	-	ID HUMAN SERVICES				PPROVED			
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0	938-0391			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>'</i>	PLE CONSTRUCTION G	(X3) DATE SU COMPLET				
		345083	B. WING		09/27/	/2018			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE				
	K MANOR - RUTHERFO	PDTO	188 OSCAR JUSTICE ROAD						
				RUTHERFORDTON, NC 28139					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)			
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE			
F 000	INITIAL COMMENTS		F 0	00					
	This recert was sche 9/17/18 and had to be Hurricane Florence								
F 636	Comprehensive Asse	ssments & Timing	F 6	36	10)/25/18			
SS=D	CFR(s): 483.20(b)(1)								
	a comprehensive, ac	luct initially and periodically							
	A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following: (i) Identification and c (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (v) Vision. (vi) Mood and behavi (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutritid (xii) Skin Conditions. (xii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvi) Discharge plann (xvii) Documentation	ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least lemographic information c. s. or patterns. ell-being. ning and structural problems. and health conditions. onal status. ts and procedures. ing. of summary information							
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE			

Electronically Signed

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.

10/12/2018

PRINTED: 10/15/2018

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 10/15/201 RM APPROVE IO. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	345083		B. WING			0	9/27/2018	
NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - RUTHERFORDTO			1	STR	REET ADDRESS, CITY, STATE, ZIP CODE	• -		
					BOSCAR JUSTICE ROAD			
				RU	ITHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 636	on the care areas trig the Minimum Data S (xviii) Documentation assessment. The as include direct observ with the resident, as licensed and nonlice members on all shifts §483.20(b)(2) When timeframes prescribed chapter, a facility mu assessment of a resi timeframes specified through (iii) of this se prescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmission significant change in mental condition. (Fo "readmission" means following a temporar or therapeutic leave. (iii)Not less than onc This REQUIREMENT by: Based on record rev facility failed to comp that addressed the u contributing factors fic are plan for 3 of 18	nal assessment performed ggered by the completion of et (MDS). In of participation in assessment process must ation and communication well as communication with nsed direct care staff s. required. Subject to the ed in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ection. The timeframes 43(b) of this chapter do not r days after admission, ons in which there is no the resident's physical or or purposes of this section, as a return to the facility y absence for hospitalization)	F	636	White Oak Manor-Rutherfordton en the completion of Care Area Assessments(CAAs)in the Minimum Set(MDS). The facility Resident Assessment Coordinators(RACs)ha been trained and re-trained to comp Care Area Assessments(CAAs)accu	ı Data ve lete		
	The findings included	d: admitted to the facility most			but the RACs did not complete the C to reflect their underlying causes an contributing factors for the developm the care plans. The identified CAAs	CAAs d nent of		

Event ID: SL8711

Facility ID: 923556

If continuation sheet Page 2 of 8

		MEDICAID SERVICES			OMB NO. 0938-03
ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL 345083 B. WIN		. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		09/27/2018	
NAME OF P	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL		CODE		
WHITE OAK MANOR - RUTHERFORDTO				188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETI THE APPROPRIATE DATE
F 636			F 63	36	
	heart failure, major de transient cerebral isc			Resident #47 (cognition),#55(Falls and F Medications) and #56(cogr reviewed.	
	dated 06/04/18, code impaired cognition, h	et (MDS), an admission ed him with moderately aving scored an 11 out of 15 r for Mental Status (BIMS).		The MDS Corporate Const complete an audit of the C from 9/27/18 to 10/24/18.	
		ificant change dated with moderately impaired red an 11 out of 15 on the		The Care Plan Team which RACs were re-educated or CAAs that include a thorou investigation of the underly contributing for the develop	n completing igh ving causes and
	dated 8/21/18, repeat MDS dated 08/14/18 answered BIMS ques	ssment (CAA) for cognition, ted the information on the stating the incorrectly stions, as well as how the ther areas. There was no ibed Resident #47's		care plans. This re-educati completed on 10/10/18 by RN/RAI Coordinator Const Wanda Swink,RN,DON. Th contacted the NC State RA Coordinator,Mary Maas,for	on was Melissa Picher, ultant and ne RACs N
	strengths or weakness and how his cognition impairments affected his ability to function day to day in the facility, or factors considered for the development of the care plan.			re-education on CAA comp 10/10/18. Newly Hired care members will receive educ their specific job orientation The CAAs will be monitore	bletion on e plan team ation during n.
	the CAA was conduct MDS Nurse stated th completed the cognit	MDS nurse who completed ted on 09/27/18 at 11:46 AM. at she had always ion CAA by repeating the vas not instructed to describe		up to 3 CAAs per week for up to 4 CAAs monthly for 3 as needed thereafter. The Administration will conduct Results from the monitorin	4 weeks, then 3 months and Nursing the monitoring.
	the resident's probler to paint a picture of th	 n. She had been instructed ne resident and to her that scored what he did on the 		discussed Monday through QI morning meetings and a issues or trends will be dis Quality Assurance meeting recommendations.	n Friday during any identified cussed at the g for further
	Nursing on 09/27/18 information on the CA	ministrator and Director of at 3:57 PM revealed that the AA was basically a repeat of mation. They stated the		The DON is responsible fo compliance of Tag F636.	r ongoing

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If continuation sheet Page 3 of 8

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/15/2018 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345083	B. WING			09/:	27/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
WHITE OA	AK MANOR - RUTHERFO	RDTO			8 OSCAR JUSTICE ROAD UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	CAA needed more inc area and that the MD2 painting a picture of th time she had to gather 2. Resident #55 was a 06/19/18 with diagnos communication deficit depressive disorder a The Minimum Data So dated 06/26/18, coder cognitive impairment, Brief Interview for Me had one fall since adm receiving antianxiety a medications 7 days of a. The Care Area Ass of falls, dated 07/02/1 found on the floor by I was nonambulatory. parts coded on the MI and medications. The circumstances of the strengths and weaknes or placed him at risk f considered for the der b. The CAA for the arm medications, dated 07 psychoactive medicat the diagnoses for eac not describe Resident weakness or any indiv the medications affect	dividualized specifics for the S nurse thought she was he resident with the limited er information. admitted to the facility on ses including cognitive ts, vascular dementia, major ind anxiety. et (MDS), an admission d him with having severe scoring a 3 out of 15 on the ntal Status (BIMS), having mission with no injury and and antidepressant ut of the previous 7 days. essment (CAA) for the area 8, stated Resident #55 was his bed on 06/25/18 and he The CAA repeated other DS such as his continence e CAA did not describe the fall or describe his individual esses that caused him to fall for further falls, or factors velopment of the care plan. ea of psychotropic 7/02/18, listed the tions his was receiving and ch medication. The CAA did	F 63	36			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
			B. WING			09/27/2018		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WHITE O	RDTO			88 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 636	An interview with the the CAA was conduct MDS Nurse stated that completed the cogniti BIMS answers and with the resident's problem to paint a picture of the meant saying why he BIMS. MDS nurse fut assumed the social with reasons for psychotron behavior CAA. Interview with the Adr Nursing on 09/27/18 at information on the CA of the MDS coded infor CAAs needed more in each area and that the was painting a picture limited time she had to 3. Resident #56 was 05/22/18 with diagnos and major depressive The Minimum Data S coded her as having in cognition, scoring an Interview for Mental S The Care Area Assess dated 06/04/18, reper MDS dated 05/29/18 answered BIMS quess MDS was coded in ot analysis which descri-	MDS nurse who completed ted on 09/27/18 at 11:46 AM. at she had always on CAA by repeating the as not instructed to describe h. She had been instructed he resident and to her that scored what he did on the rther stated that she porker would address the opic medications in the ministrator and Director of at 3:57 PM revealed that the vAs were basically a repeat ormation. They stated the ndividualized specifics for e MDS nurse thought she e of the resident with the o gather information. admitted to the facility on ses including repeated falls e disorder. et (MDS), dated 05/29/18 moderately impaired 8 out of 15 on the Brief Status (BIMS). sment (CAA) for cognition, ated the information on the stating the incorrectly tions, as well as how the her areas. There was no	F	636				

Facility ID: 923556

If continuation sheet Page 5 of 8

PRINTED: 10/15/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/15/2018 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE	
		345083	B. WING _			09/	27/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	K MANOR - RUTHERFO	RDTO		18	38 OSCAR JUSTICE ROAD		
				R	UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 636	development of the ca An interview with the the CAA was conduct MDS Nurse stated tha completed the cogniti BIMS answers and wa the resident's problem to paint a picture of th meant saying why she BIMS. Interview with the Adr Nursing on 09/27/18 a information on the CA the MDS coded inform CAA needed more inc area and that the MDS painting a picture of th time she had to gathe QAPI Prgm/Plan, Disc CFR(s): 483.75(a)(2)(actors considered for the are plan. MDS nurse who completed ed on 09/27/18 at 11:46 AM. at she had always on CAA by repeating the as not instructed to describe h. She had been instructed he resident and to her that e scored what she did on the ministrator and Director of at 3:57 PM revealed that the A was basically a repeat of nation. They stated the dividualized specifics for the S nurse thought she was he resident with the limited er information. closure/Good Faith Attmpt	F	336	DEFICIENCY)		10/25/18
	improvement (QAPI) §483.75(a)(2) Presen	program. t its QAPI plan to the State er than 1 year after the					
		ary may not require rds of such committee ch disclosure is related to ch committee with the					

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CENTER	S FUR MEDICARE &	MEDICAID SERVICES					NO. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345083			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			09/27/2018		
NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - RUTHERFORDTO				TREET ADDRESS, CITY, STATE, ZIP CODE			
					88 OSCAR JUSTICE ROAD UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 865	 65 Continued From page 6 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures from the recertification and complaint investigation conducted on 10/06/17 and was subsequently recited in September 2018 on the current recertification survey. The repeat deficiency was in the area of care area assessments. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: 		F	F 865 White Oak Manor-Rutherfordton maintains a quality assessment committee consisting of the Director Nursing(DON), a physician designate the facility, and at least three other members of the facility's staff. The Quality Assessment and Assura Committee meets at least quarterly t discuss identified issues with which of assessments and assurance activitie necessary to implement. The facility develops and implements appropriat plans of action to correct identified is		of ed by nce o quality s are e	
	Based on record revi facility failed to comp that addressed the un contributing factors for care plan for 3 of 18 for Care Area Assess and #56). During the recertifica 10/06/17 this regulati complete Care Area underlying causes an psychotropic drug us	ve assessments and timing: ew and staff interviews, the lete Care Area Assessments			The facility Resident Assessment Coordinators(RACs) have been train and re-trained to complete Care Area Assessments(CAAs) accurately, but RACs did not complete the CAAs to reflect their underlying causes and contributing factors for the developm the care plans. The identified CAAs f Resident #47(Cognition), #55(Falls a Psychotropic Medications) and #56 (cognition) were reviewed. The MDS Corporate Consultant will complete an audit of the CAA summa from 9/27/18 to 10/24/18. The Care Plan Team which includes RACs were re-educated on completing	a the ent of or nd aries the	

Facility ID: 923556

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345083		B. WING	00/07/0040				
NAME OF P	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP CODE	09/27/2018		
WHITE OAK MANOR - RUTHERFORDTO 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AP DEFICIENCY) DEFICIENCY)		IOULD BE COMPLETIO				
F 865	An interview conduct 09/27/18 at 3:18 PM Assurance Committe Area Assessments (C new interventions we Minimum Data Set N thought she was doin realize she needed to	#61, #35, #106, #64 and ed with the Administrator on revealed the Quality the had monitored the Care CAAs) and concluded the ere working. She stated the urse that prepared the CAAs ing a good job and didn't to do a more thorough triggers and analysis of	F 865	CAAs that include a thorough investigation of the underlying c contributing factors for the devel the care plans. This re-educatio completed on 10/10/18 by Melis Picher,RN/RAI Coordinator Con and Wanda Swink, RN,DON. The RAC contacted the NC Stat Coordinator, Mary Maas for add re-education on CAAs completio 10/10/18. Newly Hired care plan team men receive education during their sp orientation. The CAAs will be monitored by n up to 3 CAAs per week for 4 we up to 4 CAAs monthly for 3 mon as needed thereafter. The nursin Administration will conduct the r Results from the monitoring will discussed Monday thru Friday d morning meetings and any issue trends will be discussed at the C Assurance meeting for further recommendations. The Administrator and DON are responsible for ongoing complia F865.	lopment of n was sa sultant e RAI itional on on mbers will becific job reviewing eks, then ths and ng nonitoring. be uring QI es or Quality		

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