's bed, and out of the resident's reach, which caused Resident #69 to be unable to call or inform the nurse that she needed assistance. Nurse #10 confirmed she was the nurse responsible for the care of Resident #69 and was informed of the resident's need for assistance. On 07/15/16 at 9:25 AM, Nurse #10 was observed to go into Resident #69's room and asked her "what's going on?" Resident #69 stated "my arm is killing me!" The resident's call light was observed to be in a chair, approximately 2 arm lengths away from the resident's bed, out of the resident's reach, which caused Resident #69 to be unable to call or inform the nurse that she	F 246	safety of the residents or other resident would be endangered. Resident #69 has their call light within reach so she is able to call for assistance when needed. The nurses/nurse supervisors will monitor call light placement for each resident daily during medication passes and resident rounds daily for 4 weeks and then ongoing. The staff have been re-educated on call light placement to be within reach for each resident. This re-education was initiated on 8/1/16 by the SDC and will be completed by 8/28/16. Newly hired staff receive this education during their specific job orientation by the SDC or Department Supervisor. Identified issues or trends noted during the monitoring will be addressed at the time of the observation with the current staff and then discussed during the morning QI meeting M-F for 4 weeks, then as indicated thereafter for system review and recommendation. Re-education or progressive disciplinary action will occur per policy as indicated. The DON is responsible for compliance to F246.	

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F 246	Continued From page 4 needed assistance. On 07/15/16 at 9:55 AM, Nurse #10 was observed to return to the resident's room with gauze and tape, donned a pair of gloves, and applied the clean gauze dressing from the 3rd joint of the resident's fingers to the arm-pit/shoulder area. Nurse #10 was observed to leave the resident's room and leave the call light lying in the chair out of the reach of the resident. On 07/15/16 at 10:00 AM, an interview was conducted with Nurse #10. When asked how the resident would call out should she need assistance, Nurse #10 indicated that Resident #69 would push her call light. Nurse #10 confirmed the resident's call light was in a chair out of the resident's reach. Nurse #10 was observed to remove the call light from the chair and clipped it to the resident's bed sheet which was within the resident's reach. An interview was conducted on 07/15/16 at 4:08 PM with the Assistant Director of Nursing (ADON). She stated she would have expected the resident's call light to be within their reach at all times. An interview was conducted on 07/15/16 at 4:45 PM with the Director of Nursing (DON). She stated she expected the staff to ensure a resident's call light was always within their reach.	F 246		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		8/28/16

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F 278	Continued From page 5 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect a therapeutic diet for Resident #117 and the Level II Preadmission Screening and Resident Review (PASRR) determination for Resident #105 identified as a Level II PASRR resident for 2 of 25 MDS reviewed. The findings included:	F 278	White Oak Manor-Charlotte assures each resident's assessment accurately reflects the resident's current status, i.e. therapeutic diets and level II PASRR. Resident#117 MDS assessment was modified to accurately reflect the resident's therapeutic diet. This was completed on 7/25/16 by the RAC (Resident Assessment Coordinator). Resident #105 MDS was modified to	

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F 278	Continued From page 6 Resident #117 was admitted to the facility on 04/02/2016 with multiple diagnoses including Diabetes Mellitus, hypertension, and depression. A review of Resident #117's Quarterly MDS assessment dated 06/08/2016 revealed Resident #117's swallowing/nutritional status under the "Nutrition approach" was coded as "none of the above" . Review of Resident #117's care plan dated 03/31/16 revealed Resident #117 was having inconsistent meal intakes. The goal was for Resident #117 to maintain body weight within care plan goal range. Interventions included providing Resident #117 with food preference when possible and offering a therapeutic diet as ordered. In an interview conducted with the Dietary Manager on 07/15/16 at 12:07 PM, she stated that the Resident was on a therapeutic diet. It was consistent with Resident #117's MDS dated 04/11/16 that coded him as having a therapeutic diet. In an interview conducted with the MDS Coordinator #2 on 07/15/16 at 12:35 PM, she acknowledged that she had completed the most recent MDS dated 06/08/16. She added it was her mistake to code Resident #117's nutrition approach as "none of the above" instead of a therapeutic diet. She explained it was her carelessness that led to the error in the Resident's most recent quarterly MDS. 2. Resident #105 was re-admitted to the facility on 03/14/16 with diagnoses including mild intellectual disabilities, dementia with psychosis and schizophrenia. A review of Resident #105's annual MDS dated	F 278	accurately reflect the level II PASRR. This was completed by the RAC on 8/1/16. The RAC Nurses will audit residents on therapeutic diets with the MDS to assure accuracy of coding of the MDS and will modify assessments for any coding inaccuracies. This will be completed prior to 8/28/16. The RAC nurses will audit the MDS for residents with a level II PASRR to assure accuracy of coding of the MDS and will modify the assessments for any coding inaccuracies. This will be completed prior to 8/28/16. The SSD (Social Services Director) will update the list of residents with Level II PASRRs every Monday for 4 Weeks and as needed thereafter. The SSD will provide an updated list as needed. Each RAC nurse (3) will audit 5 MDS each week for a total of 15 MDS from the previous weeks completed MDS to check for accuracy of coding, i.e. therapeutic diet and level II PASRR. This will be completed weekly for 4 weeks and then monthly for 2 months. The Social Service Department and RAC nurses and RD will be re-educated on accuracy of the MDS on 8/4/16 by the MDS Corporate Consultant. Trends or concerns identified during the audits/reviews are discussed during the morning QI meetings M-F for 4 weeks and as needed thereafter; with recommendations and system changes being made as indicated. The RD and SSD are responsible for ongoing compliance to F 278.	

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F 278	Continued From page 7 06/14/16 indicated Resident #105 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents revealed that Resident #105 was included among the residents named on the list. An interview was conducted on 07/15/16 at 3:08 PM with the Social Services Assistant. She stated that she completed section A 1500 on the annual MDS for Resident #105 and revealed "It was an error on my part, I should have coded the PASSR Level II for this Resident." An interview was conducted on 07/15/16 at 3:30 PM with the Director of Nursing and she stated she expected the MDS to be coded accurately.	F 278		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		8/28/16

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F 309	Continued From page 8 Based on observations, record reviews, resident interview, staff, and physician interviews, the facility failed to assess and administer effective pain medication for a resident who had shingles causing the resident to have unrelenting pain for 1 of 3 sampled residents reviewed for pain management (Resident #69). The findings included: 1) Review of a document titled "Pain Management Program" with a revised date of 12/08/10 read in part the following: · Pain - whether voiced, report, or observed - will be monitored to determine location, source, intensity, and duration. · Pain Data Collection Tool will determine if interventions are needed for uncontrolled pain, through: observation, verbalization, physician orders, and pain related diagnosis. · Residents with uncontrolled pain levels will have a pain management program implemented to include a pain flow sheet. · The plan will be adjusted as needed to assure adequate pain relief is obtained, while maintaining the resident's highest quality of life, both physically and psychosocially with the fewest side effects possible. Resident #69 was admitted to the facility on 10/25/10 with diagnoses which included kidney disease, heart failure, and shingles. An annual Minimum Data Set (MDS) dated 06/01/16 indicated Resident #69 had no short or long term memory problem, was cognitively intact for daily decision making, and required extensive assistance from staff for most of her activities of daily living. Further review of the MDS indicated	F 309	White Oak Manor-Charlotte provides the necessary care and services to attain and maintain the highest practical physical, mental. and psychological well being, in accordance with the comprehensive assessment, and plan of care. Resident #69 has been reassessed by her attending physician and a pain management plan was put into place to compliment her current routine medication of Gabapentin for nerve pain. Resident # 69's call light is within reach so they are able to call for assistance whenever needed. An Audit has been completed of residents currently on a pain management plan and PRN pain medication effectiveness has been assessed. Any concerns with ineffective pain management has been referred to the attending physician for assessment and changes as indicated. This audit was completed by the DON and nurse consultant and was completed by 8/9/16. When a PRN pain medication is administered and is ineffective, a pain flow sheet will be implemented and the doctor/extender will be notified to reassess the current pain management plans for modifications. This will continue on an ongoing basis. The nurses and nurse supervisors will complete checklists daily on each shift to assure call lights are within reach of each resident. The observations will occur during medication pass times and PRN during routine rounds by the nurse supervisors. The checklist will be given to	

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F 309	Continued From page 9 Resident #69 had no behaviors exhibited and no rejection of care. A review of the physician's orders revealed the following: · On 06/24/16 at 3:10 PM: Acyclovir (an anti-viral medication) 800 milligrams (mg) by mouth (PO) 5 times every day for 7 days, diagnosis: shingles · On 07/05/16 at 2:15 PM: 1) Capsaicin (analgesic-pain-reliever) cream 0.025% apply twice daily as needed (PRN) for right arm pain for 1 week and 2) Daily dressing changes to right arm · On 07/11/16 at 12:50 PM: Tramadol (an analgesic/pain medication) 50 mg PO every 8 hours PRN for pain · On 07/12/16 at 1:15 PM: Lidocaine (a topical numbing medication/pain reliever) 2% jelly, apply to right arm every 6 hours PRN for pain A review of the electronic Medication Administration Record (MAR) dated for 07/01/16 through 07/13/16 revealed Resident #69 was administered Tylenol 325 mg (2 tablets) PO on the following dates and times: 07/03/16 at 7:34 AM and 10:24 PM 07/05/16 at 5:46 PM 07/07/16 at 5:11 AM 07/08/16 at 10:12 AM and 10:13 PM 07/09/16 at 3:33 AM 07/10/16 at 5:43 AM and 6:00 PM 07/11/16 at 4:36 AM and 5:59 PM 07/13/16 at 12:12 AM Resident #69 had no Tylenol noted as being administered for pain from 07/11/16 at 5:59 PM until 07/13/16 at 12:12 AM (approximately 30 hours between doses).	F 309	the DON daily M-F for her monitoring of the system. The checklist will be completed daily for 4 weeks then monthly for 2 months. The license nurse staff have been re-educated on the Pain Management Program, using the pain flow sheet and notifying the doctor/extender for ineffective pain management. They were also re-educated on call light placement and the BM protocol. The CNA staff along with other ancillary staff (SS Dept., Activity dept., Dietary dept., Housekeeping and Maintenance were re-educated on the call light placement within reach of each resident. The re-education was completed by the SDC or DON and will be completed prior to 8/28/16. Newly hired staff receive this education during their job specific orientation. Identified trends or concerns noted during the audit/observations are discussed during the morning QI meeting M-F for 4 weeks then as needed thereafter. The DON is responsible for ongoing compliance of F309.	

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F 309	Continued From page 10	F 309		

The MAR also revealed Resident #69 was administered Tramadol 50 mg (1 tablet) PO on the following dates and times:
07/12/16 at 2:23 AM, 12:54 PM, and 9:51 PM
07/13/16 at 5:35 PM

Resident #69 had no Tramadol noted as being administered for pain from 07/12/16 at 9:51 PM until 07/13/16 at 5:35 PM (approximately 19 hours between doses).

The MAR further revealed Resident #69 was administered a one-time dose of Norco 5 mg-325 mg (2 tablets) PO on 07/13/16 at 9:30 PM and was later administered 2 tablets of Norco for pain on 07/15/16 at 10:05 AM (approximately 36.5 hours between doses).

A review of a document titled "Individual Resident's Narcotics Record" dated 07/11/16 through 07/13/16 with an affixed pharmacy label which read Tramadol 50 mg take 1 tablet PO every 8 hours PRN for pain.
The document indicated Resident #69 was administered her first dose of Tramadol 50 mg (1 tablet) PO on 07/12/16 at 2:00 AM by Nurse #12, with subsequent doses as per the following entries:
· 07/12/16 at 1:30 PM by Nurse #10, which was indicated on the MAR as being administered by Nurse #10 at 12:54 PM
· 07/12/16 at 9:00 PM by Nurse #11, which was indicted on the MAR as being administered by Nurse #11 at 9:51 PM

A review of a nurse's note dated 07/13/16 at 12:41 AM indicated Resident #69 had been administered a pain medication (Tramadol 50 mg

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tablet PO) on 07/12/16 at 9:51 PM and the pain medication, Tramadol, was not effective. The nurse's notes were reviewed from 07/01/16 and this was the first entry in regards to Resident #69's pain or the administration of pain medication.

A review of a nurse's note dated 07/13/16 at 1:14 AM indicated Resident #69 was administered 2 tablets of Tylenol 325 mg PO on 07/13/16 at 12:12 AM due to pain medication, Tramadol, not being effective.

Further review of the Narcotics Record indicated the following entries:
· 07/13/16 at 6:00 AM, the nurse's initials, which could not be identified, this dose of Tramadol was not indicated on the MAR as being administered
· 07/13/16 at 12:00 PM by Nurse #10, this dose of Tramadol was not indicated on the MAR as being administered

Resident #69 was observed on 07/13/16 at 12:45 PM in the dining room clinching her right arm and rocking back and forth. Resident #69 was asked if she was enjoying the music and she replied "No, my arm is hurting really bad." When asked if she needed her nurse Resident #69 stated "Yes!" During this time Resident #69 was observed not eating her meal, grimacing, and continued to rock back and forth with her head down, the resident appeared to be in great pain. Within approximately 2 minutes a nurse was observed to take the resident out of the dining room.

On 07/13/16 at 1:56 PM, Nurse #10 was observed to do a dressing change to Resident #69's right arm. Resident #69 was observed to

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grimace with pain at the time her right arm was raised off of the bed to remove the old dressing. Resident #69 was asked if she would like for the nurse to stop and administer a pain medication and she replied "No, just get it over with! Oh, lord, my arm hurts." Nurse #10 was observed to remove the old dressing and Resident #69's right arm was observed to have numerous scabbed areas on the underside of the arm, up past the elbow, on the forearm, and on the posterior part of her hand. Nurse #10 applied the Capsaicin cream 0.025% liberally to the resident's right arm and wrapped the arm with a gauze type dressing (kerlix) and applied an arm sleeve over the kerlix dressing. Resident #69 was observed to still grimace and complained of pain during the time the arm sleeve was being applied. Nurse #10 indicated she had administered Tramadol 50 mg (1 tablet) PO to Resident #69 at 12:00 PM prior to doing the dressing change, however this dose of Tramadol was not indicated on the MAR as being administered.

A review of a document titled "Pain Flow Sheet" this was the first pain flow sheet that had been started for Resident #69 with the first entry dated 07/13/16 at 4:00 PM through 07/15/16 at 9:30 AM read in part the following: columns which indicated the date, time, signature of the nurse, the location of the pain, the pain scale (from 0 to 10, with 0 = no pain and
10 = unbearable pain), medication/dose administered, follow-up (F/U) pain scale (0 to 10), and time.
Throughout the Pain Flow Sheet the location of the pain was incorrectly identified as the Left Arm when it should have been the Right Arm. The following entries were noted:

· 07/13/16 at 4:00 PM Nurse #11, Left Arm "0"

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No medication administered (admin.) with no follow-up (F/U) needed.
· 07/13/16 at 6:00 PM Nurse #11, Left Arm "9" Tramadol 50 mg (1 tablet) admin.
F/U "4" at 6:25 PM
· 07/13/16 at 9:00 PM Nurse #11, Left Arm "4" Norco 5mg-325mg (1 tablet) admin.
F/U "0" at 9:45 PM

On 07/13/16 at 6:00 PM, an interview was conducted with Resident #69. She was observed to hold her right arm, grimacing with pain, and rocking back in forth while sitting in her bed. Resident #69 stated her pain was an "8" on a scale of 1 to 10. The resident further reflected her pain had been a "10" out of 10 when observed in the dining room at 12:45 PM. Resident #69 stated her pain had not been controlled "for a while" and was unable to recall the last time she was not in pain.

On 07/13/16 at 7:22 PM, Resident #69 was observed grimacing and stated "what is wrong with my arm, it is killing me, please do something" Nurse #11 was asked to assess the resident.

A continuous observation in Resident #69's room was done on 07/13/16 from 7:25 PM to 8:15 PM. Nurse #11 asked the resident "What is your pain, now?" Resident #69 advised Nurse #11 that her pain was an "8" out of 10. The nurse stated "you had pain medicine at 6:00 PM." The resident stated "I don't remember getting any pain medicine at 6:00 PM and this pain is so bad I am going to die." Nurse #11 was observed to start the removal of the gauze dressing from the resident's right arm and Resident #69 was observed during this time to grimace, moan, shake involuntarily, and yell out "Oh lord, ouch, ouch." Nurse #11 was

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observed to ask the resident "do you want me to stop?" and the resident replied, "No, go ahead but hurry" and the nurse continued to remove the old dressing and she applied the topical jelly Lidocaine and another kerlix gauze dressing. Nurse #11 asked the resident "how are you feeling now, better?" Resident #69 was observed to shake her head in an up and down motion as to indicate "Yes."

Further review of a nurse's note dated 07/13/16 at 10:15 PM indicated Resident #69 continued to have severe pain to the right arm (approximately 21 hours, 07/13/16 at 12:41 AM to 07/13/16 at 9:10 PM). The physician was notified and a one-time order was obtained to administer Norco 5 mg-325mg 2 tablets PO. Further review of the nurse's entry indicated the resident was medicated on 07/13/16 at 9:10 PM and the pain medication, Norco, was effective.

Further review of the nurse's notes indicated an entry dated 07/14/16 at 5:59 AM, Resident #69 was resting quietly and the pain medication, Norco, was effective.

On 07/14/16 at 9:23 AM, Resident #69 was observed sitting up in her bed and eating her breakfast. The resident indicated her arm was hurting and the resident was unable to voice a number on a scale of 0 to 10 as to indicate her pain score/level. The dressing on the resident's right arm was observed to be the same dressing which was applied on 07/13/16 at approximately 8:00 PM.

On 07/14/16 at 3:15 PM, an interview was conducted with the Nurse Practitioner (NP). The NP stated she was made aware of Resident

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#69's uncontrolled pain on 07/13/16 at around 8:45 PM. The NP further stated prior to that she was unaware of the resident's uncontrolled pain.

On 07/15/16 at 9:00 AM, Resident #69 was observed grimacing, rocking back and forth, and stated "Oh god, my arm is killing me!" She further stated "it is awful and I can't take it anymore, please go and get me a nurse?" The resident's call bell was observed to be in a chair, approximately 2 arm lengths away from the resident's bed, and out of the resident's reach, which caused Resident #69 to be unable to call or inform the nurse that she needed assistance. Nurse #10 confirmed she was the nurse responsible for the care of Resident #69 and was informed of the resident's request. She stated she had not assessed or been in the resident's room and was unaware of the resident's pain. The nurse further stated she had obtained from the 3rd shift nurse that the resident had been administered Tylenol around 6:00 AM.

On 07/15/16 at 9:25 AM, Nurse #10 was observed to go into Resident #69's room and asked her "what's going on?" Resident #69 stated "my arm is killing me!" The nurse stated "so it's hurting?" Nurse #11 asked the resident "how bad is your pain on a scale of 1 to 10?" Resident #69 voiced an "8 or 9" and the nurse stated "which is it an 8 or a 9?" The resident then stated "it's a 9." Nurse #10 was observed to leave the resident's room and return after approximately 5 minutes with 2 tablets of Norco 5mg-325mg and administered the pain medication to Resident #69.

On 07/15/16 at 10:00 AM, an interview was conducted with Nurse #10. She confirmed she

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was the nurse responsible for Resident #69 on 1st shift (7:00 AM through 3:00 PM). She confirmed she was aware of the resident's uncontrolled pain and she indicated she had administered Resident #69's pain medication as ordered by the physician. Nurse #10 confirmed that the electronic MAR dated 07/13/16 indicated she had not administered any pain medication to Resident #69. Nurse #10 stated she was unable to recall if she had actually administered Resident #69's pain medication on 07/13/16. Nurse #10 further confirmed she had applied the wrong topical pain medication on 07/13/16.

A telephone interview was conducted on 07/15/16 at 3:30 PM with Nurse #9. She confirmed she was responsible for the care of Resident #69 on 07/13/16 from 11:00 PM until 7:00 AM (3rd shift). Nurse #9 stated Resident #69 had complained of right arm pain being that of a 10 on a scale of 1 to 10 during her shift on 07/13/16. Nurse #9 further stated she did not notify the physician or the NP of Resident #69's uncontrolled pain. Nurse #9 indicated she had reported the resident's pain to the third shift supervisor and was advised to administer the pain medications which was already ordered and "it would be okay." Nurse #9 further indicated she completed a concern/communication form for the physician or NP. She also indicated she had reported the resident's uncontrolled pain to the on-coming first shift nurse and to the first shift unit supervisor prior to leaving her shift the morning of 07/14/16.

The 3rd shift supervisor was unable to be contacted for an interview.

An interview was conducted on 07/15/16 at 3:52 PM with the 1st shift unit nurse supervisor (Nurse

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#6). She stated she did recall Nurse #9 completing the concern/communication form for the physician or NP and also recalled obtaining a verbal report from Nurse #9 in regards to Resident #69's uncontrolled pain the night of 07/13/16. Nurse #6 reviewed the concern/communication notebook and was unable to find or provide the form/report completed by Nurse #9. Nurse #6 stated she had not contacted the physician or the NP on 07/14/16 but was aware the second shift nurse had contacted the NP and had obtained a one-time order for Norco. Nurse #6 further stated she was unable to recall why she had not contacted the physician or NP on 07/14/16.

An interview was conducted on 07/15/16 at 4:08 PM with the Assistant Director of Nursing (ADON). She stated she would have expected the 3rd shift nurse or the 3rd shift supervisor to have contacted the physician or NP in regards to Resident #69's uncontrolled pain. The ADON further stated she would have expected the nurses to have been more attentive to Resident #69's pain and the management of getting her pain under control.

An interview was conducted on 07/15/16 at 4:45 PM with the Director of Nursing (DON). She stated they would notify the NP or the physician should there be a significant change in a resident outside of what could be done within the facility protocol. The DON further stated the Pain Assessment Flow Sheets were not routinely started on all residents but was started on resident's who had been identified as having problems with pain. The DON indicated Resident #69's pain assessment flow sheet was started on 07/13/16 after Resident #69's uncontrolled pain

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F 309	Continued From page 18 was discussed and the physician was contacted and the one-time dose of Norco was ordered. 2. The facility's Physician Standing Orders, undated, recorded in part: "Run the "No BM (bowel movement)" report daily. Residents who have not had a charted bowel movement in 3 days will trigger in this report. Check for impaction for resident who was triggered. If the resident was not impacted, give 30 millimeter (ml) of milk of Magnesia suspension by mouth for one time. If no results after 12 hours, proceed with Dulcolax 10 milligram (mg) suppository rectally for one time. If no results after one hour, may give Fleets enema per rectum. Notify physician if no results." Resident #125 was admitted to the facility on 12/27/2013 with multiple diagnoses including dementia, constipation, and osteoporosis. The most recent Minimum Data Set (MDS) dated 06/08/16 coded Resident #125 with having severely impaired cognition, requiring extensive assistance with one person physical assist for toileting, and occasionally incontinent of bladder. Review of care plan dated 03/25/16 revealed that Resident #125 was at risk of constipation due to decreased mobility. The goal was for Resident #125 to have more than 2 bowel movements weekly. Intervention included reviewing current drug regimen for drugs that may have constipation as a side effect, administering medication as ordered by physician, and documenting Resident's bowel evacuation status at least daily and report any abnormal findings to the Charge Nurse for implementation of standing orders for constipation.	F 309		

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Review of medical record revealed Resident #125 had physician's order dated 10/27/15 for Senna S 2 tablets by mouth twice daily and an additional physician's order dated 06/27/16 for Miralax powder 17 grams once daily for constipation.
Review of the July 2016 Medication Administration Record (MAR) revealed that these two medications were administered as ordered daily from 07/01/16 to 07/14/16.
Review of physician's orders and July 2016 MAR revealed Resident #125 was also receiving the following medications from 07/01/16 to 07/14/16 with constipation as a drug-related side effect:
Depakote 125 mg, 2 tablets by mouth in the morning, 1 tablet at noon and 1 tablet before bed time for dementia with behaviors causing significant distress to self.
Ativan 0.5 mg, one tablet by mouth every 8 hours as needed for dementia with behaviors causing significant distress to self.
Tramadol 50 mg, one-half tablet by mouth three times daily as needed for pain related to age-related osteoporosis without current pathological fracture.
Review of Bowel Movement Details Roster from 06/12/16 to 07/12/16 and subsequent interviews with Nurse Aide (NA) #3 on 07/14/16 at 11:08 AM, NA #2 on 07/15/16 at 11:00 AM, and Nurse #4 on 07/15/16 at 3:03 PM confirmed that Resident #125 did not have bowel movements from 07/04/16 to 07/07/16, 4 consecutive days.
Resident #125 had a bowel movement on his own on 07/08/16 at 1:44 AM. There was no documentation in the Resident #125's medical record or the July 2016 MAR of the implementation of a bowel protocol for constipation from 07/04/16 to 07/07/16.
An interview on 07/14/16 at 11:08 AM with NA #3 revealed that he worked routinely on the 7 AM to

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3 PM shift and he was providing care for Resident #125 from 07/04/16 to 07/07/16. NA #3 stated he was responsible for checking on resident's bowel movement for his shift and documenting the information in the facility's Bowel Movement Details Roster. NA #3 confirmed that Resident #125 did not have bowel movements from 07/04/16 to 07/07/16. He normally would update the nurse at the shift transition for resident's bowel-related issues.

In an interview on 07/15/16 at 11:00 AM with NA #2, she stated that Resident #125 was on a mechanically altered diet, able to feed himself, and usually had a poor appetite. She worked on the 3 PM to 11 PM shift and she was providing care for Resident #125 from 07/04/16 to 07/07/16. NA #2 confirmed Resident #125 did not have bowel movements for all the shifts she worked for the above 4 days.

An interview on 07/15/16 at 3:03 PM with Nurse #4 revealed that Resident #125 was constipated and was on 2 scheduled constipation medications. Nurse #4 stated that she was the nurse providing care for Resident #125 during the second shift on 07/04/16, first shift on 07/05/16, second shift on 07/06/16, and first shift on 07/07/16. She confirmed that Resident #125 did not have any bowel movements during all her shifts. Nurse #4 stated that the nurse supervisor would typically bring her the "No BM" report at the beginning of the shift regarding residents who had not had a bowel movement after 3 consecutive days for implementation of the standing orders for constipation. Nurse #4 could not recall if she had received the "No BM" report on 07/06/16 from the nurse supervisor. She did not know that Resident #125 did not have a bowel movement for more than 3 days and therefore she did not implement the bowel protocol for him.

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F 309	Continued From page 21 Review of the facility's "No BM" reports from 07/04/16 to 07/07/16 revealed that Resident #125 was included in the report on 07/07/16. An interview on 07/15/16 at 3:31 PM with Nurse #6 confirmed that as a nurse supervisor, she used to generate the "No BM" report for the nurses at the beginning of the shift. However, she could not recall whether she had done it on the 07/07/16 morning. She added that the nurses had been trained on how to generate this report and she expected them to generate and review the report if she did not provide it to them. In an interview on 07/15/16 at 4:23 PM with Director of Nursing (DON), she stated it was her expectation for all the nurses to generate and review the "No BM" report at the beginning of their shift and implement the bowel protocol for constipation accordingly. She agreed that the nurse should have implemented the bowel protocol for constipation for Resident #125 on 07/07/16 morning per physician's standing orders.	F 309		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and a nurse practitioner interview, the facility failed to prevent a significant medication error by administering a discontinued analgesic-pain-reliever topical medication to 1 of 3 residents reviewed for medication administration (Resident #69).	F 333	White Oak Manor- Charlotte ensures that their residents are free of any significant medication errors. resident#69 medications are administered as ordered by the attending physician. Nurse #10 has been re-educated by the DON on removing discontinued medications/treatments from the	8/28/16

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F 333	Continued From page 22 The findings included: Resident #69 was admitted to the facility on 10/25/10 with diagnoses which included kidney disease, heart failure, a stroke, and shingles. An annual Minimum Data Set (MDS) dated 06/01/16 indicated Resident #69 had no short or long term memory problem, was cognitively intact for daily decision making, and required extensive assistance from staff for most of her activities of daily living. Further review of the MDS indicated Resident #69 had no behaviors exhibited and no rejection of care. A review of the physician's orders dated 07/05/16 revealed an order for Capsaicin (analgesic-pain-reliever) cream 0.025% apply twice daily as needed (PRN) for right arm pain for 1 week. A review of the Treatment Administration Record (TAR) dated July 2016 revealed Resident #69 had applied the Capsaicin cream only one time on 07/10/16 at 10:18 PM and the cream was ordered to be stopped on 07/12/16. A review of the Medication Administration Record (MAR) dated July 2016 revealed the Capsaicin cream was not noted on any of the MAR pages 1 through 16 as being applied or administered to the resident. A review of a document titled "Consolidated Delivery Sheets" dated 07/12/16 indicated the medication Lidocaine 2% jelly was delivered to the facility on 07/12/16 at 8:00 PM and signed by receiving nurse, Nurse #11.	F 333	medication/ treatment cart so it can not be used after it has been discontinued. This will prevent residents from receiving discontinued medications. The licensed nurses staff were re-educated on receiving orders to discontinue a medication and the process for removing the discontinued medication from the medication/treatment cart in a timely manner; and on checking the MAR/TAR prior to administering any medication to assure it is an active order. The re-education was conducted by SDC/DON and will completed prior to 8/28/16. The QIM (Quality Information Manager) who is also a Pharmacy technician will each morning, M-F, run medication orders that were discontinued since the previous day and will check each medication/treatment cart to assure discontinued medications have been removed. This will be continued for 4 weeks then weekly for 2 months and as indicated thereafter. Any discontinued medications found in the medication/treatment cart will be brought to the DON by the QIM. The DON will re-educate the nurse who received the discontinued medication order and who should have removed it from the cart. Trends or concerns identified by the QIM are discussed during the morning QI meeting M-F for 4 weeks and as indicated thereafter for recommendations or suggestion as warranted. The DON is responsible for ongoing	

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F 333	Continued From page 23 On 07/13/16 at 1:56 PM, Nurse #10 was observed to do a dressing change to Resident #69's right arm. Resident #69 was observed to grimace with pain at the time her right arm was raised off of the bed to remove the old dressing. Resident #69 was asked if she would like for the nurse to stop and administer a pain medication and she replied "No, just get it over with! Oh, lord, my arm hurts." Nurse #10 was observed to remove the old dressing and Resident #69's right arm was observed to have numerous scabbed areas on the underside of the arm, up past the elbow, on the forearm, and on the posterior part of her hand. Nurse #10 applied the Capsaicin cream 0.025% liberally to the resident's right arm and wrapped the arm with a gauze type dressing (kerlix) and applied an arm sleeve over the kerlix dressing. Resident #69 was observed to still grimace and complained of pain during the time the arm sleeve was being applied. On 07/13/16 at 2:13 PM, an interview was conducted with Nurse #10. She confirmed she was the nurse responsible for Resident #69 on 1st shift (7:00 AM through 3:00 PM). Nurse #10 further confirmed she had applied the wrong topical pain medication, Capsaicin. Nurse #10 was unable to verify the Capsaicin order on the electronic MAR. Nurse #10 indicated she was aware the Capsaicin medication had been discontinued and that she had applied the Capsaicin medication during the dressing change observation because she was unaware that the Lidocaine, topical medication, had been received by the facility from the pharmacy on the night of 07/12/16. Nurse #10 verified she had not reviewed the physician's orders prior to administering the Capsaicin cream and she stated she should not have administered a	F 333	compliance to F333.	

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F 333	Continued From page 24 medication which had been stopped by the physician. On 07/13/16 at 2:35 PM a telephone interview was conducted with a Pharmacy Technician. She stated the Lidocaine medication was delivered to the facility on 07/12/16 at approximately 8:00 PM. On 07/13/16 at 5:47 PM an interview was conducted with Nurse #11. She confirmed the Lidocaine medication was received from the pharmacy on 07/12/16 at 8:00 PM. She also confirmed she had placed the medication in the treatment cart. On 07/14/16 at 3:15 PM an interview was conducted with the Nurse Practitioner (NP). The NP stated she expected the nursing staff to follow the physician's orders. The NP further stated she would have expected Nurse #10 to have found and applied the Lidocaine 2% jelly instead of the Capsaicin cream. On 07/15/16 at 4:08 PM an interview was conducted with the Assistant Director of Nursing (ADON). She stated she expected the nurse's to follow the physician's orders. The ADON stated she would have expected Nurse #10 to have called the physician in regards to the wrong medication being applied. On 07/15/16 at 4:45 PM an interview was conducted with the Director of Nursing (DON). She stated she would expect the nurses to follow the physician's orders.	F 333		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367		8/28/16

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F 367	Continued From page 25 Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on a meal observation, a resident interview, staff interviews and medical record review, the facility failed to provide a mechanical soft hot dog according to a physician prescribed therapeutic diet for 1 of 4 sampled residents observed during dining (Resident #1). The findings included: Resident #1 was re-admitted to the facility on 11/22/13. Diagnoses included intracranial injury, spastic hemiplegia affecting the dominant side, and dysphagia. Medical record review revealed Resident #1 had a physician's order dated 01/27/14 for a mechanical soft diet. A care plan dated 03/16/16 identified that Resident #1 had fluctuating meal intake, dysphagia, and received a mechanical soft diet. Interventions included to provide Resident #1 with a diet as ordered. A quarterly Minimum Data Set dated 05/31/16, assessed Resident #1 as having modified independence with cognition, able to understand and be understood, requiring the assistance of 1 staff person with meals and a mechanically altered diet due to his diagnoses of dyspahgia. Resident #1 was observed on 07/13/16 at 12:42 PM in the main dining room having lunch.	F 367	White Oak Manor- Charlotte provides therapeutic diet as prescribed by the attending Physician. Resident #1 has been evaluated by ST (speech therapist) for a diet upgrade and the ST has recommended upgrading the diet to a regular textured diet. The current physician ordered diet is for regular textured diet for resident #1. Resident #1 is offered and alternative food item if they do not want the food served. Other residents on physician prescribed therapeutic diets receive the diet ordered by the physician and if the resident does not want the food item served the staff offers an alternative food item. The RD/CDM/Cook will monitor the tray line for 4 weeks to assure food preferences are followed for each resident and as needed thereafter. The dietary staff re-educated on assuring they follow the therapeutic diet listed on the resident's tray card each meal. The re-education was conducted by the RD/CDM (Certified Dietary Manager) and completed by 8/8/16. The nursing staff were re-educated on offering residents alternative food items if they do not want the food served. The re-education was conducted by the DON or SDC and will be completed prior to 8/28/16. Newly hired dietary staff and nursing staff	

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F 367	Continued From page 26 Resident #1 received a regular hot dog with chili. Review of the tray card for Resident #1 revealed he should have received a mechanical soft hot dog. Resident #1 stated that at times he received foods that were not mechanical soft or chopped and he did not eat them. Resident #1 did not eat the hot dog he received and self propelled out of the main dining room at 1:00 PM without staff offering him an alternate food item. An interview occurred on 07/15/16 at 11:12 AM with the Registered Dietitian (RD) and the Certified Dietary Manager (CDM). During the interview, the CDM stated he monitored the lunch meal tray line on 07/13/16, but must have missed the regular hot dog Resident #1 received. The CDM referred to the therapeutic diet spreadsheet and stated that residents on a physician prescribed mechanical soft diet should have received a mechanical soft hot dog. The RD stated that the hot dog served to Resident #1 should have come from the kitchen mechanical soft or ground. The RD stated that that his diagnosis of dysphagia put him at increased risk for swallowing difficulties if he tried to bite a hot dog that was not mechanical soft or ate foods that were not mechanical soft or ground.	F 367	receive this education during their specific job orientation with the SDC or department manager. Trends or concerns identified during the tray line observations are discussed during the QI meetings M-F for 4 weeks and as needed thereafter with recommendations made as indicated. The DON and RD are responsible for ongoing compliance to F367.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		8/28/16

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F 441	Continued From page 27 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to properly dispose of a dirty dressing removed from a resident who had shingles for 1 of 2 sampled residents observed during a dressing change (Resident #69). The findings included:	F 441	White Oak Manor-Charlotte has an established as does maintain an infection control program designed to provide a safe, sanitary and comfortable environment that helps prevent the development and transmission of disease and infection. Resident #69 physician orders have	

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F 441	Continued From page 28 Review of a nurse's note dated 06/26/16 at 8:30 AM indicated Resident #69 was on an anti-viral medication for shingles. A nurse's note dated 07/01/16 at 3:00 PM indicated Resident #69 had intact blisters to her right arm, staff had been informed to keep the blistered areas covered with gauze, and that the areas would need to be dried up before they were to be uncovered. Review of a physician's progress note dated 07/05/16 indicated Resident #69 had a diagnosis of shingles with painful lesions to the right arm and was to have her right arm wrapped daily with a gauze type dressing (kerlix). The progress note further indicated the resident had a previous outbreak which had not improved with an anti-viral medication (Acyclovir) that was administered for 7 days and the resident was started on Valacyclovir (an anti-viral medication) 1000 milligrams by mouth every 8 hours for 7 days. Review of a physician's order dated 07/05/16 with a start date of 07/06/16 indicated for Resident #69 to have daily dressing changes to the right arm with kerlix. Review of the document titled "24 Hour Report Sheet" dated 07/11/16 and 07/12/16 indicated Resident #69 was on anti-viral medications for shingles. On 07/15/16 at 9:35 AM, Nurse #10 was observed with gloved hands, stood on the left side of the resident's bed, reached across the resident, and removed the dressing from the resident's right arm which was dated 07/14/16.	F 441	changed and she currently no longer has an order for a dressing to her right arm since the blistered areas are now resolved. Nurse #10 has been re-educated on following the infection control policy during a dressing change by the DON/SDC and was completed prior to 8/28/16. Dressing changes performed by the nurses will be completed following infection control policy for dressing changes. The licensed nursing staff were re-educated by the SDC/DON on how to change a dressing and dispose of the soiled dressing following infection control guidelines prior to 8/28/16. Newly hired nurse staff receives this education by the SDC during their job specific orientation. The ADON will educate the nurses on removing a dressing and have the nurses do a return demonstration and observation of the nurse doing the dressing change to assure compliance to F441. This will be completed prior 8/28/16 and will be repeated if incorrect procedure is observed. The ADON, DON or SDC will observe a dressing changed with 3 nurses weekly for 4 weeks, then monthly for 2 months and as needed thereafter to assure compliance to infection control standards and compliance to F 441. Trends will be discussed M-F during the mornings for 4 weeks and as indicated thereafter with recommendations made as necessary. The DON is responsible for ongoing	

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F 441	Continued From page 29 The resident was observed to grimace and yell out when the nurse stopped what she was doing and asked the resident "do you want me to wait until the pain medication starts working before I continue?" Resident #69 stated "No, go ahead." Nurse #10 was observed to completely remove the old dressing and laid it on the right side of the resident's bed onto the bed linens. Nurse #10 was observed to wash her hands and don clean gloves and she applied the medication Lidocaine (a topical numbing medication/pain reliever) jelly to the resident's right arm. While the nurse stood on the left side of the resident's bed, Nurse #10 was observed to raise the resident's arm to apply the topical jelly underneath the upper part of the arm when the resident began to shake with pain, grimace, and yell out. The nurse was asked to move to the right side of the bed as to prevent the pulling and lifting of the resident's arm across her body. The nurse moved to the right side of the bed and finished applying the Lidocaine topical pain jelly. Nurse #10 was observed to pick up the dirty dressing off of the right side of the bed and laid the dirty dressing on the over bed table on the left side of the resident's bed. She was observed to remove her gloves, turning them wrong side out, laid the gloves on the over bed table with the dirty dressing, placed the lidocaine jelly back into the box, picked up the dirty gauze dressing and the gloves with her bare (ungloved) hand, threw it all into a trash bag, placed the box of lidocaine on the right side of the sink, tied a not in the trash bag, flipped on the light switch for the light over the sink, washed her hands, picked up the trash bag with her left hand, picked up the lidocaine box with her right hand, flipped the light switch off, and stated to the resident "let me go and get some more gauze and I will be right back."	F 441	compliance to F441.	

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F 441	Continued From page 30	F 441		

On 07/15/16 at 9:55 AM, Nurse #10 was observed to return to the resident's room with gauze and tape, donned a pair of gloves, and applied the clean gauze dressing from the 3rd joint of the resident's fingers to the arm-pit/shoulder area. Nurse #10 also was observed to prop Resident #69's arm upon a pillow and re-positioned the resident in bed. Nurse #10 was observed to not clean or wipe off the resident's over bed table with a disinfectant.

On 07/15/16 at 10:00 AM, an interview was conducted with Nurse #10. Nurse #10 indicated she discarded the dirty dressing and the gloves in the trash can. She further indicated she was unaware of placing the dirty dressing on the bed or on the over bed table.

An interview was conducted on 07/15/16 at 4:08 PM with the Assistant Director of Nursing (ADON). She stated she would have expected Nurse #10 to have discarded the dirty dressing and the dirty gloves into a trash bag immediately up removal and that they should have not been placed on the resident's bed or on her over bed table.

An interview was conducted on 07/15/16 at 4:30 PM with Nurse #3 the infection control coordinator. She stated she would have expected Nurse #10 to have placed a barrier between the resident's arm and on the over bed table. Nurse #3 further stated she would have expected Nurse #3 to have placed the dirty dressing and dirty gloves into the trash bag and not on the bed linens or on the over bed table. Nurse #3 also stated she would have expected Nurse #3 to have disinfected the resident's over bed table.

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F 441	Continued From page 31 An interview was conducted on 07/15/16 at 4:45 PM with the Director of Nursing (DON). She stated she expected the nursing staff to dispose of dirty dressings and dirty gloves properly in trash bags.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to accurately assess and document a resident's pain for 1 of 3 sampled resident's reviewed for medical record accuracy (Resident #69). The findings included: A review of a document titled "Individual Resident's Narcotics Record" dated 07/11/16 through 07/13/16 with an affixed pharmacy label which read Tramadol 50 mg take 1 tablet PO	F 514	White Oak Manor-Charlotte maintains the clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Resident # 69 medication administration on the narcotic sheets/ MAR (medication administration record) and the pain flow sheet accurately reflect the time, date, and location when the medication was administered.	8/28/16

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F 514	Continued From page 32 every 8 hours PRN for pain. The document indicated Resident #69 was administered her first dose of Tramadol 50 mg (1 tablet) PO on 07/12/16 at 2:00 AM by Nurse #12, with subsequent doses as per the following entries: · 07/12/16 at 1:30 PM by Nurse #10, which was indicated on the MAR as being administered by Nurse #10 at 12:54 PM · 07/12/16 at 9:00 PM by Nurse #11, which was indicted on the MAR as being administered by Nurse #11 at 9:51 PM Further review of the Narcotics Record indicated the following entries: · 07/13/16 at 6:00 AM, the nurse's initials, which could not be identified, this dose of Tramadol was not indicated on the MAR as being administered · 07/13/16 at 12:00 PM by Nurse #10, this dose of Tramadol was not indicated on the MAR as being administered On 07/13/16 at 1:56 PM, Nurse #10 applied the Capsaicin cream 0.025% liberally to the resident's right arm and wrapped the arm with a gauze type dressing (kerlix) and applied an arm sleeve over the kerlix dressing. Resident #69 was observed to still grimace and complained of pain during the time the arm sleeve was being applied. Nurse #10 indicated she had administered Tramadol 50 mg (1 tablet) PO to Resident #69 at 12:00 PM prior to doing the dressing change, however this dose of Tramadol was not indicated on the MAR as being administered. A review of a document titled "Pain Flow Sheet" this was the first pain flow sheet that had been started for Resident #69 with the first entry dated	F 514	An audit of residents who have pain flow sheets compared to the MAR will be completed by the Nursing Administration (DON, ADON, SDC, nursing supervisors, HIM (Health Information manager) and completed prior to 8/28/16. The licensed nurse staff were re-educated on accurately completing the pain flow sheet, the narcotic sheet and how the MAR should accurately reflect what medications were given; the location of the pain should be accurately reflected on the pain flow sheet. The re-education was provided by the DON/SDC and will be completed prior to 8/28/16. The 11-7 nursing supervisor and HIM will complete weekly audits of random narcotic sheets compared to the MAR to assure compliance to F514 for 4 weeks and as indicated thereafter. The pain flow sheets will be discussed M-F during the QI meeting with recommendations and system change suggestions given as needed for 4 weeks and as indicated thereafter. The DON is responsible for ongoing compliance to F514.	

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F 514	Continued From page 33	F 514		

07/13/16 at 4:00 PM through 07/15/16 at 9:30 AM read in part the following: columns which indicated the date, time, signature of the nurse, the location of the pain, the pain scale (from 0 to 10, with 0 = no pain and
10 = unbearable pain), medication/dose administered, follow-up (F/U) pain scale (0 to 10), and time. Throughout the Pain Flow Sheet the location of the pain was incorrectly identified as the Left Arm when it should have been the Right Arm. The following entries were noted:

· 07/13/16 at 4:00 PM Nurse #11, Left Arm "0" No medication administered (admin.) with no follow-up (F/U) needed.
· 07/13/16 at 6:00 PM Nurse #11, Left Arm "9" Tramadol admin. F/U "4" at 6:25 PM
· 07/13/16 at 9:00 PM Nurse #11, Left Arm "4" Norco admin. F/U "0" at 9:45 PM
· 07/14/16 at 6:00 AM Nurse #12, Left Arm "5" Tramadadol admin. F/U "0: at 7:00 AM
· 07/14/16 at 10:00 AM Nurse #10, Left Arm "5" Tylenol admin. F/U "5" at 11:00 AM
· 07/14/16 at 12:00 PM Nurse #10, Left Arm "5" Tramadol admin. F/U "5" at (Nurse #10 had written the f/u time of 11:15 AM)

On 07/13/16 at 6:00 PM, an interview was conducted with Resident #69. She was observed to hold her right arm, grimacing with pain, and rocking back in forth while sitting in her bed. Resident #69 stated her pain was an "8" on a scale of 1 to 10. The resident further indicated her pain was a "10" out of 10 when observed in the dining room at 12:45 PM.

A continuous observation in Resident #69's room was done on 07/13/16 from 7:25 PM to 8:15 PM. Nurse #11 asked the resident "What is your pain, now?" Resident #69 advised Nurse #11 that her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345238	A. BUILDING _____ B. WING _____	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - CHARLOTTE	4009 CRAIG AVENUE CHARLOTTE, NC 28211

(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 514	Continued From page 34 pain was an "8" out of 10. The nurse stated "you had pain medicine at 6:00 PM." The resident stated "I don't remember getting any pain medicine at 6:00 PM and this pain is so bad I am going to die." An interview was conducted on 07/15/16 at 3:52 PM with the 1st shift unit nurse supervisor (Nurse #6). She stated she expected the nursing staff to document accurately for a resident's permanent medical record. An interview was conducted on 07/15/16 at 4:08 PM with the Assistant Director of Nursing (ADON). She stated she expected the nursing stated assess and accurately document their findings whether it would be in regards to the resident's pain, location of the pain, and the pain scale number. An interview was conducted on 07/15/16 at 4:45 PM with the Director of Nursing (DON). She stated they tried to maintain accurate medical records and that the location noted on the pain flow sheet was being too picky and that they had implemented a pain flow sheet on 07/13/16 at 4:00 PM.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		8/28/16

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F 520	Continued From page 35 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July 2015. This was for one recited deficiency which was originally cited in June 2015 on a recertification survey and complaint investigation and again on the current recertification survey. The deficiency was in the area of infection control. The facility's continued failure to implement and maintain procedures from a QAA Committee, during two federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included:	F 520	White Oak Manor-Charlotte maintains a quality assessment committee consisting of the director of nursing services; a physician designated by the facility; and at least three other members of the facility's staff. The Quality Assessment and assurance committee meets at least quarterly to identify issues with which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identify quality deficiencies. White Oak Manor-Charlotte has an active Infection Control Program and procedure for dressing changes and disposal of the soiled dressings. Nurse #10 was re-educated at the time of the survey 7/15/16on dressing protocol and infection	

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F 520	Continued From page 36 This tag is cross referred to: F 441: Infection Control: Based on observations, record review, and staff interviews, the facility failed to properly dispose of a dirty dressing removed from a resident who had shingles for 1 of 2 sampled residents observed during a dressing change. During the June 2015 recertification survey and complaint investigation, the facility was cited for failure to complete hand hygiene after closing the lid of a bedside commode and prior to setting up the meal tray for a resident. On the present survey, the facility failed to properly dispose of a soiled dressing. An interveiw conducted on 07/15/16 at 5:24 PM with the Administrator revealed she attributed a repeat deficiency in the area of infection control to the fact that infection control practices depended heavily on the actions of staff. The Administrator stated that due to staff turnover, upper management would have to focus on individual employees regarding the development of good infection control habits.	F 520	control. The nursing staff were re-educated by the ADON/DON/SDC on following the procedure for dressing changes and disposal of soiled dressings following the infection control guidelines. The re-education will be completed prior to 8/28/16. Newly hired nursing staff receive this education during their job specific orientation by the SDC. The ADON will educate the nurses on removing a dressing and have nurses do a return demonstration and observation of the nurses do a return demonstration and observation of the nurse doing the dressing changes to assure ongoing compliance to the dressing change procedure. this will be completed prior to 8/28/16 and will be repeated if incorrect procedure is observed. Annual Infection Control education is provided to staff each year. The facility meets monthly and quarterly for QI meetings and infection control trends are reviewed with recommendations and suggestions discussed and implemented as necessary. Trends will be discussed M-F during the morning QI Meetings for 4 weeks and as indicated thereafter with recommendations made as necessary. The DON and Administrator are responsible for ongoing compliance to F520.	