STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING ______ B. WING ______	C 10/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - RUTHERFORDTO	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# 6VUX11. On 10/27/17 the facility was provided with an amended 2567 report because the State Agency made revisions to tag F-272. Event ID# 6VUX11.	F 000		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services 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 maintain the flooring and tiles in resident bathrooms free of dirt build up and stains. This affected 9 bathrooms on 5 of 5 halls (Rooms 101, 103, 206, 311, 314, 401, 402, 506 and 511). The findings included: The following resident bathrooms were observed with dark discolored flooring, with dark removable dirt build up around the base of commodes and/or dark removable build up in the tile grout in showers as follows: a. Room 101 a shared bathroom: *On 10/03/17 the floor around the commode was stained and the caulking at the base of the commode was stained; *On 10/04/17 at 10:01 AM there was dark build up and stain around the base of the commode; *On 10/04/17 at 4:14 PM the base of the commode was soiled and the floor discolored;	F 253	F253 White Oak of Rutherfordton ensures the floors and tiles in resident bathrooms are free from dirt buildup and stains. The commode that were previously replaced in room 101 shared bathroom left a non removable stain on the flooring due to the base of the new commode being smaller that the previous commode leaving a discolored indentation which made it collect dirt around the commode and the caulking. The commode that were previously replaced in room 103 shared bathroom left a non removable stain on the flooring due to the base of the new commode being smaller that the previous toilet leaving a discolored indentation which made it collect dirt around the commode and the caulking.	10/26/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/25/2017

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

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F 253	Continued From page 1 *On 10/05/17 at 3:14 PM the floor was stained around he commode; and *On 10/06/17 at 2:02 PM the flooring discoloration remained the same during observations made with the Housekeeping Supervisor. b. Room 103 a shared bathroom: *On 10/03/17 at 4:36 PM the flooring around the commode was discolored and the the caulking at the base of the commode was dark; and *On 10/05/17 at 3:15 PM the floor around the base of the commode had a dark stain. c. Room 206 a shared bathroom: *On 10/04/17 at 4:10 PM the floor was stained around the base of the commode and was discolored all around the baseboards; *On 10/05/17 at 3:12 PM the flooring remained stained and appeared dirty around the baseboards; and *On 10/06/17 at 2:00 PM with the Housekeeping Supervisor, the floor remained discolored and dirty in appearance. The Housekeeping Supervisor stated the floor needed to be replaced. d. Room 311 a shared bathroom: *On 10/03/17 at 10:58 AM there was black build up around the base of the commode; *On 10/04/17 at 9:16 AM there was black build up around the base of the commode; *On 10/04/17 at 4:06 PM the black build up remained around the base of the commode and could be removed with a paper towel; *On 10/05/17 at 3:09 PM the black build up remained around the base of the commode; and *On 10/06/17 at 1:53 PM the black build up remained around the base of the commode	F 253	The commode that were previously replaced in room 206 shared bathroom left a non removable stain on the flooring due to the base of the new commode being smaller that the previous toilet leaving a discolored indentation which made it appear dirty. There was wax build up around the baseboard which made it dirty in appearance. The commode that were previously replaced in room 311 shared bathroom left a non removable stain on the flooring due to the base of the new commode being smaller that the previous toilet leaving a discolored indentation which made it collect dirt. The commode that were previously replaced in room 314 private bathroom left a non removable stain on the flooring due to the base of the new commode being smaller that the previous commode leaving a discolored indentation which made it collect dirt. There was missing grout around the shower drain tile which made it collect dirt. The commode that were previously replaced in room 401 shared bathroom left a non removable stain on the flooring around the base of the commode and behind the commode due to the base of the new commode being smaller that the previous toilet leaving a discolored indentation which made it collect dirt. The commode that were previously replaced in room 402 shared bathroom	

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F 253 Continued From page 2

during observations made with the Housekeeping Supervisor.

e. Room 314 a shared bathroom:
*On 10/03/17 at 11:00 PM there was dark build up of dirt in front of the base of the commode, discolored tile around the commode and dark build up in the tile around the shower drain which could be removed with a paper towel;
*On 10/04/17 at 9:22 AM there was dark build up of dirt in front of the base of the commode, discolored tile around the commode and dark build up in the tile around the shower drain;
*On 10/04/17 at 4:09 PM the dark build up around the base of the commode could be removed with a paper towel and the tile in the shower remained discolored at the grout lines;
*On 10/05/17 at 3:09 PM the tile remained soiled as did the base of the commode;
*On 10/06/17 at 9:49 AM the housekeeper was observed cleaning the bathroom; and
*On 10/06/17 at 1:55 PM the floor remained discolored and a towel did not remove any discoloration when attempted by the Housekeeping Supervisor. The dark build up around the base of the commode remained the same.

bf. Room 401 a shared bathroom:
*On 10/03/17 at 11:06 AM there was dark build up around the base of the commode and discolored flooring behind the commode;
*On 10/04/17 at 9:25 AM there was dark build up around the base of the commode and discolored flooring behind the commode;
*On 10/04/17 at 2:10 PM there was black build up around the base of the commode and discolored flooring; and
*On 10/06/17 at 1:51 PM the floor remained

F 253

left a non removable stain on the flooring due to the base of the new commode being smaller that the previous commode leaving a discolored indentation which made it dirty in appearance.

The commode that were previously replaced in room 506 shared bathroom left a non removable stain on the flooring due to the base of the new commode being smaller that the previous commode leaving a discolored indentation which made it collect dirt around the commode. The caulking was cracked and made it collect dirt.

The bathroom in room 511 were missing grout around some of the tiles in the shower which made it collect dirt.

The flooring in Resident rooms 101,103,206,311,314,401,402,506,and 511 are being replaced and grout repaired beginning 10/24/17 by Hodge Flooring and the Maintenance Director.

All other bathroom floorings will be checked and replaced/repaired as necessary upon delivery of flooring supplies that have been ordered. This should be completed over the next 90 days. The housekeeping staff will be in-serviced on 10/24/17 to clean floors daily and report any stains that are not removable or repairs needed to the Housekeeping Supervisor/Maintenance Director. Newly hired Housekeeping staff will receive education during their orientation.

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F 253	Continued From page 3 discolored and the base of the commode with black build up. At this time the Housekeeping Supervisor was able to get some discoloration up using a wet wash cloth. g. Room 402 a shared bathroom: *On 10/03/17 at 11:24 AM there was a dark stain approximately 3 inches in front of the commode; *On 10/04/17 at 9:31 AM there was a dark stain approximately 3 inches in front of the commode; *On 10/04/17 at 1:58 PM the bathroom flooring remained discolored and stained in front of the commode; *On 10/05/17 at 3:05 PM the stain in front of the commode and discolored flooring remained; and *On 10/06/17 at 1:50 PM the stain remained the same when observed with the Housekeeping Supervisor. At this observations the Housekeeping Supervisor stated that the original toilet which was larger than the current was replaced and left the stained tile at the old base. h. Room 506: *On 10/03/17 at 10:50 AM there was dark build up around the base of the commode; *On 10/04/17 at 8:45 AM there was dark build up around the base of the commode; *On 10/04/17 at 4:03 PM there was dark cracked caulking at base of commode which came off with a paper towel; *On 10/05/17 at 3:06 PM the same dark caulking was observed at the base of the commode; and *On 10/06/17 at 1:45 PM the same dark caulking at the base of the commode was observed with the Housekeeping Supervisor. i. Room 511: *On 10/04/17 at 8:40 AM there was discolored grout in between the shower grout which could be	F 253	The Housekeeping Supervisor/Assistant Housekeeping Supervisor will monitor all resident room bathrooms weekly times 4 weeks to ensure they are free from dirt buildup, non removal stains or in need of grout repair. Then monitored monthly for 3 months. Results from the monitoring will be discussed Monday through Friday during QI morning meetings and any identified issues or trends will be further discussed with the Quality Assurance meeting and team. The Housekeeping Supervisor/Maintenance Director will be responsible for ongoing compliance to F253.	

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removed with a paper towel;
*On 10/05/17 at 3:07 PM the grout remained discolored in the shower; and
*On 10/06/17 at 1:47 PM with the Housekeeping Supervisor the tile remained discolored and could be removed with a paper towel.

On 10/04/17 at 2:16 PM housekeeper #3 stated that she mopped the bathroom floors daily and sprayed and mopped the shower room floors for those resident rooms with showers.

On 10/06/17 at 9:33 AM housekeeper #1 was interviewed and stated that she cleaned each bathroom each day and used two types of cleaners for the floors and commodes.

On 10/06/17 beginning at 1:45 PM and throughout the last environmental tour, the Housekeeping Supervisor stated that on Monday of this week the housekeeping staff were instructed to clean around the bases of the commodes. She stated that the water will sometimes be trapped around the commode bases and will not come up with a mop. The housekeepers have disinfectant and cleaners for this use and magic erasers and scrub brushed to use both around the commodes and the tiles in the showers. She stated that sometimes the staff will also scrape along the floors to get up build up dirt. The gaps between the shower tiles made it hard for staff to maintain them in a clean manner. The Housekeeping Supervisor stated that the bathrooms and commode bases could be cleaner and some floors needed replacement.

On 10/06/17 at 2:12 PM interview with the Maintenance Director revealed that he discussed the discolored flooring with the administration but

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F 253	Continued From page 5 has not heard anymore relating to plans for repair. On 10/06/17 at 1:41 PM the Administrator stated that the Maintenance Director has been working on work orders for some of the grouting in he showers and they have been discussing how to proceed with the discolored flooring.	F 253		
F 272 SS=E	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. (xvii) Documentation of summary information	F 272		10/26/17

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F 272	Continued From page 6 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 reviews and staff interviews, the facility failed to complete Care Area Assessments that addressed underlying causes and contributing factors for psychotropic drug use, cognitive loss/dementia, and activities of daily living for 7 of 16 sampled residents (#33, #71, #61, #35, #106, #64 and #49). The findings included: 1. Resident #33 was admitted to the facility on 09/14/15 with current diagnoses of Alzheimer's disease, anxiety and depression. Review of the annual Minimum Data Set (MDS) dated 09/12/17 revealed Resident #33 was moderately impaired but was able to make her needs know. The MDS further revealed Resident #33 received antianxiety and antidepressant	F 272	F272 White Oak of Rutherfordton ensures the completion of Care Area Assessments(CAAs) in the Minimum Data Set(MDS). The CAAs that addressed the underlying causes and contributing factors for Psychotropic Medication Use, Cognitive Loss/Dementia and ADL Functional/Rehabilitation Potential for Resident #33,#71,#61,#35,#106,#64, and #49 have been identified. The MDS Coordinators were previously educated to ensure the underlying causes and contributing factors on the CAAs by the White Oak Management MDS Corporate Consultant on 09/30/15,09/30/16,09/13/17,and 09/22/17. Another re-education was completed by the MDS Corporate Consultant on	

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F 272	Continued From page 7 medication during the 7 day assessment period. Review of the Care Area Assessment (CAA) Summary for Psychotropic Medication Use dated 09/19/17 revealed it was completed by MDS Nurse #2. The CAA Summary stated Resident #33 received and antidepressant medication at bedtime related to insomnia, an antidepressant medication once a day related to depression and an antianxiety medication as needed for anxiety for significant distress to self and others. See the September medication administration record. She is at risk for side effects of medication. The CAA Summary did not analyze how the psychotropic medications actually affected her day to day function and activities. The CAA Summary did not indicate if there had been any adverse reactions or attempted dose reductions. The CAA did not state if a referral was necessary or if Resident #33 had received psychiatric services. An interview was conducted on 10/06/17 at 11:03 AM with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #2 stated she had been doing MDS Assessments for 4 years and had received training from the corporate MDS Nurse. MDS Nurse #1 stated she had been doing MDS Assessments for 8 years and also received training from the corporate MDS Nurse. They stated the corporate MDS audits their assessments and CAA summaries and have told them they were doing them correctly. They further stated they were not aware a summary of how the care area affected the resident's day to day activities was required. An interview conducted on 10/06/17 at 3:00 PM with the Administrator revealed the corporate MDS nurse had provided recent training to the	F 272	10/12/17. An audit of the CAAs summaries for 10/09/17 through 10/26/17 will be completed, and modified as identified. This will be completed by the MDS Corporate Consultant by 10/26/17. The Administrator had explained during Survey, the MDS Corporate Consultant had attended State training from DHSR and had trained the MDS Coordinators regarding the CAAs. The education was previously completed on 09/30/15,09/30/16,09/13/17 and 09/22/17. Another re-education was completed on 10/12/17. Newly hired care plan team members will receive education during their specific orientation. All CAAs will be reviewed for residents' assessments for 2 weeks, then up to 4 CAAs a week for 4 weeks and then up to 6 CAAs monthly for 3 months. MDS Corporate consultant will conduct the monitoring for the first 2 weeks. The Director of Nursing (DON) and/or designee will conduct the remainder of the monitoring. Results from the monitoring will be discussed Monday through Friday during QI morning meetings and any identified issues or trends will be further discussed with the Quality Assurance meeting and team. The Director of Nursing (DON) is	

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F 272	Continued From page 8 facility MDS nurses which included the need for the CAAs to be more thoroughly completed, so the analysis section would show a more complete picture of the resident. 2. Resident #71 was admitted to the facility on 08/09/17 with diagnoses of heart failure and cognitive communication deficit. Review of the admission Minimum Data Set (MDS) dated 08/26/17 revealed Resident #71 was severely cognitively impaired but was able to make his needs known. Review of the Care Area Assessment (CAA) Summary for Cognitive Loss/Dementia dated 09/01/17 revealed it was completed by MDS #1. The CAA Summary revealed Resident #71's BIMS score was 4. He could repeat 3 of 3 items clearly. He did not know the year or the day of the week. He stated the month was September. He would not answer when asked to recall 3 of 3 items. The CAA Summary did not describe how his severely impaired cognition impacted his day to day life. An interview was conducted on 10/06/17 at 11:03 AM with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #2 stated she had been doing MDS Assessments for 4 years and had received training from the corporate MDS Nurse. MDS Nurse #1 stated she had been doing MDS Assessments for 8 years and also received training from the corporate MDS Nurse. They stated the corporate MDS audits their assessments and CAA summaries and have told them they were doing them correctly. They further stated they were not aware a summary of how the care area affected the resident's day to day	F 272	responsible for ongoing compliance of F272.	

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F 272	Continued From page 9 activities was required. An interview conducted on 10/06/17 at 3:00 PM with the Administrator revealed the corporate MDS nurse had provided recent training to the facility MDS nurses which included the need for the CAAs to be more thoroughly completed, so the analysis section would show a more complete picture of the resident. 3. Resident #61 was admitted to the facility on 12/08/14 with current diagnoses of anxiety, depression and age related osteoporosis. Review of the annual Minimum Data Set (MDS) dated 11/01/16 revealed Resident #61 was cognitively intact and required limited assistance with most activities of daily living (ADL). Review of the Care Area Assessment (CAA) Summary for ADL Functional/Rehabilitation Potential dated 11/08/16 revealed Resident #61 required limited assist with bed mobility, transfers, toileting and dressing related to weakness secondary to chronic obstructive pulmonary disease and had an unsteady gait and balance. Gait belt with transfers, toileting, and ambulation. Self-propels wheelchair for mobility. The CAA Summary did not state how the ADL Function impacted his day to day activities. The CAA Summary was signed by MDS Nurse #2. An interview was conducted on 10/06/17 at 11:03 AM with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #2 stated she had been doing MDS Assessments for 4 years and had received training from the corporate MDS Nurse. MDS Nurse #1 stated she had been doing MDS Assessments for 8 years and also received	F 272		

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training from the corporate MDS Nurse. They stated the corporate MDS audits their assessments and CAA summaries and have told them they were doing them correctly. They further stated they were not aware a summary of how the care area affected the resident's day to day activities was required.

An interview conducted on 10/06/17 at 3:00 PM with the Administrator revealed the corporate MDS nurse had provided recent training to the facility MDS nurses which included the need for the CAAs to be more thoroughly completed, so the analysis section would show a more complete picture of the resident.
4. Resident #35 was admitted on 06/16/09. Her diagnoses included Alzheimer's Disease, anxiety disorder, and depressive disorder.

A significant change Minimum Data Set (MDS) dated 05/25/17 coded her with severely impaired cognition, having other behaviors, requiring extensive assistance with most activities of daily living skills and being incontinent. She was also coded with receiving anti-psychotropic, anti-anxiety and antidepressant medications.

The Care Area Assessment (CAA) dated 06/01/17 relating to cognition included her diagnoses, her psychiatric medications, her incontinence of bowel and bladder, her behavior of moaning and the answers she provided during the Brief Interview for Mental Status. The CAA did not provide a description of the problem, causes and contributing factors, her strengths or weaknesses or how her cognitive deficits impacted her day to day routines and function.

On 10/06/17 at 11:02 AM MDS Nurse #1 stated

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she has been doing MDS and assessments for 8 years. She was trained by her corporate MDS representative and that she completed the cognition CAA as she was taught. She was not taught to put in more detail about the individual resident. She further stated that corporate representatives have told her she was doing the CAAs correctly.

An interview conducted on 10/06/17 at 3:00 PM with the Administrator revealed the corporate MDS nurse had provided recent training to the facility MDS nurses which included the need for the CAAs to be more thoroughly completed, so the analysis section would show a more complete picture of the resident.

5. Resident #106 was admitted to the facility on 06/09/17. His diagnoses included traumatic subarachnoid hemorrhage with loss of consciousness, cerebral infarction and anxiety disorder.

The admission Minimum data Set (MDS) dated 06/16/17 coded him with moderately impaired cognition, rejection of care behaviors, requiring extensive assistance with most activities of daily living skills, and receiving anti-anxiety and anti-depressant medications.

a. The Care Area Assessment (CAA) dated 06/21/17 relating to cognition repeated the answers he provided for the Brief Interview of Mental Status, his psychotropic medications and diabetic medications, his expression of pain and his activities of daily living skills. The CAA did not provide a description of the problem, causes and contributing factors, his strengths or weaknesses

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F 272	Continued From page 12 or how his cognitive deficits impacted his day to day routines and function. On 10/06/17 at 11:02 AM MDS Nurse #1 stated she has been doing MDS and assessments for 8 years. She was trained by her corporate MDS representative and that she completed the cognition CAA as she as taught. She was not taught to put in more detail about the individual resident. She further stated that corporate representatives have told her she was doing the CAAs correctly. b. The CAA relating to the psychotropic medications dated 06/21/17 listed the medications he was receiving, noted his unsteady gait, and his history of falls. The analysis failed to provide a description of the problem, causes and contributing factors, his strengths or weaknesses or how his medications affected him either positively or negatively. On 10/06/17 at 11:02 AM MDS Nurse #1 stated she has been doing MDS and assessments for 8 years. She was trained by her corporate MDS representative and that she completed the psychotropic drug use CAA as she was taught. She was not taught to put in more detail about the individual resident. She further stated that corporate representatives have told her she was doing the CAAs correctly. An interview conducted on 10/06/17 at 3:00 PM with the Administrator revealed the corporate MDS nurse had provided recent training to the facility MDS nurses which included the need for the CAAs to be more thoroughly completed, so the analysis section would show a more complete picture of the resident.	F 272		

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6. Resident # 64 was admitted to the facility on 09/30/13 with current diagnoses of dementia, anxiety and depression.

Review of the quarterly Minimum Data Set (MDS) dated 08/24/17 revealed Resident #64 was severely impaired and unable to make needs known. The MDS further revealed Resident #64 received antianxiety and antidepressant medication during the 7 day assessment period.

Review of the Care Area Assessment (CAA) Summary for Psychotropic Medication Use dated 06/15/17 revealed it was completed by MDS Nurse #1. The CAA Summary stated Resident #64 had received Ativan (an anti-anxiety medication) 0.5 milligrams (mg) every 12 hours since 05/11/17. The CAA Summary further stated Resident #64 had received Buspirone (an anti-anxiety medication) 10 mg by mouth two times daily related to her dementia since 02/01/17. Resident #64 also received Zoloft (an anti-depressant medication) 50 mg by mouth daily related to her depression since 02/17/17 (see June physician orders). The CAA Summary did not indicated if there had been any adverse reactions or attempted dose reductions. The CAA Summary did not state if a referral was necessary or if Resident # 64 had received psychiatric services.

An interview was conducted on 10/06/17 at 11:03 am with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #1 stated she had been doing MDS assessments for 8 years and had received training from the corporate MDS Nurse. MDS Nurse #2 stated she had been doing MDS assessments for 4 years and had also received training from the corporate MDS Nurse. They

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stated the corporate MDS audits their assessments and CAA summaries and had told them they were doing them correctly. They further stated they were not aware a summary of how the care area affected the residents' day to day activities was required.

An interview conducted on 10/06/17 at 3:00 PM with the Administrator revealed the corporate MDS nurse had provided recent training to the facility MDS nurses which included the need for the CAAs to be more thoroughly completed, so the analysis section would show a more complete picture of the resident.

7. Resident #49 was admitted to the facility on 06/23/17 with current diagnoses of dementia, Schizophrenia and depression.

Review of the significant change Minimum Data Set (MDS) dated 09/19/17 revealed Resident #49 was moderately impaired but was able to make her needs known. The MDS further revealed Resident #49 received antipsychotic and antidepressant medication during the 7 day assessment period.

Review of the Care Area Assessment (CAA) Summary for Psychotropic Medication Use dated 09/26/17 revealed it was completed by MDS Nurse #2. The CAA Summary stated Resident #49 received Seroquel (an anti-psychotic medication) by mouth three times daily for undifferentiated Schizophrenia with behavioral disturbances and hallucinations. The CAA Summary also revealed Resident #49 received Remeron (an antidepressant medication) and Trazodone (an antidepressant medication used to treat insomnia) related to depression and

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F 272	Continued From page 15 adjustment disorder. See the September medication administration record (MAR) and physician notes. The CAA Summary also stated Resident #49 was at risk for side effects of the medication. The CAA Summary did not analyze how the psychotropic medications actually affected her day to day function and activities. The CAA Summary did not indicate if there had been any adverse reactions or attempted dose reductions. The CAA Summary did not state if a referral was necessary or if Resident #49 had received psychiatric services. An interview was conducted on 10/06/17 at 11:03 am with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #1 stated she had been doing MDS assessments for 8 years and had received training from the corporate MDS Nurse. MDS Nurse #2 stated she had been doing MDS assessments for 4 years and had also received training from the corporate MDS Nurse. They stated the corporate MDS audits their assessments and CAA summaries and had told them they were doing them correctly. They further stated they were not aware a summary of how the care area affected the residents' day to day activities was required. An interview conducted on 10/06/17 at 3:00 PM with the Administrator revealed the corporate MDS nurse had provided recent training to the facility MDS nurses which included the need for the CAAs to be more thoroughly completed, so the analysis section would show a more complete picture of the resident.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		10/26/17

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F 274	Continued From page 16 (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change in condition assessment for 1 of 4 sampled residents (Resident #71). The findings included: Resident #71 was admitted to the facility on 08/09/17 with diagnoses of heart failure, peripheral vascular disease and muscle weakness. Review of the admission Minimum Data Set (MDS) dated 08/26/17 revealed Resident #71 was severely cognitively impaired. The MDS further revealed Resident #71 did not have behaviors or receive psychoactive medications during the assessment period. Review of the care plan revealed Resident #71 was care planned for suicidal ideations as expressed by verbalization of suicide on 08/27/17. Resident #71 was care planned on 08/28/17 for a diagnoses of depression that	F 274	F274 White Oak of Rutherfordton ensures the completion of Significant Changes in the Minimum Data Set(MDS). Resident#71 Minimum Data Set (MDS)Significant Change assessment was set for Assessment Reference Date (ARD) of 10/19/17. Resident #71 expired on 10/17/17 and assessment could not be completed. There was not a significant change completed due to not recognizing there were two different changes that would have warranted a significant change- the addition of antidepressant medication and behavior. Social thought the medication was for the wandering behavior since the doctor cleared him from the suicidal ideation behavior. All residents with Change in behaviors such as wandering, newly ordered anti-depressants and change in mood such as suicidal ideations in the last 30	

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F 274	Continued From page 17 required medication. A care was also developed for Resident #71 for exit seeking behaviors on 09/03/17. An interview conducted on 10/06/17 at 11:03 AM with MDS Nurse #1 revealed she was aware of Resident #71's suicidal ideation and addition of antidepressant medication but was not aware of a change in his behavior of wandering. She stated the Social Worker took care of the Behavior Section of the MDS and let her know if behaviors had changed and a significant change assessment was needed. An interview conducted with the Social Worker on 10/06/17 at 1:55 PM revealed she did not think a significant change MDS was needed for Resident #71 because the physician cleared him from suicide ideations and the medication was started to help with the behavior. She stated she did not think behaviors and medications were two different changes on the MDS but could now see they were and a significant change assessment should have been completed for Resident #71. An interview conducted with the Administrator on 10/06/17 at 3:00 PM revealed she expected a significant change assessment to be completed when resident changes occurred.	F 274	days will be audited for the potential need of a Significant Change assessment. The Significant Change assessments will be completed as identified. Newly identified residents with changes in behavior, mood, and anti-depressants will be reviewed for the potential Significant Change in the MDS. The White Oak Management MDS Corporate Consultant re-educated the care plan team(MDS Coordinators and Social Services)regarding the criteria for Significant Change in status assessments per the RAI User's Manual on 10/12/17. All newly ordered anti-depressants, changes in behavior and changes in mood will be monitored for the need of a significant Change MDS assessment weekly for 4 weeks, then monthly for 3 months. The Director of Nursing (DON) and /or designee will conduct the monitoring for the need of Significant Change assessments. Results from the monitoring will be discussed Monday through Friday during QI morning meetings and any identified issues or trends will be further discussed with Quality Assurance meeting and team. The Director of Nursing (DON) is responsible for ongoing compliance of F274.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		10/26/17

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483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its

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F 279	Continued From page 19 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update and maintain a plan of care with measurable goals and interventions for 2 of 18 residents sampled (Resident # 106 and # 71). Findings included: 1. Resident # 106 was initially admitted to the facility on 6/9/17 with diagnoses that included anemia, difficulty walking, and muscle weakness. An admission Minimum Data Set (MDS) dated 6/16/17 indicated resident #106 was cognitively impaired and required extensive assistance with walking and limited assistance with transfers. The MDS also revealed Resident # 106 had a history of falls prior to admission.	F 279	F279 White Oak of Rutherfordton ensures the completion of updating and maintaining a Plan of Care with measurable goals and interventions. Resident #106 discharged from the facility on 7/30/17. Although the interventions were put in place, the Care Plans were not updated to reflect the non-skid material in the recliner, and the defined perimeter mattress(DPM)- MDS nurse unaware of the intervention. The hourly checks for 24 hours was already past and the MDS nurse felt it was short term and did not need to be added to the care plan because the time frame had past. Resident #71 expired on 10/17/17. The	

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F 279	Continued From page 20 A care plan dated 7/10/17 included interventions for fall risk to keep call bell within reach, keep room and hallway free of clutter, gait belt, and care giver alarm while in bed. A facility occurrence report dated 7/14/17 at 12:35 PM revealed Resident # 106 had an unwitnessed fall and was found on the floor in front of his recliner. The new intervention implemented was to apply non-skid material to Resident's #106 recliner. A facility occurrence report dated 7/20/17 at 7:20 PM revealed Resident #106 had an unwitnessed fall and was found on floor by bed. The new intervention implemented was for a defined perimeter mattress (DPM). A facility occurrence report dated 7/25/17 at 5:15 AM revealed Resident #106 had an unwitnessed fall and was found on the bathroom floor. The new intervention implemented was for hourly checks for 24 hours. A facility occurrence report dated 7/26/17 at 8:10 AM revealed Resident #106 had a witnessed fall and lost his balance in the bathroom. The new intervention implemented was for a gait belt with two persons assist. The care plan had no interventions added after Resident's # 106 falls on 7/14/17, 7/20/17, 7/25/17, and 7/26/17. On 10/5/17 at 3:16 PM the Restorative Nurse stated when a resident had a fall the interventions was supposed to be implemented by the nurse and reviewed during the morning meeting the	F 279	resident's care plan for verbalizing suicidal ideations was achieved in a short time frame. The physician had cleared him from being suicidal so the MDS nurse discontinued it. All residents with falls in the last 30 days will be audited to ensure the newly implemented interventions are on the Plan of Care, and will be corrected as identified. There were no other residents identified in the last 30 days for suicidal ideations. Residents with new falls and expressed verbalization of suicidal ideations will have Plan of Cares in place for a sufficient period of time to make sure goals are met, and appropriate interventions will be addressed in the Plan of Care. The Director of Nursing(DON)re-educated the care plan team (MDS Coordinators, Restorative and Social Services and other team members) regarding residents' Care Plans are in place for a sufficient period of time to make sure goals are met, and appropriate interventions will be addressed in the Plan of Care. The re-education was completed 10/24/17. Residents that may sustain a fall will be monitored weekly for 4 weeks, then monthly for 3 months to ensure that newly implemented interventions are addressed in the Plan of Care. Newly identified residents who verbalize suicidal ideations will be monitored weekly for 4 weeks ,then monthly for 3 months to ensure the care	

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F 279	Continued From page 21 following day. The Restorative Nurse also stated the MDS nurse received a copy of the occurrence report and was supposed to update the fall care plan with the new interventions. The Restorative Nurse further stated the care plan was supposed to reflect the fall interventions for the residents. On 10/5/17 at 3:51 PM an interview with MDS Nurse # 1 revealed after a resident had a fall the Restorative Nurse or the primary nurse was supposed to make a recommendation about the new intervention. MDS Nurse # 1 then stated the fall interventions were reviewed during the morning meeting and the MDS nurses was supposed to update the fall care plan with the new interventions. MDS Nurse # 1 also stated she was supposed to get a copy of the fall occurrence with the recommended intervention. MDS Nurse # 1 indicated that Resident # 106 had falls during his stay in the facility and his care was discussed in the morning meetings. MDS Nurse # 1 indicated Resident #106 had a fall on 7/14/17 and the intervention was to place non-skid material in the recliner. MDS Nurse # 1 stated the intervention was not care planned. MDS Nurse #1 also stated Resident # 106 had a fall on 7/20/17 and the intervention was for a DPM and this intervention was not added to the care plan because she was unaware Resident # 106 had a fall that day. MDS Nurse # 1 went on to say Resident # 106 had a fall on 7/25/17 and the intervention was for hourly checks for 24 hours. MDS Nurse # 1 stated the intervention was not placed on the care plan because the time frame had already passed when the fall was discussed. MDS Nurse # 1 then stated Resident # 106 had a fall on 7/26/17 and the intervention was for a gait belt with 2 person assist. MDS Nurse # 1 further stated the gait belt intervention was added to the	F 279	plan remains in effect for a sufficient period of time in order to make sure goals are met. Results from the monitoring will be discussed Monday through Friday during QI morning meetings and any identified issues or trends will be further discussed with Quality Assurance meeting and team. The Director of Nursing(DON) is responsible for ongoing compliance of F279.	

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care plan on 8/1/17 and didn't know why because Resident # 1 was discharged from the facility on 7/30/17.

On 10/5/17 at 4:40 PM an interview with the DON revealed the fall incident report was supposed to go to the MDS nurses and the care plan interventions are then updated by the MDS nurses. The DON also stated the fall care plan was supposed to be updated with each new fall and intervention. The DON went on to say she expected for the fall care plan reflect the interventions in place.

ON 10/6/17 at 2:54 PM an interview with the Administrator revealed she expected for the fall interventions to be updated on the care plan.

2. Resident #71 was admitted to the facility on 08/09/17 with diagnoses of heart failure, peripheral vascular disease and cognitive communication deficit.

Review of the admission Minimum Data Set (MDS) dated 08/26/17 revealed Resident #71 was severely cognitively impaired but could make his needs known.

Review of the care plan dated 08/27/17 revealed Resident #71 had apparent suicidal ideations as expressed by verbalization of suicide. The goal was to remain free of self-inflicted injury through 11/27/17. The interventions included: every 15 minute checks, notify on-call doctor, begin suicide

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(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 279	Continued From page 23	F 279		

precautions, remove all sharp objects from room, place on acute board for doctor to see, and notify all departments. This care plan was achieved on 08/28/17.

Review of the care plan dated 09/04/17 revealed Resident #71 had apparent suicidal ideations as expressed by verbalization of suicide. The goal was to remain free of self-inflicted injury through 12/06/17. The interventions included: every 15 minute checks, notify on-call doctor, begin suicide precautions, remove all sharp objects from room, place on acute board for doctor to see, and notify all departments. This care plan was achieved on 09/06/17.

An interview conducted on 10/06/17 at 1:55 PM with the Social Worker (SW) revealed she initiated the suicide care plan for Resident #71 on 08/27/17 and 09/04/17. She stated Resident #71 had threatened to kill himself to his family and they informed the facility. The SW stated Resident #71 was assessed by the physician on 08/28/17 and was cleared from being suicidal. She stated she felt like the suicide care plan was no longer needed so she discontinued it. The SW stated Resident #71 threatened to kill himself again on 09/04/17 so she initiated the suicide care plan again and after he was cleared by the physician she discontinued it on 09/06/17. She stated she thought his mood care plan covered and changes that might lead to suicide. The SW stated the care plan should not have been discontinued one day or three days after being initiated due to there not being enough time to see if the goal was really met.

An interview conducted on 10/06/17 at 3:00 PM with the Administrator revealed it was her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING ______ B. WING ______	C 10/06/2017

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F 279	Continued From page 24 expectation for care plans to remain in effect for a sufficient time period to make sure the goals were met.	F 279		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to have a system in place for the routine cleaning of the ice scoop holders resulting in 1 of 2 ice scoop holders in use being soiled. The findings included:	F 371	F371 White Oak of Rutherfordton ensures there is a system in place for the routine cleaning of the ice scoop holders. On inspection by the CMS Surveyor on 10/3/17, the ice scoop holder in the main	10/26/17

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F 371	Continued From page 25 On 10/03/17 at 11:31 AM, the ice scoop holder on the side of the ice machine was observed to have dark slimy water in the bottom around the drain holes. The scoop itself appeared clean. At this time the Dietary Manager removed the ice scoop holder from the side of the ice machine and sent it to the dish machine. She stated that housekeeping staff were responsible for the cleaning of the ice scoop holder. On 10/05/17 at 8:41 AM the housekeeping assistant stated during interview that she cleaned the dining room every morning after breakfast and that housekeeper #2 cleaned it in the afternoons. She further stated that it was housekeeper #2's responsibility to clean the ice scoop holder via wiping with a clean wet cloth and that the kitchen staff were to run the ice scoop and holders through the dish machine daily. Interview with the Dietary Manager (DM) on 10/04/17 at 12:09 PM revealed the ice scoops were brought nightly to the kitchen to be run through the dish machine. DM further stated that after discussing with the administration, staff will be inserviced to also bring the ice scoop holders to the kitchen nightly. Interview with housekeeper #2 on 10/04/17 at 2:20 PM revealed he cleaned the ice scoop holder with a clean wet cloth and no chemical about once a week. Follow up interview with the DM on 10/05/17 at 9:30 AM revealed she was unaware of any set schedule to clean the ice scoop holder. Someone will bring them to the kitchen with the pitchers and ice scoops but there was no set	F 371	dining room was found to have dark slimy water in the bottom of the holder. The scoop itself was clean. The ice scoop holder was immediately removed by the Dietary Director and cleaned by sending through the dish machine. There was not a clear understanding between housekeeping and dietary as to who was responsible for sanitation. Housekeeping was wiping the ice scoop holder daily with a clean wet clothe and but did not send to the kitchen to run through the dish machine. The two ice scoop holders in the facility have been placed on a daily cleaning schedule. The Dietary staff was in-serviced on 10/5/2017to retrieve holders daily and send through the dish machine , returning them to their proper place afterwards. Newly hired dietary staff will receive education during their orientation. The Dietary Director or Assistant Dietary Director will monitor both ice scoop holders weekly times 3 weeks,then monthly times 3 months. Results from the monitoring will be discussed Monday through Friday during the QI morning meeting and any identified issues or trends will be further discussed with Quality Assurance meeting and team. The Dietary Director will be responsible for the ongoing compliance of F371.	

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F 371	Continued From page 26 schedule. On 10/05/17 at 9:32 Am an interview with the dish washer revealed that the nurse aides will bring the scoop holder to the kitchen to run through the dish machine and that kitchen staff do not go get the ice scoop holders for cleaning. During an interview with the Administrator on 10/06/17 at 2:27 PM, she stated there was confusion over who was responsible for ensuring the ice scoop holder was run through the dish machine. Housekeeping wiped it down and it was sent to the kitchen when it was observed soiled. She stated there was no set schedule for ice scoop holder to be run through the dish machine.	F 371		