STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. BUILDING _____ B. WING _____	C 06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - SHELBY	401 N MORGAN STREET SHELBY, NC 28150

(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 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, staff and resident interview, the facility failed to honor the choice to smoke unsupervised for 1 of 1 sampled resident, who was assessed as being able to smoke safely. Resident #99 was not permitted to smoke without supervision and could only smoke at designated times. The findings included: Resident #99 was admitted to the facility on 09/28/09. His diagnoses included peripheral vascular disease, mononeuropathy, and hypertension. Resident #99 was identified as the only resident in the facility who smoked. Review of the smoking policy with a revision date of 05/23/17 stated that the company's "facilities are smoke-/tobacco free. The only exceptions are residents who were 'grandfathered in'	F 242	White Oak Manor-Shelby does honor the residents' right to make choices. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. Resident #99 has been assessed to be able to smoke independently. Resident #99 is the only resident who is "grandfathered in" to be able to smoke, as the facility is now a tobacco-free campus. The Smoking Policy was revised for the facility and signed by Resident #99 to smoke unsupervised and at times of his choosing in the designated outdoor smoking area. 2. How Corrective Action will be	7/24/17

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

Electronically Signed | 07/24/2017

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F 242	Continued From page 1 (already a resident of the facility when this policy became effective). Those residents are assisted to continue to smoke/use tobacco in designated area(s) outside the building." A smoking schedule dated 02/02/17 noted the times listed were to be used for the resident who needed supervised smoking. There were 5 different times during the day with assigned staff. This schedule stated a smoking apron was required. On this form was listed only Resident #99 who smoked. The most recent Smoking Safety Data Collection dated 04/20/17 assessed Resident #99 as being able to self extinguish a cigarette, being able to appropriately utilize an ashtray, he did not drop ashes on himself, he complied with the facility smoking rules, and he was able to stand independently. The form marked that there were no concerns. Under evaluation the form stated he demonstrated the ability to safely smoke cigarettes with minimal supervision and an individual care plan was developed. Under the area of comments was that he wore a smoking apron as required by facility policy. This form was completed by the Social Service Director. His most recent Minimum Data Set, a quarterly dated 05/24/17 coded him with intact cognition, having no behaviors, and walked independently. The current care plan with an onset date of 03/11/11 stated under problem that Resident #99 was reassessed for smoking on 03/11/11 related to the desire to start back smoking after trying to quit. The facility policy had changed and resident was now supervised smoking as all residents must be supervised. The goal was for the	F 242	Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice. There are no other residents with the potential to be affected, as Resident #99 is the only resident who smokes and is "grandfathered in" to be able to smoke. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. The facility Smoking Policy has been revised to allow for Resident #99 to be able to smoke independently and at times of his choosing at the designated outside smoking area. Staff have been educated on Resident #99 being able to smoke unsupervised and at times of his choosing. All newly hired staff will be educated during Orientation by the Staff Development Nurse and/or the Social Service Director. Compliance to F242 will be monitored by the Administrator and/or the Social Services Director by completing observations once a week for eight weeks that Resident #99 is obtaining his smoking supplies and going to smoke independently at times of his choosing. This will continue on an ongoing basis when the monthly smoking assessment is completed. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure	

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F 242	Continued From page 2 resident to follow the facility policy for smoking through 09/01/17. Interventions included: *05/27/11 Assist resident in obtaining cigarettes and lighters as needed; *05/27/11 Supply resident with schedule for smoking so that he can make plans to attend when he wants to participate; *05/27/11 Make smoking apron available for resident use; and *05/27/11 Assess every 3 months/or change of resident's medical condition to monitor for safety needs. Review of nursing notes revealed no documentation that referred to smoking safety concerns. On 06/25/17 at 2:56 PM, Resident #99 stated during interview that he smoked in the courtyard. He further stated that ever since a resident was burned while smoking at another facility, this facility makes him be supervised. He stated he has his right mind, has no seizure history and does not feel good about having to be supervised as he'd like to smoke independently. On 06/27/17 at 9:25 AM, Resident #99 independently walked using his walker to the courtyard to smoke. He was joined by an activity assistant who carried his lighter and cigarette to him at 9:33 AM. This activity assistant gave him an apron which he donned himself, and staff lit his cigarette. Resident #99 was observed to smoke safely, flicking ashes into the ashtray. The activity assistant stated during this time that Resident #99 was grandfathered in when the smoking policy changed and he had to be supervised because the facility required all residents who smoked had to be supervised. She	F 242	That Solutions are Sustained and Dates When Corrective Action will be Complete. Ongoing compliance to F242 will monitored by review of the observations once a week for eight weeks that Resident #99 is obtaining his smoking supplies and going to smoke independently at times of his choosing. This will continue on an ongoing basis when the monthly smoking assessment is completed. The results of these reviews, or any concerns about the resident smoking independently will be discussed in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results of these observations will also be reviewed during the monthly QA meeting for any further discussion and recommendations, if needed. The Administrator and Social Services Director are responsible for the ongoing compliance of F242.	

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F 242	Continued From page 3 stated Resident #99 was the only resident remaining in the facility who was grandfathered in. During follow up interview with the activity assistant on 06/27/17 at 10:46 AM, she stated she had never observed any unsafe smoking behaviors from Resident #99 as he has always been very careful and wore his smoking apron. The Social Service Director was interviewed on 06/28/17 at 11:16 AM. She stated that she assessed Resident #99 for smoking safety every three months by actually observing him. She stated that the facility policy required the use of a smoking apron on Resident #99 and that he always smoked with supervision. She described him as being very high functioning. She stated he tried to quit smoking and made sure that he would be permitted to smoke at this facility if he could not quit and that was approved. She stated he was supervised during smoking as per facility policy he had to be supervised for his safety. She further stated that she has worked with him on the schedule and has changed it several times with his input. The Social Service Director stated he always followed the rules. Interview with the Administrator on 06/29/17 at 11:51 AM revealed that when the smoking policy changed 6 years ago, Resident #99 never said he wanted to smoke independently and staff worked with him to schedule the smoking times per his choice.	F 242		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services	F 253		7/27/17

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F 253	Continued From page 4 necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store a bed pan in a shared bathroom (room # 211) on 1 of 2 halls and failed to repair a broken toilet paper holder in a shared bathroom (room # 103) on 1 of 2 halls. The findings included: A memo labeled "Things to Remember" dated 9/12/16 provided by the facility read in part, #8. Check bathrooms for soiled urine graduates, label bed pans, bath pans, denture cups, urinals, and urinal graduates with resident's name. #9. Clean urinals, bedpans, and wash basins after each use and put "out of sight." 1. On 6/25/17 at 1:06 PM a bed pan was observed on the bathroom floor in room # 211 not labeled or covered. On 6/26/17 at 9:59 AM a bed pan was observed on the bathroom floor in room # 211 not labeled or covered. On 6/27/17 at 9:24 AM a bed pan was observed on the bathroom floor in room # 211 not labeled or covered. On 6/27/17 at 9:32 AM an interview with Nurse aide # 4 stated bed pans were supposed to be cleaned, dried and stored in a clear plastic bag. Nurse aide # 4 stated the bed pan in room # 211 was not stored properly and should have been labeled and covered.	F 253	White Oak Manor-Shelby does provide Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. (a) The unlabeled, unbagged bed pan in Room 211 was discarded on June 27, 2017 and a new bed plan was labeled and stored appropriately. The Administrator initiated reeducation/reinservicing on Storing and Labeling Bed Pans/Bath Basins on June 27, 2017 for the Nursing Department. (b) The toilet paper holder for Room 103 was repaired by Maintenance on June 27, 2017. The Maintenance Department initiated and completed a facility wide resident room audit of toilet paper holders on June 27, 2017. Interviews by the Administrator with the Department Manager responsible for this room check and the Maintenance Supervisor revealed the toilet paper holder in Room 103 had been repaired multiple times, as the resident's wheelchair was noted to often hit the holder and cause the need for repair. 2. How Corrective Action will be	

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F 253	Continued From page 5 On 6/27/17 at 9:36 AM Housekeeper # 1 stated the bed pan in room # 211 was on the floor in the bathroom this morning and she just cleaned around it. Housekeeper # 1 stated the nurses threw the bed pans away if they were not being used. On 6/27/17 at 9:42 AM The Assistant Director of Nursing (ADON) stated basins and bed pans were supposed to be labeled and stored in a plastic bag if in a semi private room. The ADON stated the bed pan in room # 211 was stored incorrectly and should have been labeled and covered. The ADON indicated she did not know who the bed pan belonged to so she would throw the bed pan away. On 6/27/17 at 11:55 AM an interview with the Administrator revealed her expectations were for bed pans to be labeled in shared rooms and stored properly in a clean plastic bags. 2. On 6/26/17 at 3:04 PM a toilet paper holder was observed to be broken with a piece in the bathroom floor in room # 103. On 6/27/17 at 9:51 AM a toilet paper holder was observed to be broken with a piece in the bathroom floor in room # 103. On 6/27/17 at 9:51 AM an interview with a private sitter for a resident in room # 103 indicated the toilet paper holder had been broken for about 6 months and the housekeeping staff cleaned the bathroom daily so they should have noticed it was broken. On 6/27/17 at 9:55 AM an interview with Nurse aide # 5 stated the toilet paper holder in room #	F 253	Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice. (a) The Administrator initiated reeducation/reinservicing on Storing and Labeling Bed Pans/Bath Basins on June 27, 2017 for the Nursing Department. Additional reeducation/reinservicing was completed by the Director of Nursing on July 17 and July 18th, 2017, at scheduled Nurses' and Nursing Assistant meetings. Reeducation/reinservicing was also initiated on July 13, 2017 for the Housekeepers. This was initiated by the Administrator and addressed Housekeepers' monitoring of bed pans/bath basins during daily room cleaning. Staff members who are on approved leave of absences or off due to vacation/etc. will have their inservicing completed upon reporting back to work. (b) The Maintenance Supervisor will oversee weekly audits of checking toilet paper holders in all resident rooms for four weeks (beginning June 27, 2017). These audits will then be completed monthly and as needed. The Administrator will be responsible for reviewing these audits. Work order forms will also continue to be used to communicate any room maintenance needs. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur.	

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F 253	Continued From page 6 103 had been broken for a while and she did not recall if it had been reported to maintenance. On 6/27/17 at 9:59 AM an interview with Housekeeper # 2 indicated the toilet paper holder in room # 103 had been broken since December 2016. Housekeeper # 2 stated she had reported the broken toilet paper holder to her supervisor and the maintenance guys and it still had not been fixed. On 6/27/17 at 10:32 AM an interview with the Maintenance Assistant revealed he did not recall a work order slip for the toilet paper holder to be fixed in room # 103. The Maintenance Assistant picked up the broken piece out of bathroom floor and stated the piece looked like it could have been broken for a few days. The Maintenance Assistance further indicated work requests slips are filled out by the staff and the maintenance staff was supposed to walk around and inspect the facility for things needing to be fixed. On 6/27/17 at 11:55 AM an interview with the Administrator revealed her expectations for the staff to complete routine room checks and fix broken toilet paper holders when found.	F 253	(a) The Administrator initiated reeducation/reinservicing on Storing and Labeling Bed Pans/Bath Basins on June 27, 2017 for the Nursing Department. Additional reeducation/reinservicing was completed by the Director of Nursing on July 17 and July 18th, 2017, at scheduled Nurses' and Nursing Assistant meetings. Reeducation/reinservicing was also initiated on July 13, 2017 for the Housekeepers. This was initiated by the Administrator and addressed Housekeepers' monitoring of bed pans/bath basins during daily room cleaning. Staff members who are on approved leave of absences or off due to vacation/etc. will have their inservicing completed upon reporting back to work. This inservicing will be repeated with newly hired staff during Orientation by the Staff Development Nurse. This training will also be reinforced as necessary to ensure compliance by the Staff Development Nurse and/or the Administrator. Ongoing compliance will be monitored by the Administrator, Director of Nursing, and the Housekeeping Supervisor by review of random observations of bed pans to ensure proper labeling and storing. These audits are to be completed by Department Managers/Ancillary Staff and at least 100 total observations will be completed weekly for four weeks, then at least twenty observations weekly for one month, and then ten per month for three quarters, and then as needed.	

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F 253	Continued From page 7	F 253	(b) The Maintenance Supervisor will oversee weekly audits of checking toilet paper holders in all resident rooms for four weeks (beginning June 27, 2017). Ongoing compliance will be monitored by the Maintenance Supervisor and the Administrator by completing/reviewing ongoing audits completed monthly and as needed. Work order forms will also continue to be used to communicate any room maintenance needs. Any newly hired Maintenance worker will be inserviced during Orientation on regularly scheduled checks of toilet paper holders. This inservicing will be completed by the Administrator, Maintenance Supervisor, or Staff Development Nurse. Newly hired facility staff will also be trained during Orientation on reporting Maintenance issues, such as toilet paper holders. This training will be completed by the Staff Development Nurse. This training will also be reinforced as necessary to ensure compliance by the Staff Development Nurse and/or the Administrator. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete. Ongoing compliance to F253 will monitored by review of the audits/observations on bed pans and toilet paper holders. The results of these audits/observations will be reviewed by in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results	

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F 253	Continued From page 8	F 253	of these audits/observations will also be reviewed during the monthly QA meeting for any further discussion and recommendations, if needed. The Administrator, Director of Nursing, Maintenance Supervisor and Housekeeping Supervisor are responsible for ongoing compliance to F253.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 272		7/21/17

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F 272	Continued From page 9 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the Minimum Data Set section involving cognition for 1 of 33 sampled residents (Resident #230). The findings included: Resident #230 was admitted to the facility on 06/09/17 for rehabilitation after a hospitalization for end stage renal disease, encephalopathy, anemia, and the need for dialysis. The admission Minimum Data Set dated 06/16/17 coded him as "not assessed" for the Brief Interview for Mental Status (BIMS). The staff assessed Resident #230 has having no short term or long term memory impairments and being independent with decision making. The Care	F 272	White Oak Manor-Shelby does make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the RAI. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. Resident #230 discharged home on June 29, 2017. 2. How Corrective Action will be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice.	

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F 272	Continued From page 10 Area for Activities of Daily Living Skills, dated 06/22/17, stated he was alert and oriented and able to make his needs known. Interview with the MDS Coordinator #2 on 06/29/17 at 10:10 AM revealed that corporate staff had instructed the MDS Coordinators to complete the BIMS on the last day of the look back period. When she went to complete Resident #230's BIMS, he was at dialysis and would no be returning until around 5:30 PM and she would be off work by then. She opted to talk to staff and do record review in order to complete this section. The Director of Nursing was interviewed on 06/29/17 at 10:56 AM and stated she expected the MDS Coordinator to plan around Resident #230's dialysis schedule in order to complete the BIMS assessment. On 06/29/17 at 11:51 AM the Administrator stated she expected the MDS coordinator to plan around Resident #230's dialysis schedule in order to complete the assessment with his input.	F 272	An audit of current residents was completed on June 30, 2017, to ensure BIMS were completed appropriately. All admitted and readmitted residents' BIMS will be conducted/completed with the resident as appropriate. Reeducation/reinserving with current MDS Coordinators was completed on July 21, 2017 and conducted by the Corporate RAI Coordinator. This reinservicing addressed that staff assessments should not be conducted in place of the BIMS interview, and completing these timely and during the MDS observation period. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. Reeducation/reinserving with current MDS Coordinators was completed on July 21, 2017 and conducted by the Corporate RAI Coordinator. This reinservicing addressed that staff assessments should not be conducted in place of the BIMS interview, and completing these timely and during the MDS observation period. This inservicing will also be completed for any new MDS Coordinator by the Corporate RAI Coordinator. Compliance to F272 will be monitored by the Corporate RAI Coordinator and the Administrator. The Corporate RAI Coordinator will complete random audits of BIMS completion on six residents weekly for four weeks, then six residents monthly for three months, then as	

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F 272	Continued From page 11	F 272	needed. The Administrator will review these random audits. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete. Ongoing compliance to F272 will be monitored by the review of the random audits for the BIMS completion on the MDS. The results of these audits will be reviewed by in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results of these audits/observations will also be reviewed during the monthly QA meeting for any further discussion and recommendations, if needed. The Administrator and Director of Nursing are responsible for ongoing compliance to F272.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that	F 309		7/27/17

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F 309	Continued From page 12 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to follow the physician ordered fluid restriction for 1 of 2 sampled residents with fluid restriction orders (Resident #230). The findings included: Resident #230 was admitted to the facility on 06/09/17. His diagnoses included end stage renal disease, encephalopathy, and anemia. The history and physical dated 06/14/17 stated Resident #230 was admitted to the hospital and found to be encephalopathy and uremic. It was	F 309	White Oak Manor-Shelby does provide services to maintain the highest well-being and care for the residents. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. Staff removed the water pitcher from Resident #230's room when identified as being on a fluid restriction. Resident #230 was discharged home on June 29, 2017. Re-education/inservicing was initiated with	

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F 309	Continued From page 13 determined by nephrology that he required dialysis. Since undergoing dialysis, his encephalopathy had cleared and he felt much better. He was admitted to the facility for short term rehabilitation. Physician orders dated 06/16/17 included a 1000 cubic centimeters (cc) per 24 hours fluid restriction diet which stated nursing would provide 90 milliliters (equaling 270 cc) with med pass 3 times daily and dietary would provide 730 cc on the trays. The Minimum Data Set, an admission dated 06/16/17 noted he had intact cognition and was independent with decision making skills, received a therapeutic diet and ate with set up and supervision. It was also coded that he received dialysis. The admission nutritional screen dated 06/16/17 noted he received a low concentrated sweets diet, no added salt and was on a 1000 cc which was distributed by 270 cc for medication pass per day and 730 cc from the dietary department per day. On 06/25/17 at 12:48 PM Resident #230 was observed eating in his room. On his table was a water pitcher with water in it. On 06/27/17 at 12:37 PM, Resident #230 was observed eating in his room. He had a full water pitcher by his side in addition to the fluids on his tray. Resident #230 stated at this time that he doesn't drink a lot from the water pitcher. Nurse Assistant (NA) #1 stated during interview on 06/27/17 at 4:23 PM that she normally filled	F 309	the Nursing Department on July 17 and July 18, 2017 by the Director of Nursing during Nurse's Meetings and Nursing Assistant Meetings. This re-education/inservicing addressed following physician's orders and not placing a water pitcher in a resident's room who is on fluid restrictions. 2. How Corrective Action will be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice. An audit was conducted of current residents with physician orders for fluid restrictions and there is one current resident on fluid restrictions. That resident did not have, nor does have a water pitcher in the room. The re-education/inservicing on following physician orders and not placing a water pitcher in a resident's room on fluid restrictions was initiated with the Nursing Department on July 17 and July 18, 2017 by the Director of Nursing during Nurse's Meetings and Nursing Assistant Meetings. Staff members who are on approved leave of absences/vacation/etc. will have their inservicing completed upon reporting back to work. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. Current Nursing Staff have been	

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F 309	Continued From page 14 the water pitchers after supper. She stated those residents on fluid restrictions should not have a water pitcher and that no one on the rehabilitation unit was currently on a fluid restriction. Resident #230 was observed with a full water pitcher on 06/27/17 at 4:25 PM. He stated that he poured water from the pitcher into the small plastic cup he had at bedside. He further stated that he was unaware of being in any fluid restriction diet. He stated staff filled his water pitcher two times a day. On 06/28/17 at 2:59 PM, NA #2 was interviewed. She stated that she was unaware of Resident #230 being on a fluid restriction diet. At this time Nurse #1 entered the conversation and stated he did not see the water pitcher in his room yesterday (06/27/17) and he stated this morning Resident #230 asked for a water pitcher and was informed of his fluid restriction. NA #2 was interviewed on 06/29/17 at 9:37 AM. She stated she had filled Resident #230's water pitcher on first shift on 06/27/17 as she did not know he was on a fluid restriction. She further stated that normally the nurses will inform the nurse aides of fluid restrictions and she forgot to ask. The Director of Nursing stated during interview on 06/29/17 at 10:52 AM that she expected staff to know who was on a fluid restriction diet from the care guide in the computer or by verbal communication. Those residents on a fluid restriction should not receive a water pitcher. The Administrator stated on 06/29/17 at 11:51 AM that staff should know who was on a fluid	F 309	inserviced on following physician orders and not placing a water pitcher in the room of a resident on fluid restrictions. This re-education/inservicing was initiated with the Nursing Department on July 17 and July 18, 2017 by the Director of Nursing during Nurse's Meetings and Nursing Assistant Meetings. Staff members who are on approved leave of absences/vacation/etc. will have their inservicing completed upon reporting back to work. This inservicing will also be repeated with newly hired staff during Orientation by the Staff Development Nurse. This training will also be reinforced as necessary to ensure compliance by the Staff Development Nurse and/or the Director of Nursing. Compliance to F309 will be monitored by the Administrator and Director of Nursing by reviewing observations of any resident on fluid restriction and not having a water pitcher in the room (currently one resident). These will be completed daily for fourteen days, then three times a week for four weeks, then once a week for three months, then twice monthly for three quarters, and then as needed. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete. Ongoing compliance to F309 will be monitored by the review of the observations of any resident on fluid restriction and not having a water pitcher	

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F 309	Continued From page 15 restriction diet via the care guide and those residents should not receive a water pitcher.	F 309	in the room. The results of these audits will be reviewed in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results of these observations will also be reviewed during the monthly QA meeting for any further discussion and recommendations, if needed. The Administrator and Director of Nursing are responsible for ongoing compliance to F309.	
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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, record review and resident and staff interviews the facility failed to provide scheduled showers for 2 of 5 sampled residents (Residents #160 and #18) and failed to trim chin hairs for 2 of 5 sampled residents (Residents #24 and #132) reviewed for activities of daily living. The findings included: 1. Resident #160 was admitted to the facility on 02/10/16 with diagnoses of heart failure, Parkinson's disease and acute and chronic respiratory failure. Review of the quarterly Minimum Data Set dated 05/25/17 revealed Resident #160 was cognitively	F 312	White Oak Manor-Shelby does provide ADL /care for dependent residents. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. (a) Scheduled showers are being provided for Residents #160 and #18 as they are scheduled and/or requested (if requested on a non-scheduled shower day) by the residents. The Day Shift LPN is ensuring Residents #160 and #18 showers are being provided as scheduled and/or requested.	7/27/17

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F 312	Continued From page 16 intact and required extensive assistance with toileting, personal hygiene and bathing. Review of the care plan dated 06/01/2017 revealed Resident #160 required varying degrees of assistance with activities of daily living related to Parkinson's disease and recent exacerbation of chronic obstructive pulmonary disease and congestive heart failure. The goal was for Resident #160 to perform hygiene tasks with limited assistance. The interventions included assisting with bathing, hygiene, dressing and grooming daily and the interventions stated the resident preferred a male Nurse Aide (NA) or older female NA for bathing assistance. Review of the facility shower schedules revealed Resident #160's showers were scheduled for Monday and Thursday on the 7:00 AM to 3:00 PM shift. Review of the facility shower sheet documentation revealed Resident #160 received a shower on 06/22/17 and 06/27/17. There was no other documentation of showers being given or refused by Resident #160 for 06/01/17, 06/05/17, 06/08/17, 06/12/17 or 06/15/17. An interview conducted on 06/28/17 at 9:22 AM with NA #5 revealed she worked on Resident #160's hall Monday through Friday. She stated Resident #160's showers were scheduled for Monday and Thursday on the day shift. NA #5 stated they had been so short staffed for the past few months there wasn't enough time for showers to be given on the days there were only two to three NAs on the hall. She stated a shower sheet should be completed with each shower and if there wasn't a shower sheet the shower most likely wasn't done.	F 312	(b) Residents #24 and #132's chin hairs were removed by the Director of Nursing when these were identified. Re-education/reinservicing was immediately initiated on June 28, 2017 for the Nursing Department (Nurses and Nursing Assistants) on Removal of Facial Hair. This was conducted by the Director of Nursing and addressed removing facial hair during ADL cares, and if the resident refuses, notifying the supervisor. 2. How Corrective Action will be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice. (a) Re-education/reinservicing on providing residents showers as scheduled and/or requested, and addressing refusals by residents was initiated with the Nursing Department on July 17 and July 18, 2017 by the Director of Nursing during Nurse's Meetings and Nursing Assistant Meetings. Staff members who are on approved leave of absences/vacation/etc. will have their inservicing completed upon reporting back to work. The Administrator and the Social Services Director also reviewed any concerns/grievances and there were no other residents who have expressed concern with their bathing/shower schedule. (b) An immediate audit was conducted by Nursing to identify any resident(s) that may have any unwanted facial hair. Re-education/reinservicing was also immediately initiated on June 28, 2017 for	

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F 312	Continued From page 17 An interview conducted on 06/28/17 at 10:03 AM with the Director of Nursing revealed it was her expectation for showers to be given to residents on their scheduled shower day. She stated the facility had been short staffed but showers should be given. She further stated she had not found documentation that Resident #160 had received shower's other than on 06/22/17 and 06/27/17. She stated Resident #160 was out of the facility on 06/08/17 and would not have received a shower that day but she felt sure he received his other scheduled showers but could not find a staff member that recalled giving him a shower. An interview conducted on 06/28/17 at 2:27 PM with NA #13 revealed she worked with Resident #160 most days. She stated there had been many times in the past few months when showers couldn't be completed due to having two to three NAs on the hall. She stated the facility had been short staffed since October 2016 and staffing wasn't improving. She further stated if a shower sheet wasn't completed for Resident #160 the shower was not given. 2. Resident #18 was admitted to the facility on 01/26/16 with diagnoses of non-Alzheimer's dementia, anxiety and depression. Review of the quarterly Minimum Data Set dated 06/01/17 revealed Resident #18 was severely cognitively impaired and required extensive assistance for toileting, personal hygiene and bathing. Review of the care plan dated 06/08/17 revealed Resident #18 required assistance with activities of daily living due to limited mobility, secondary to multiple sclerosis, cognitive impairment and	F 312	the Nursing Department (Nurses and Nursing Assistants) on Removal of Facial Hair. This was conducted by the Director of Nursing and addressed removing facial hair during ADL cares, and if the resident refuses, notifying the supervisor. Re-education/reinservicing on removal of facial hair was also continued with the Nursing Department on July 17 and July 18, 2017 by the Director of Nursing during Nurse's Meetings and Nursing Assistant Meetings. Staff members who are on approved leave of absences/vacation/etc. will have their inservicing completed upon reporting back to work. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. (a) Current staff have been inserviced on providing showers to residents as scheduled and/or requested by the resident. This was initiated with the Nursing Department on July 17 and July 18, 2017 by the Director of Nursing during Nurse's Meetings and Nursing Assistant Meetings. Staff members who are on approved leave of absences/vacation/etc. will have their inservicing completed upon reporting back to work. This inservicing will also be repeated with newly hired staff during Orientation by the Staff Development Nurse. This training will also be reinforced as necessary to ensure compliance by Staff Development Nurse, Director of Nursing, and/or Assistant Director of Nursing. In addition to this	

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F 312	Continued From page 18 incontinence. The interventions included assist with bathing, hygiene, dressing and grooming daily and as needed. Review of the facility shower schedules revealed Resident #18's showers were scheduled for Monday and Thursday on the 7:00 AM to 3:00 PM shift. Review of the facility shower sheet documentation revealed Resident #18 received a shower on 06/22/17 and 06/27/17. There was no other documentation of showers being given or refused by Resident #160 for 06/01/17, 06/05/17, 06/08/17, 06/12/17 or 06/15/17. An interview conducted on 06/28/17 at 9:22 AM with NA #5 revealed she worked on Resident #18's hall Monday through Friday. She stated Resident #18's showers were scheduled for Monday and Thursday on the day shift. NA #5 stated they had been so short staffed for the past few months there wasn't enough time for showers to be given on the days there were only two to three NAs on the hall. She stated a shower sheet should be completed with each shower and if there wasn't a shower sheet the shower most likely wasn't done. An interview conducted on 06/28/17 at 10:03 AM with the Director of Nursing revealed it was her expectation for showers to be given to residents on their scheduled shower day. She stated the facility had been short staffed but showers should be given. She further stated she had not found documentation that Resident #18 had received shower's other than 06/22/17 and 06/27/17. She stated she felt sure she received her showers but could not find a staff member that recalled giving her a shower.	F 312	training, the facility has also added an additional function in the Nursing Assistants' Smart Charting for documenting showers or whirlpool baths. The Nursing Assistants will now have a specific question populate for daily Smart Charting on ADL cares provided for residents that asks if the resident received a shower or whirlpool bath based on the resident's shower/whirlpool bath schedule. Inservicing on this new Smart Charting function was initiated by the Assistant Director of Nursing on July 21, 2107 and the function will populate in Smart Charting as of July 24, 2017. Staff members who are on approved leave of absences/vacation/etc. will have their inservicing completed upon reporting back to work. This inservicing will also be repeated with newly hired staff during Orientation by the Staff Development Nurse. This training will also be reinforced as necessary to ensure compliance by Staff Development Nurse, Director of Nursing, and/or Assistant Director of Nursing. Nursing Administration (DON, ADON, SDC, Unit Coordinators) will monitor any documented "No" by the Nursing Assistants about residents showers/whirlpool baths to determine cause (such as refusal). These reviews will be completed three times a week for two weeks, then weekly for six weeks, then monthly for three months, and then as needed thereafter. (b) Current Nursing staff have been inserviced on Removal of Facial Hair.	

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F 312	Continued From page 19 An interview conducted on 06/28/17 at 2:27 PM with NA #13 revealed she worked with Resident #18 most days. She stated there had been many times in the past few months when showers couldn't be completed due to having two to three NAs on the hall. She stated the facility had been short staffed since October 2016 and staffing wasn't improving. She further stated if a shower sheet wasn't completed for Resident #18 the shower was not given. 3. Resident #24 was admitted to the facility on 7/13/15 with diagnoses that included heart disease, and dementia without behavioral disturbance. A review of the annual Minimum Data Set (MDS) dated 4/11/17 revealed Resident #24 was severely cognitively impaired and required limited assistance with personal hygiene. The MDS also revealed no rejection of care or other behaviors. A care plan reviewed on 4/30/17 indicated Resident #24 required assistance with her activities of daily living (ADL) and the care plan last reviewed on 4/30/17 included interventions to assist her with grooming daily and as needed. Review of the shower schedule revealed Resident # 24 received showers on the day shift on Tuesday and Fridays. On 6/25/17 at 1:13 PM Resident #24 was observed with multiple chin hairs ½ inch in length scattered across her chin. On 6/26/17 at 9:55 AM Resident #24 was observed with multiple chin hairs ½ inch in length scattered across her chin. On 6/27/17 at 9:21 AM Resident #24 was	F 312	This was completed on June 28, 2017, and then further addressed by the Director of Nursing with the Nursing Department on July 17 and July 18, 2017 by the Director of Nursing during Nurse's Meetings and Nursing Assistant Meetings. Staff members who are on approved leave of absences/vacation/etc. will have their inservicing completed upon reporting back to work. This inservicing will also be repeated with newly hired staff during Orientation by the Staff Development Nurse. This training will also be reinforced as necessary to ensure compliance by Staff Development Nurse, Director of Nursing, and/or Assistant Director of Nursing. Ongoing compliance will be monitored by the Administrator and Director of Nursing by review of random observations of resident facial hair. These audits are to be completed by Department Managers/Ancillary Staff and at least 100 total observations will be completed weekly for four weeks, then at least twenty observations weekly for one month, and then ten per month for three quarters, and then as needed. Compliance to F312 will be monitored by the Administrator and Director of Nursing by review of the newly added question for Showers/whirlpool bath in Smart Charting and review of the audits on facial hair. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete.	

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F 312	Continued From page 20 observed with multiple chin hairs ½ inch in length scattered across her chin. On 6/27/17 at 2:35 PM Resident #24 was observed with multiple chin hairs ½ inch in length scattered across her chin. On 6/28/17 at 8:01 AM Resident #24 was observed with multiple chin hairs ½ inch in length scattered across her chin. On 6/27/17 at 2:25 PM Nurse Aide #6 revealed the nursing assistants' responsibilities were to shave the men and women on shower days if needed. Nurse aide # 6 indicated that Resident #24 had received a shower earlier that day by another nurse aide. On 6/28/17 at 9:50 AM Nurse Aide #7 revealed the nursing assistants' responsibilities were to remove facial hair for men and women not only on shower days but as needed. Nurse Aide #7 indicated Resident #24 should have been shaved and facial hair removed. The nurse aide further indicated Resident #24 was not resistive to care and would allow staff to care for her. On 6/28/17 at 9:53 AM the Director of Nursing (DON) asked Resident # 24 about the presence of the chin hairs and Resident #24 stated "Will you remove the chin hairs because I can't see well? I used to go down to the mirror but I can't see anything now. I used to have a razor but they took them from us." On 6/28/17 at 9:56 AM an interview with the DON revealed her expectations were for men and women's facial hair to be removed every day and not just on shower days. The DON stated removing facial hair should be performed daily	F 312	Ongoing compliance to F312 will be monitored by the Administrator and Director of Nursing by review of the newly added question for Showers/whirlpool bath in SmartCharting and review of the audits on facial hair. The results from both of these audits/reviews will be reviewed in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results of these observations will also be reviewed during the monthly QA meeting for any further discussion and recommendations, if needed. The Administrator and Director of Nursing are responsible for ongoing compliance to F312.	

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during ADL care. The DON further stated she would shave the resident.

On 6/28/17 at 10:16 AM an interview with the Administrator stated she expected for ADL care to be offered daily and as needed as long as the resident was not refusing or declining care.

4. Resident #132 was readmitted to the facility on 11/21/16 with diagnoses that included hypertension and dementia without behavioral disturbance. A review of the annual Minimum Data Set dated 12/6/16 revealed Resident # 132 had moderately impaired decision making skills, required total assistance with personal hygiene, and had no rejection of care.

Review of the shower schedule revealed Resident # 132 received showers on the day shift on Wednesday and Fridays.

On 6/26/17 at 8:33 AM Resident #132 was observed with multiple chin hairs ¼ in length scattered across her chin.
On 6/27/17 at 9:22 AM Resident #132 was observed with multiple chin hairs ¼ in length scattered across her chin.
On 6/28/17 at 8:02 AM Resident #132 was observed with multiple chin hairs ¼ in length scattered across her chin.

On 6/28/17 at 9:31 AM Nurse Aide #7 revealed the nursing assistants' responsibilities were to remove facial hair for men and women not only on shower days but as needed. Nurse Aide #7 stated Resident #132 received a shower that morning and should have been shaved and facial

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F 312	Continued From page 22 hair removed. The nurse aide further indicated Resident #132 was not resistive to care and would allow staff to care for her. Nurse Aide #7 stated she would shave the resident's face when she returned from therapy. On 6/28/17 at 9:56 AM an interview with the DON revealed her expectations were for men and women's facial hair to be removed every day and not just on shower days. The DON stated removing facial hair should be performed daily during ADL care. On 6/28/17 at 10:16 AM an interview with the Administrator stated she expected for ADL care to be offered daily and as needed as long as the resident was not refusing or declining care.	F 312		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff.	F 353		7/27/17

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F 353	Continued From page 23 (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide assistance with activities of daily living due to insufficient nursing staff for 2 of 5 sampled residents (Residents #160 and #18). The findings included: 1. Resident #160 was admitted to the facility on 02/10/16 with diagnoses of heart failure,	F 353	White Oak Manor-Shelby does provide sufficient 24-hour Nursing Staff Per Care Plans. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. Nursing staff are available to provide	

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F 353	Continued From page 24 Parkinson's disease and acute and chronic respiratory failure. Review of the quarterly Minimum Data Set dated 05/25/17 revealed Resident #160 was cognitively intact and required extensive assistance with toileting, personal hygiene and bathing. Review of the care plan 06/01/2017 revealed Resident #160 required varying degrees of assistance with activities of daily living related to Parkinson's disease and recent exacerbation of chronic obstructive pulmonary disease and congestive heart failure. The goal was for Resident #160 to perform hygiene tasks with limited assist. The interventions included assisting with bathing, hygiene, dressing and grooming daily and resident preferred a male Nurse Aide (NA) or older female NA for bathing assistance. Review of the facility shower schedules revealed Resident #160's showers were scheduled for Monday and Thursday on the 7:00 AM to 3:00 PM shift. Review of the facility shower sheet documentation revealed Resident #160 received a shower on 06/22/17 and 06/27/17. There was no other documentation of showers being given or refused by Resident #160 for 06/01/17, 06/05/17, 06/08/17, 06/12/17 or 06/15/17. An interview conducted on 06/28/17 at 9:22 AM with NA #5 revealed she worked on Resident #160's hall Monday through Friday. She stated Resident #160's showers were scheduled for Monday and Thursday on the day shift. NA #5 stated they had been so short staffed for the past few months there wasn't enough time for showers to be given on the days there were only two to	F 353	scheduled showers for Residents #160 and #18 as they are scheduled and/or requested (if requested on a non-scheduled shower day) by the residents. The Day Shift LPN is ensuring Residents #160 and #18 showers are being provided as scheduled and/or requested. Additionally, there is nothing to indicate either resident experienced a negative change in condition. 2. How Corrective Action will be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice. Re-education/reinservicing on providing residents showers as scheduled and/or requested, and addressing refusals by residents was initiated with the Nursing Department on July 17 and July 18, 2017 by the Director of Nursing during Nurse's Meetings and Nursing Assistant Meetings. Staff members who are on approved leave of absences/vacation/etc. will have their inservicing completed upon reporting back to work. The Administrator and the Social Services Director also reviewed any concerns/grievances and there were no other residents who have expressed concern with their bathing/shower schedule. The daily Nursing schedule that was referenced did not reflect daily facility occupancy has been averaging approximately fifteen percent under full occupancy. The Administrator, Director of Nursing, and Scheduler continue to review daily staffing schedules to ensure nurse	

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F 353	Continued From page 25 three NAs on the hall. She stated a shower sheet should be completed with each shower and if there wasn't a shower sheet the shower most likely wasn't done. An interview conducted on 06/28/17 at 10:03 AM with the Director of Nursing revealed it was her expectation for showers to be given to residents on their scheduled shower day. She stated the facility had been short staffed but showers should be given. She further stated she had not found documentation that Resident #160 had received shower's other than 06/22/17 and 06/27/17. She stated Resident #160 was out of the facility on 06/08/17 and would not have received a shower that day but she felt sure he received his other scheduled showers but could not find a staff member that recalled giving him a shower. An interview conducted on 06/28/17 at 2:27 PM with NA #13 revealed she worked with Resident #160 most days. She stated there had been many times in the past few months when showers couldn't be completed due to having two to three NAs on the hall. She stated the facility had been short staffed since October 2016 and staffing wasn't improving. She further stated if a shower sheet wasn't completed for Resident #160 the shower was not given. A follow up interview with the DON on 06/29/17 at 2:44 PM revealed the facility had struggled with staffing since the first of the year. She stated that they had made salary adjustments recently but did not feel that new staff had a good work ethic. The DON stated that the facility used staffing agencies in the past but stopped when their staffing got better. She stated that recently there had been 2 orientations a month for new staff but	F 353	staffing attains or maintains the highest practical physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. Current staff have been inserviced on providing showers to residents as scheduled and/or requested by the resident. This was initiated with the Nursing Department on July 17 and July 18, 2017 by the Director of Nursing during Nurse's Meetings and Nursing Assistant Meetings. In addition to this inservicing, the facility has also added an additional function in the Nursing Assistants' Smart Charting for documenting showers or whirlpool baths. The Nursing Assistants will now have a specific question populate for daily Smart Charting on ADL cares provided for residents that asks if the resident received a shower or whirlpool bath based on the resident's shower/whirlpool bath schedule. Inservicing on this new Smart Charting function was initiated by the Assistant Director of Nursing on July 21, 2107 and the function will populate in Smart Charting as of July 24, 2017. For both of these inservices, staff members who are on approved leave of absences/vacation/etc. will have their inservicing completed upon reporting back to work. Inservicing will also be repeated	

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for some reason the new staff did not stay after orientation. The DON stated when third shift (11:00 PM-7:00 AM) had only 2 NAs they would ask the Nurses to help out or ask other shifts to cover, and if that did not happen then they instructed the staff to "buddy up together" to assure safety.

Interview with the Administrator on 06/29/17 at 3:03 PM that revealed she was aware of the staffing issues in the facility. The Administrator stated that the facility did not utilize staffing agencies because they were not needed. She stated the facility offered bonuses to staff who came in or stayed over. The Administrator stated she was made aware on Friday night (06/23/17) that they were short with staffing at 3 Nurses and 4 NAs for the building for the third (11:00 PM to 7:00 AM) shift and she directed them to offer bonuses to get staff to cover the shift. She stated that they called her back and informed her that they could not get anyone to stay and she instructed them to carry on the best they could.

2. Resident #18 was admitted to the facility on 01/26/16 with diagnoses of non-Alzheimer's dementia, anxiety and depression.

Review of the quarterly Minimum Data Set revealed Resident #18 was severely cognitively impaired and required extensive assistance for toileting, personal hygiene and bathing.

Review of the care plan dated 06/08/17 revealed Resident #18 required assistance with activities of daily living due to limited mobility, secondary to multiple sclerosis, cognitive impairment and

with newly hired staff during Orientation by the Staff Development Nurse. These trainings will also be reinforced as necessary to ensure compliance by Staff Development Nurse, Director of Nursing, and/or Assistant Director of Nursing. Nursing Administration (DON, ADON, SDC, Unit Coordinators) will monitor any documented "No" by the Nursing Assistants about residents showers/whirlpool baths to determine cause (such as refusal). These reviews will be completed three times a week for two weeks, then weekly for six weeks, then monthly for three months, and then as needed thereafter.

From June 26 to July 24, 2017, the facility has hired twelve Nursing Assistants, two LPNs, and four RNs. To assist with Nursing staff recruitment and retention, new programs have also been implemented. These programs are: new Nursing Staff Sign-On Bonus program--the new employee receives monetary incentives at 30 days of employment, 90 days of employment and then at 6 months of employment; new Nursing Staff Referral program where any staff member referring a hired nursing staff member will receive monetary incentives at 30 days of employment, 90 days of employment and then at 6 months of employment; and a new "points forgiveness" program for the Nursing department that incentivizes picking up extra shifts. The facility has also made staffing changes which include a new Staff Development Nurse in place,

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F 353	Continued From page 27 incontinence. The interventions included assist with bathing, hygiene, dressing and grooming daily and as needed. Review of the facility shower schedules revealed Resident #18's showers were scheduled for Monday and Thursday on the 7:00 AM to 3:00 PM shift. Review of the facility shower sheet documentation revealed Resident #18 received a shower on 06/22/17 and 06/27/17. There was no other documentation of showers being given or refused by Resident #160 for 06/01/17, 06/05/17, 06/08/17, 06/12/17 or 06/15/17. An interview conducted on 06/28/17 at 9:22 AM with NA #5 revealed she worked on Resident #18's hall Monday through Friday. She stated Resident #18's showers were scheduled for Monday and Thursday on the day shift. NA #5 stated they had been so short staffed for the past few months there wasn't enough time for showers to be given on the days there were only two to three NAs on the hall. She stated a shower sheet should be completed with each shower and if there wasn't a shower sheet the shower most likely wasn't done. An interview conducted on 06/28/17 at 10:03 AM with the Director of Nursing revealed it was her expectation for showers to be given to residents on their scheduled shower day. She stated the facility had been short staffed but showers should be given. She further stated she had not found documentation that Resident #18 had received shower's other than 06/22/17 and 06/27/17. She stated she felt sure she received her showers but could not find a staff member that recalled giving her a shower.	F 353	and a new Nursing Scheduler in place. The Administrator, HR Manager, and other Administrative staff attended an in-service on staff retention that was conducted by White Oak Management, Inc. on July 20, 2017. The Administrator, DON, and HR Manager will evaluate the effectiveness of retention and recruitment by reviewing how many sign-on and referral bonuses are paid in a payperiod, as well as how many additional shifts were worked for the points forgiveness program, and how many new Nursing department hires there were. These reviews will be completed each payperiod (every two weeks) times four, then monthly for three months, and then as needed (as well as the continued daily reviews of the Nursing Department schedules). Compliance to F353 will be monitored by the Administrator and Director of Nursing by review of the newly added question for Showers/whirlpool bath in Smart Charting and reviews completed on recruitment and retention. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete. Ongoing compliance to F353 will be monitored by the Administrator and Director of Nursing by review of the newly added question for Showers/whirlpool bath in Smart Charting and the reviews completed on recruitment and retention,	

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F 353	Continued From page 28 An interview conducted on 06/28/17 at 2:27 PM with NA #13 revealed she worked with Resident #18 most days. She stated there had been many times in the past few months when showers couldn't be completed due to having two to three NAs on the hall. She stated the facility had been short staffed since October 2016 and staffing wasn't improving. She further stated if a shower sheet wasn't completed for Resident #18 the shower was not given. A follow up interview with the DON on 06/29/17 at 2:44 PM revealed the facility had struggled with staffing since the first of the year. She stated that they had made salary adjustments recently but did not feel that new staff had a good work ethic. The DON stated that the facility used staffing agencies in the past but stopped when their staffing got better. She stated that recently there had been 2 orientations a month for new staff but for some reason the new staff did not stay after orientation. The DON stated when third shift (11:00 PM-7:00 AM) had only 2 NAs they would ask the Nurses to help out or ask other shifts to cover, and if that did not happen then they instructed the staff to "buddy up together" to assure safety. Interview with the Administrator on 06/29/17 at 3:03 PM that revealed she was aware of the staffing issues in the facility. The Administrator stated that the facility did not utilize staffing agencies because they were not needed. She stated the facility offered bonuses to staff who came in or stayed over. The Administrator stated she was made aware on Friday night (06/23/17) that they were short with staffing at 3 Nurses and 4 NAs for the building for the third (11:00 PM to	F 353	as well as any concerns with nursing staff/resident care. The results from these reviews will be reviewed in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results of these reviews will also be addressed during the monthly QA meeting for any further discussion and recommendations, if needed. The Administrator and Director of Nursing are responsible for ongoing compliance to F353.	

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7:00 AM) shift and she directed them to offer bonuses to get staff to cover the shift. She stated that they called her back and informed her that they could not get anyone to stay and she instructed them to carry on the best they could.

3. On 06/27/17 at 2:45 PM an interview was conducted with NA #5 who stated she had been employed with the facility for years. NA #5 stated that sometime the work load for 1 NA was 16 or 17 residents and was impossible to get all of the care done. She stated you just had to do the best you could do.

On 06/27/17 at 2:47 PM an interview with NA #9 revealed she had been at the facility for years and stated that staffing was so low that it was not unusual for a NA to be assigned 17 residents to provide all of their care for them. NA #9 stated it was impossible to complete all of her assigned work but she had to do the best she could.

On 06/28/17 at 9:25 AM an interview with NA #10 revealed she had been employed with the facility for years and stated she had never seen the staffing this short in all of her years here. NA #10 continued to state that she worked 11:00 PM to 7:00 AM and twice in the last month she had to work the unit by herself.

An interview conducted with Nurse #4 on 06/28/17 at 9:28 AM revealed she had been employed by the facility for years and had never seen the staffing this low. She stated that recently on the 11:00 PM to 7:00 AM shift the facility was staffed with only 4 NAs and 5 Nurses with the recent time being 06/23/17. (The desired staffing was 12 NAs and 5 Nurses for the shift). Nurse #4 stated that when they had staffing issues they

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were to call the Scheduler and if she did not respond they were to call the Director of Nursing (DON). Nurse #4 stated that when they called the DON the night of 06/23/17 to report the staffing the DON told them to do the best they could.

On 6/28/17 at 9:40 AM an interview was conducted with Nurse #5 who worked 11:00 PM to 7:00 AM shift stated that Friday night (06/23/17) the facility worked with 4 NAs in the building and there were several female residents that would not allow male NAs to provide personal care to them so those residents do not get the care they need. Nurse #5 stated the morale was bad because people were tired of working short.

On 06/28/17 at 2:46 PM NA #11 stated yesterday (06/27/17) she was assigned 14 residents to provide care for and one resident fell in the early morning which put her even more behind than she already was. She continued to state that with a work load that large the residents did not get their proper baths and she did not have time to assist them with the activities of daily living such as brushing teeth twice a day or toileting them.

On 06/29/17 at 10:39 AM an interview was conducted with the Scheduler who explained she started working on finding coverage for the schedule 6 weeks before it was posted. The Scheduler stated the facility needed the following direct care staff in order to complete the daily schedule:

7:00 AM-3:00 PM 3:00 PM-11:00 PM 11:00 PM-7:00 AM

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8 Nurses 8 Nurses
5 Nurses
17 Nurse Aides 17 Nurse
Aides 12 Nurse Aides

Review of the nursing staff schedules and time sheets for as far back as 01/2017 revealed the facility had been short staffed (according to their calculations) the majority of the days. A focus of the nursing staff time sheets from the most recent time frame of complaints of short staffing from staff and residents revealed the approximate staffing was:

06/26/17 06/25/17
06/24/17 06/23/17
7:00 AM-3:00 PM 7:00 AM-3:00 PM
7:00 AM-3:00 PM 7:00 AM-3:00
PM
9 Nurses 7.5 Nurses
8 Nurses 8 Nurses
16.5 Nurse Aides 16.5
13 Nurse Aides 20 Nurse Aides

3:00 PM-11:00 PM 3:00 PM-11:00 PM
3:00 PM-11:00 PM 3:00 PM-11:00
PM
6 Nurses 3.5 Nurses
3 Nurses 7 Nurses
9 Nurse Aides 16 Nurse Aides
13 Nurse Aides 8 Nurse Aides

11:00 PM-7:00 AM 11:00 PM-7:00 AM
11:00 PM-7:00 AM 11:00 PM-7:00
AM
3 Nurses 4 Nurses
2 Nurses 5 Nurses
8 Nurse Aides 4 Nurse Aides
5 Nurse Aides 2.5 Nurse Aides

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F 353	Continued From page 32 Interview with the DON on 06/29/17 at 2:44 PM revealed the facility had struggled with staffing since the first of this year. She stated that they had made salary adjustments recently but did not feel that staff had a good work ethic now. The DON stated that the facility used to utilize staffing agencies but stopped when their staffing got better. She stated that recently there had been 2 orientations a month for new staff but for some reason the new staff did not stay with them. The DON stated that when third shift (11:00 PM-7:00 AM) had only 2 NAs they would ask the Nurses to help out or ask other shifts to cover, and if that did not happen then they instructed the staff to "buddy up together" to assure safety. Interview with the Administrator on 06/29/17 at 3:03 PM that revealed she was aware of the staffing issues in the facility. The Administrator stated that the facility did not utilize staffing agencies because they were not needed. She stated the facility offered bonuses to staff who came in or stayed over. The Administrator stated she was made aware on Friday night (06/23/17) that they were short with staffing at "3 Nurses and 4 NAs" for the building for the third (11:00 PM to 7:00 AM) shift and she directed them to offer bonuses to get staff to cover the shift. She stated that they called her back and informed her that they could not get anyone to stay and she instructed them to carry on the best they could.	F 353		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35	F 356		7/18/17

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(g) Nurse Staffing Information
(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)

(C) Certified nurse aides.

(iv) Resident census.

(2) Posting requirements.

(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public

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F 356	Continued From page 34 for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post the nurse staffing hours at the beginning of the first shift for 5 of 5 days of the survey and failed to post hours during the weekends. The findings included: The annual recertification survey for the facility began on 06/25/17 through 06/30/17. Observation on 06/25/17 at 12:06 PM (Sunday) noted the posted nurse staffing hours were dated for 06/23/17 (Friday). Additional observations of the posted nurse staffing hours were as follows: *On 06/25/17 at 12:22 PM the Director of Nursing (DON) was observed adjusting the nurse staffing hours from 06/23/17 to the staff, hours and census for 06/25/17. *On 06/26/17 at 8:11 AM the nurse staffing hours for 06/25/17 were posted. *On 06/26/17 at 10:23 AM the nurse staffing hours for 06/26/17 were correctly posted. *On 06/27/17 at 8:19 AM, at 9:38 AM and at 10:55 AM nurse staffing hours for 06/26/17 were still posted. *On 06/28/17 at 8:20 AM and at 10:40 AM the nurse staffing hours for 06/27/17 were still posted. *On 06/29/17 at 8:15 AM and at 11:51 AM the	F 356	White Oak Manor-Shelby does post Daily Nurse Staffing Information per requirements. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. There were no specific residents referenced in the 2567. The Director of Nursing did update the Daily Nurse Staffing Board on June 25, 2017. Written reeducation/reinservicing was initiated on July 5th, 2017 with the Nursing Staff Scheduler and with Weekend Supervisor on July 8, 2017. The Director of Nursing also verbally discussed with third shift LPN assigned to update the Daily Nurse Staffing Board and written reeducation/reinservicing was completed July 18, 2017. This reeducation/inservicing was completed by the Administrator and the Director of Nursing. 2. How Corrective Action will be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice.	

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F 356	Continued From page 35 nurse staffing hours for 06/28/17 were still posted. Interview with the Nursing Staff Coordinator (NSC) on 06/28/17 at 11:00 AM revealed she posted the nurse staffing hours after she received the census every day and that she was unaware of a specific time the nurse staffing hours were required to be posted. The NSC further added that she did not think the nurse staffing hours were posted over the weekends because there was no one in the facility over the weekend who collected the resident census and when she posted the nurse staffing hours on Monday's, the nurse staffing hours for Friday were still posted. Interview with the Administrator on 06/29/17 at 11:30 AM revealed the nurse staffing hours were supposed to be posted every day by the NSC and by the Nurse Supervisor (NS) on the weekends. The Administrator stated she thought the nurse staffing hours were required to be posted daily which was her expectation. Interview with the DON on 06/29/17 at 2:34 PM revealed the nurse staffing hours were updated first thing in the morning by the NSC during the week and by the NS on the weekends. The DON was unaware of when and how often the nurse staffing hours were required to be posted or that they were not posted by the requirements during the survey. Interview with the weekend NS on 06/29/17 at 2:51 PM revealed she was informed today about posting the nurse staffing hours and other than that she never knew she was responsible for posting nurse staffing information.	F 356	The Director of Nursing did update the Daily Nurse Staffing Board on June 25, 2017. Written reeducation/reinservicing was initiated on July 5th, 2017 with the Nursing Staff Scheduler and with Weekend Supervisor on July 8, 2017. The Director of Nursing also verbally discussed with third shift LPN assigned to update the Daily Nurse Staffing Board and written reeducation/reinservicing was completed July 18, 2017. This reeducation/inservicing was completed by the Administrator and the Director of Nursing. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. Current staff members assigned to update the Daily Nurse Staffing Board have been reinserviced by the Administrator and the Director of Nursing and was completed on July 18, 2018. This inservicing will be repeated with any newly hired staff appointed to update the Daily Nurse Staffing Board during Orientation by Administrator or Director of Nursing. This training will also be reinforced as necessary to ensure compliance by the Administrator and/or the Director of Nursing. Compliance to F356 will be monitored by the Administrator, Director of Nursing, and/or Weekend Supervisor(s) by completing observations of Daily Nurse	

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F 356	Continued From page 36	F 356	Staffing Board that will be completed daily for 14 days (beginning July 5, 2017), then three times a week for four weeks, then once a week for three months, then twice monthly for three quarters, then as needed. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete. Ongoing compliance to F356 will be monitored by the Administrator, Director of Nursing, and/or Weekend Supervisor(s) by completing the observations of the Daily Nurse Staffing Board. The results from these reviews will be reviewed in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results of these observations will also be reviewed during the monthly QA Meeting for further discussion and recommendations, if needed.	
F 367 SS=E	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.	F 367		7/21/17

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F 367	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews and staff interviews, the facility failed to served the correct therapeutic diet including no added salt to 3 of 5 sampled residents with orders for a no added salt diet (Residents #230, #231, and #232). The findings included: 1. Resident #231 was admitted to the facility on 06/08/17. Her diagnoses included acute diastolic congestive heart failure, dementia, and hypertension. Her 06/08/17 diet orders included a regular no added salt diet. The history and physical dated 06/14/17 stated she had been in the hospital for bibasilar pulmonary opacities and congestive heart failure. She was diuresed with intravenous lasix with marked improvement. She was admitted to the facility for rehabilitation and strengthening. The admission Minimum Data Set dated 06/15/17 coded her with intact cognition, being tired, having trouble concentrating, requiring set up and supervision for eating and receiving a therapeutic diet. The nutritional screen dated 06/15/17 noted she was currently on a daily diuretic and was being weighed daily for congestive heart failure. The weight loss she had experienced since admission was possibly due to a decrease in edema. Resident #231 was noted to make food choice known and ate independently with tray set up.	F 367	White Oak Manor-Shelby does provide the residents with a therapeutic diet as prescribed by a physician. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. Residents #230, #231, and #232 all had their meal trays corrected upon identification of having salt added items on their trays. Resident #230 was discharged on June 29, 2017 and Resident #232 was discharged on July 4, 2017. The Corporate RD initiated inservicing on June 28, 2017 to the Dietary staff that addressed tray accuracy. All current Dietary staff have completed the inservicing. 2. How Corrective Action will be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice. The Corporate RD initiated inservicing on June 28, 2017 to the Dietary staff that addressed tray accuracy, including no salt packet being placed on a tray of a resident on a no added salt diet. All current Dietary staff have completed the inservicing. An audit of current residents with a	

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F 367	Continued From page 38 A care plan was developed on 06/22/17 for weight fluctuations due to diuretic therapy and a history of edema. The goal was to not experience significant weight changes. Interventions included a therapeutic diet. On 06/25/17 at 12:31 PM, Resident #231 received her noon meal. The tray card noted she was on a regular no added salt diet and observations at this time revealed she received a salt packet. Two nurse aides entered and repositioned her prior to her starting to eat. On 06/25/17 at 3:14 PM, Resident #231 was interviewed. She was noted to not be able to state the year or the president of the United States. Family present at this time stated she had dementia. On 06/27/17 at 12:40 PM, Resident #231 received her tray which included a salt packet and saltine crackers. She stated at this time she did not pay attention to whether she received salt packets routinely. On 06/28/2017 at 7:18 AM, Nurse Aide (NA) #2 stated that salt and pepper packets come on the trays via dietary for those residents allowed to have them. Resident #231 was observed being served her tray by NA #2 on 06/28/2017 at 7:24 AM. The tray included a salt packet. NA #2 confirmed at this time that the resident was on a no added salt diet and should not receive a salt packet. She left the resident without removing the salt packet. On 06/28/17 at 8:44 AM, Resident #231 stated	F 367	therapeutic diet of no added salt has been completed and the Dietary department is currently completing audits of these residents' trays prior to delivery to the resident. This monitoring is being completed for all 3 meals daily for fourteen days, then all three meals three days a week for four weeks, and then ten random trays monthly for three months, and as needed thereafter. New admissions or readmissions will be reviewed for therapeutic diet orders. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. Current Dietary Staff have been inserviced on ensuring tray accuracy, to include not adding a salt packet to the tray of a resident on a no added salt diet. All Dietary staff completed the inservicing. This inservicing will be repeated with newly hired staff during Orientation by the Dietary Manager and/or Corporate RD. This training will also be reinforced as necessary to ensure compliance by the Dietary Manager and/or Corporate RD. For ongoing compliance, the Dietary Manager is responsible for the completion of audits of residents' trays prior to delivery to the resident to ensure no salt packets are placed on the tray for a resident receiving a no added salt diet. This monitoring is being completed for all 3 meals daily for fourteen days, then all three meals three days a week for four	

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F 367	Continued From page 39 she did not know what diet she was on. She stated she sometimes salted her food. On 06/28/2017 2:12 PM, the Dietary Director stated that for those residents on a no added salt diet, no salt packets should be added to their trays. Dietary staff had been educated on this and the diet was listed on each resident's tray ticket. Staff in the kitchen were to complete a final check of the trays for accuracy at the end of the tray line as the trays are loaded on the cart. The corporate dietician stated on 06/28/2017 at 2:25 PM that the facility tried to liberalize diets once residents were admitted but for those who are planning a short term stay, time usually did not permit the liberalization of diets. She further stated no added diets should not receive salt packets. On 06/29/2017 10:51 AM, the Director of Nursing stated that before a tray was delivered to a resident, staff should review the tray ticket to confirm the tray is being delivered to the correct resident and the correct diet was being followed. Interview with the Administrator on 06/29/17 at 11:51 AM revealed staff were expected to follow a no added salt diet which meant no salt packets on the tray. 2. Resident #230 was admitted to the facility on 06/09/17 with end stage renal disease, encephalopathy and anemia. The admission Minimum Data Set dated 06/16/17 noted he had intact short and long term memory and no decision making impairments. He ate with set up and supervision and was on a	F 367	weeks, and then ten random trays monthly for three months, and as needed thereafter. New admissions or readmissions will be reviewed for therapeutic diet orders. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete. Ongoing compliance to F367 will be monitored by the review of the tray audits by the Dietary Manager and the Administrator. The results of these audits will be reviewed in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results of these audits/observations will also be reviewed during the monthly QA meeting for any further discussion and recommendations, if needed. The Administrator and Dietary Manager are responsible for ongoing compliance to F367.	

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therapeutic diet.

The nutritional screen dated 06/16/17 noted he was on a regular low concentrated sweet and no added slat diet with fluid restrictions. He was noted to receive dialysis three times a week and had a pacemaker.

An interim care plan dated 06/22/17 noted he was on a regular low concentrated sweet diet with no added salt.

On 06/25/17 at 12:48 PM, Resident #230 was served his meal and the tray card stated low concentrated sweet no added salt diet. He was observed with a salt packet on his tray.

Resident #230 stated on 12/27/17 at 12:37 PM that he could not recall if he received salt with his trays.

On 06/28/2017 2:12 PM, the Dietary Director stated that for those residents on a no added salt diet, no salt packets should be added to their trays. Dietary staff had been educated on this and the diet was listed on each resident's tray ticket. Staff in the kitchen were to complete a final check of the trays for accuracy at the end of the tray line as the trays are loaded on the cart.

The corporate dietician stated on 06/28/2017 at 2:25 PM that the facility tried to liberalize diets once residents were admitted but for those who are planning a short term stay, time usually did not permit the liberalization of diets. She further stated no added diets should not receive salt packets.

On 06/29/2017 10:51 AM, the Director of Nursing

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stated that before a tray was delivered to a resident, staff should review the tray ticket to confirm the tray is being delivered to the correct resident and the correct diet was being followed.

Interview with the Administrator on 06/29/17 at 11:51 AM revealed staff were expected to follow a no added salt diet which meant no salt packets on the tray.

3. Resident #232 was admitted to the facility on 06/22/17 with diagnoses including hypertensive chronic kidney disease, cellulitis of the left lower limb, pulmonary hypertension and diabetes.

Her admission physician orders dated 06/22/17 included a regular low concentrated sweet no added salt diet.

Her Minimum data Set was not complete. Nursing notes dated 06/25/17 at 12:43 PM noted she was alert with confusion.

On 06/25/17 at 12:42 PM, Resident #232 received her tray which included the tray card noting she was on a no added salt diet. On this tray was a salt packet. Family present at this time stated her orientation varied.

On 06/27/17 at 1:20 AM, nursing notes stated she was noted to be alert and verbal with confusion noted. Resident #232 had plus 2 bilateral lower extremity edema.

On 06/28/2017 2:12 PM, the Dietary Director stated that for those residents on a no added salt diet, no salt packets should be added to their trays. Dietary staff had been educated on this and the diet was listed on each resident's tray ticket.

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F 367	Continued From page 42 Staff in the kitchen were to complete a final check of the trays for accuracy at the end of the tray line as the trays are loaded on the cart. The corporate dietician stated on 06/28/2017 at 2:25 PM that the facility tried to liberalize diets once residents were admitted but for those who are planning a short term stay, time usually did not permit the liberalization of diets. She further stated no added diets should not receive salt packets. On 06/29/2017 10:51 AM, the Director of Nursing stated that before a tray was delivered to a resident, staff should review the tray ticket to confirm the tray is being delivered to the correct resident and the correct diet was being followed. Interview with the Administrator on 06/29/17 at 11:51 AM revealed staff were expected to follow a no added salt diet which meant no salt packets on the tray.	F 367		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		7/27/17

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F 431	Continued From page 43 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431		

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F 431	Continued From page 44 Based on observations and staff interviews, the facility failed to remove 3 vials of expired medication from 1 of 8 medication carts. The findings included: A review of the facility policy dated 5/31/17 titled "Medication Storage In The Facility" read in part, # 9. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exists. An observation of the 100 hall medication cart on 6/25/17 at 10:45 AM revealed a box of Albuterol Sulfate inhalation 0.083% 2.5 mg/3 ml with 3 vials in the box. The vials expired February 2017. An interview on 6/25/17 at 10:45 AM with Nurse #3 indicated the nurses were supposed to check the medication cart periodically for expired medications and remove expired medications from the cart. Nurse #3 stated the medication was administered on 5/14/17 at 6:20 AM and the medication was expired at the time it was administered. On 6/25/17 at 10:51 AM an interview with the Director of Nursing (DON) stated her expectation was for the expiration date to be checked prior to administration of the medication and the medication cart to be checked by nurses between shifts for expired medications. The DON also stated the pharmacy was supposed to check the medication carts monthly for expired medications.	F 431	White Oak Manor-Shelby does provide routine and emergency drugs and biological to its residents, or obtain them under an agreement and stores drugs and biological in accordance with State and Federal laws. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice. The 3 Vials of Albuterol Sulfate inhalation were immediately removed from the medication cart. The resident used Albuterol twice in May and it was not used at all the month of June. The Albuterol was discontinued by the physician on June 25, 2017. The Nurses were immediately reminded to check medications/inhalers on the medication carts at each shift and prior to administration. Formal reeducation/inservicing on checking medication carts for expired medications/inhalers was completed by the Director of Nursing at a Nurses Meeting on July 17, 2017. 2. How Corrective Action Will Be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice. A Pharmacy Representative completed an audit of all medication carts and medication rooms on July 7, 2017 and there were no issues noted. This audit will continue as a monthly audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. BUILDING _____ B. WING _____	C 06/29/2017

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F 431	Continued From page 45 On 6/27/17 at 11:57 AM an interview with the Administrator stated her expectations were for the medication carts to be checked every shift by the oncoming nurse and to remove out dated medications during that check.	F 431	Formal reeducation/inservicing on checking medication carts for expired medications/inhalers was completed by the Director of Nursing at a Nurses Meeting on July 17, 2017. This reeducation/inservicing will continue for Nurses that were off or on approved leave of absences and will have their inservicing completed upon reporting back to work. 3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure that the Deficient Practice Will Not Recur. Current Nurses have been inserviced on checking medication carts for expired medications/inhalers prior to administration and on each shift. This reeducation/inservicing will continue for Nurses that were off or on approved leave of absences and will have their inservicing completed upon reporting back to work. This inservicing will be repeated with newly hired staff during Orientation by the Staff Development Nurse and/or the Director of Nursing. Monthly Pharmacy audits will also continue to be completed on a monthly basis with any findings reported to the Administrator. Compliance to F431 will be monitored by the Administrator and Director of Nursing by review of Nurse audits for medications carts to ensure the medication carts have no expired inhalers/medications. These	

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F 431	Continued From page 46	F 431	audits will be conducted by Second Shift Medication Nurses and the Nurses will document on an audit tool. This audit will be completed daily for each Medication Cart for 14 days, then three times a week for 6 weeks, then once weekly for six weeks, then as needed. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete. Ongoing compliance to F431 will be monitored by review of the Nurse audits for medication carts to ensure no expired inhalers/medication. The results of these audits will be reviewed by the Director of Nursing and Administrator, as well as review of the results in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results of these audits will also be reviewed during the monthly QA meeting for any further discussion and recommendations, if needed.	