DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345171	B. WING _			C	3/2018
NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - SHELBY				STREET ADDRESS, CITY, STATE, ZIP CO 401 N MORGAN STREET SHELBY, NC 28150	ODE	<u> 10/0</u>	3/2016
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD B HE APPROPRIA		(X5) COMPLETION DATE
F 000	No deficiencies were	e cited as a result of this on. Event ID #8LXK11.	F	DEFICIENCE DEFICIENCE DEFICIENCE DEFICIENCE DE LA COMPANION DE			
ABODATODY		SUPPLIER REPRESENTATIVE'S SIGNATI	lipe	TITLE			K6) DATE

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345171 B. WING			R 10/03/2018			
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	1 10/	00/2010	
WHITE OA	AK MANOR - SHELBY			401 N MORGAN STREET				
0/0/15	OUNDARY OF PERIODS			SHELBY, NC 28150	CORRECTION		(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 000	INITIAL COMMENTS		FC	000				
	and Certification cond	Nursing Home Licensure ducted a revisit. The facility implaince effictive 08/30/18.						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUI	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

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10/16/2018