PRINTED: 07/25/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		PLETED
		345171	B. WING _				C / 29/2017
	ROVIDER OR SUPPLIER			40	REET ADDRESS, CITY, STATE, ZIP CODE 1 N MORGAN STREET HELBY, NC 28150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 242 SS=D	(f)(1) The resident has schedules (including shealth care and provide consistent with his or and plan of care and of this part. (f)(2) The resident has about aspects of his care significant to the resident to the resident has members of the common community activities by facility. This REQUIREMENT by: Based on record reviresident interview, the choice to smoke unsuresident, who was assemble safely. Resident smoke without supervat designated times. The findings included Resident #99 was add 09/28/09. His diagno vascular disease, mon hypertension. Reside only resident in the face review of the smoking of 05/23/17 stated that	s a right to choose activities, sleeping and waking times), ders of health care services her interests, assessments, other applicable provisions as a right to make choices or her life in the facility that esident. Is a right to interact with munity and participate in both inside and outside the is not met as evidenced ew, policy review, staff and a facility failed to honor the apervised for 1 of 1 sampled sessed as being able to ent #99 was not permitted to ent #99 was not permitted to rision and could only smoke that #99 was identified as the cility who smoked. Is a right to make choices or her life in the facility failed to honor the apervised for 1 of 1 sampled sessed as being able to ent #99 was not permitted to ent #99 was not permitted to the facility on sees included peripheral moneuropathy, and ent #99 was identified as the cility who smoked. Is a right to make choices or her life in the facility on sees included peripheral moneuropathy, and ent #99 was identified as the cility who smoked. Is a right to make choices or her life in the facility on sees included peripheral moneuropathy, and ent #99 was identified as the cility who smoked. Is a right to make choices or her life in the facility on sees included peripheral moneuropathy, and ent #99 was identified as the cility who smoked.	F2	242	White Oak Manor-Shelby does honor to residents' right to make choices. 1. How Corrective Action will be Accomplished for Each Resident Found 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, the facility is now a tobacco-free camput. 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	d to t as us.	7/24/17
ARODATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

BURATURY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed 07/24/2017

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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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	
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		345171	B. WING_			06/2	29/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE OA	AK MANOR - SHELBY			40	01 N MORGAN STREET		
WIIILO	IN MANON - SHEED I			S	HELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	became effective). The to continue to smoke/area(s) outside the but A smoking schedule of times listed were to be needed supervised stidifferent times during. This schedule stated required. On this form #99 who smoked. The most recent Smoddated 04/20/17 assessable to self extinguish appropriately utilize a ashes on himself, he smoking rules, and he independently. The fino concerns. Under the demonstrated the cigarettes with minimal individual care plan warea of comments wat apron as required by completed by the Social His most recent Minimulated 05/24/17 coded having no behaviors, The current care plan 03/11/11 stated under was reassessed for sito the desire to start by	the facility when this policy nose residents are assisted use tobacco in designated uilding." Idated 02/02/17 noted the e used for the resident who moking. There were 5 the day with assigned staff. a smoking apron was m was listed only Resident Isking Safety Data Collection used Resident #99 as being a cigarette, being able to a shtray, he did not drop complied with the facility e was able to stand form marked that there were evaluation the form stated ability to safely smoke all supervision and an areas developed. Under the is that he wore a smoking facility policy. This form was	F2	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 #8 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 Ensure that the Deficient Practice Will I Recur. The facility Smoking Policy has been revised to allow for Resident #99 to be able to smoke independently and at tim of his choosing at the designated outsid smoking area. Staff have been educat 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 Stat Development Nurse and/or the Social Service Director. Compliance to F242 will be monitored the Administrator and/or the Social Services Director by completing observations once a week for eight wee that Resident #99 is obtaining his smok supplies and going to smoke independently at times of his choosing. This will continue on an ongoing basis when the monthly smoking assessmen completed.	t to Not nes de ed	
	was now supervised smust be supervised.	smoking as all residents The goal was for the			4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345171	B. WING					0
		345171	B. WING_				06/	29/2017
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
WHITE O	AK MANOR - SHELBY			401	N MORGAN STREET			
*************	AR MANOR - OHLLD			SHI	ELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE C			(X5) COMPLETION DATE	
F 242	Continued From page	ae 2	F 2	242				
F 242	through 09/01/17. In *05/27/11 Assist res and lighters as need *05/27/11 Supply res smoking so that he owhen he wants to pa *05/27/11 Make smoresident use; and *05/27/11 Assess ex resident's medical coneeds. Review of nursing nodocumentation that concerns. On 06/25/17 at 2:56 during interview that He further stated the burned while smoking facility makes him be has his right mind, hodoes not feel good as he'd like to smoke. On 06/27/17 at 9:25 independently walke courtyard to smoke. assistant who carried him at 9:33 AM. This an apron which he do	e facility policy for smoking interventions included: ident in obtaining cigarettes led; sident with schedule for can make plans to attend articipate; oking apron available for very 3 months/or change of condition to monitor for safety otes revealed no referred to smoking safety. PM, Resident #99 stated is the smoked in the courtyard. At ever since a resident was ang at another facility, this is e supervised. He stated he can no seizure history and about having to be supervised in independently.	F 2		That Solutions are Sustained and D When Corrective Action will be Comon Ongoing compliance to F242 will monitored by review of the observationce 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 between the monthly smoking assessmonted. The results of these revor any concerns about the resident smoking independently will be discuring the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The of these observations will also be reviewed during the monthly QA meeting any further discussion and recommendations, if needed. The Administrator and Social Service Director are responsible for the ongcompliance of F242.	pplete ing. ing. sis nent views resu resu eting	e. is s, d	
	smoke safely, flickin The activity assistan Resident #99 was g smoking policy chan supervised because	g ashes into the ashtray. It stated during this time that randfathered in when the liged and he had to be the facility required all led had to be supervised. She						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345171	B. WING		C 06/29/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	00/20/2011
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 242	remaining in the facilitin. During follow up inter assistant on 06/27/17 she had never observed behaviors from Residue been very careful and The Social Service D 06/28/17 at 11:16 AM assessed Resident # three months by actustated that the facility smoking apron on Realways smoked with him as being very high tried to quit smoking would be permitted to could not quit and the was supervised dipolicy he had to be significant for the schedule and has with his input. The She always followed the Interview with the Add 11:51 AM revealed the changed 6 years ago wanted to smoke indexes.	was the only resident ity who was grandfathered view with the activity at 10:46 AM, she stated wed any unsafe smoking alent #99 as he has always d wore his smoking apron. irector was interviewed on a stated that she it was approved the use of a sesident #99 and that he is upervision. She described it functioning. She stated he and made sure that he is smoke at this facility if he is at was approved. She stated uring smoking as per facility upervised for his safety. She is changed it several times ocial Service Director stated	F 24	2	
F 253 SS=D	483.10(i)(2) HOUSER SERVICES	KEEPING & MAINTENANCE	F 25	33	7/27/17
	(i)(2) Housekeeping a	and maintenance services			

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NAME OF PR	ROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • • •		STREET ADDRESS, CITY, STATE, ZIP COD	•	06/29/2017
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WHITE OF	AK MANOR - SHELBY			SHELBY, NC 28150		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 253	Continued From page	e 4	F 25	53		
F 253	necessary to maintain comfortable interior; This REQUIREMENT by: Based on observation facility failed to store a bathroom (room # 21 to repair a broken toil bathroom (room # 10.5) The findings included A memo labeled "Thir 9/12/16 provided by the Check bathrooms for label bed pans, bath pand urinal graduates Clean urinals, bedpareach use and put "ou 1. On 6/25/17 at 1:06 observed on the bath labeled or covered. On 6/26/17 at 9:59 Al on the bathroom floor or covered. On 6/27/17 at 9:24 Al on the bathroom floor or covered. On 6/27/17 at 9:32 Al on the bathroom floor or covered.	n a sanitary, orderly, and is not met as evidenced ins and staff interviews the a bed pan in a shared i) on 1 of 2 halls and failed et paper holder in a shared i) on 1 of 2 halls. : ings to Remember" dated the facility read in part, #8. soiled urine graduates, pans, denture cups, urinals, with resident's name. #9. is, and wash basins after t of sight."	F 25	White Oak Manor-Shelby do Housekeeping and maintenan necessary to maintain a sanit and comfortable interior. 1. How Corrective Action will Accomplished for Each Resid Have Been Affected by the D Practice. (a) The unlabeled, unbagged Room 211 was discarded on 2017 and a new bed plan was stored appropriately. The Adinitiated reeducation/reinservicestoring and Labeling Bed Pal Basins on June 27, 2017 for the Department. (b) The toilet paper holder for was repaired by Maintenance 2017. The Maintenance Depinitiated and completed a faci resident room audit of toilet pon June 27, 2017. Interviews Administrator with the Depart Manager responsible for this and the Maintenance Supervithe toilet paper holder in Roobeen repaired multiple times,	be dent Found to eficient d bed pan in June 27, s labeled and ministrator icing on ns/Bath the Nursing r Room 103 e on June 27, artment dility wide aper holders is by the ment room check isor revealed m 103 had	
	cleaned, dried and sto Nurse aide # 4 stated	ored in a clear plastic bag. the bed pan in room # 211 rly and should have been		resident's wheelchair was not hit the holder and cause the r repair. 2. How Corrective Action will	ted to often need for	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY IPLETED
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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	72372017
					01 N MORGAN STREET		
WHITE OA	K MANOR - SHELBY				HELBY, NC 28150		
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F 253	Continued From page	e 5	F 2	253			
		M Housekeeper # 1 stated # 211 was on the floor in the			Accomplished for Those Residents Having a Potential to be Affected by the	e	
	around it. Housekeep	g and she just cleaned per # 1 stated the nurses			Same Deficient Practice.		
	threw the bed pans a used.	way if they were not being			(a) The Administrator initiated reeducation/reinservicing on Storing ar	nd	
	On 6/27/17 at 9:42 A	M The Assistant Director of			Labeling Bed Pans/Bath Basins on Jur 27, 2017 for the Nursing Department.	ne	
		ed basins and bed pans labeled and stored in a			Additional reeducation/reinservicing was completed by the Director of Nursing o		
	plastic bag if in a sen	ni private room. The ADON room # 211 was stored			July 17 and July 18th, 2017, at schedu Nurses' and Nursing Assistant meeting	led	
	incorrectly and should	d have been labeled and indicated she did not know			Reeducation/reinservicing was also initiated on July 13, 2017 for the	,	
		onged to so she would throw			Housekeepers. This was initiated by the Administrator and addressed	ne	
		AM an interview with the			Housekeepers' monitoring of bed pans/bath basins during daily room		
	Administrator revealed	ed her expectations were for			cleaning. Staff members who are on	4-	
	stored properly in a c	ed in shared rooms and lean plastic bags.			approved leave of absences or off due vacation/etc. will have their inservicing completed upon reporting back to work		
		PM a toilet paper holder proken with a piece in the			(b) The Maintenance Supervisor will	ι.	
	bathroom floor in roo				oversee weekly audits of checking toile paper holders in all resident rooms for	et	
	On 6/27/17 at 9:51 A observed to be broke	M a toilet paper holder was n with a piece in the			four weeks (beginning June 27, 2017). These audits will then be completed		
	bathroom floor in roo	m # 103.			monthly and as needed. The Administrator will be responsible for		
	sitter for a resident in	M an interview with a private room # 103 indicated the			reviewing these audits. Work order for will also continue to be used to	ms	
	months and the hous	Id been broken for about 6 ekeeping staff cleaned the ey should have noticed it was			communicate any room maintenance needs.		
	broken.				3. Address What Measures Will be Pu Into Place or Systemic Changes Made	to	
		M an interview with Nurse ilet paper holder in room #			Ensure that the Deficient Practice Will Recur.	Not	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345171	B. WING		C 06/29/2017
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	, 00:20:20:1
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 253	On 6/27/17 at 9:59 Al Housekeeper # 2 indi in room # 103 had be 2016. Housekeeper # the broken toilet paper and the maintenance been fixed. On 6/27/17 at 10:32 Al Maintenance Assistant a work order slip for the fixed in room # 103. The picked up the broken and stated the piece been broken for a few Assistance further indicate filled out by the sistaff was supposed to the facility for things in On 6/27/17 at 11:55 Al Administrator revealed.	AM an interview with the toilet paper holder to he toilet paper holder to her supervisor aguys and it still had not the toilet paper holder to her supervisor aguys and it still had not the toilet paper holder to be the toilet paper holder to be the toilet paper holder to be the Maintenance Assistant piece out of bathroom floor looked like it could have to days. The Maintenance dicated work requests slips taff and the maintenance of walk around and inspect the heed her expectations for the line room checks and fix	F 253	(a) The Administrator initiated reeducation/reinservicing on Storing a Labeling Bed Pans/Bath Basins on Ju 27, 2017 for the Nursing Department. Additional reeducation/reinservicing we completed by the Director of Nursing July 17 and July 18th, 2017, at schedu Nurses' and Nursing Assistant meeting Reeducation/reinservicing was also initiated on July 13, 2017 for the Housekeepers. This was initiated by 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 vacation/etc. will have their inservicing completed upon reporting back to wor This inservicing will be repeated with newly hired staff during Orientation by Staff Development Nurse. This trainin will also be reinforced as necessary to ensure compliance by the Staff Development Nurse and/or the Administrator. Ongoing compliance with monitored by the Administrator, Direct Nursing, and the Housekeeping Supervisor by review of random observations of bed pans to ensure proper labeling and storing. These autare to be completed by Department Managers/Ancillary Staff and at least total observations will be completed weekly for four weeks, then at least two observations weekly for one month, at then ten per month for three quarters, then as needed.	ane vas on uled gs. the e to g kk. v the ng o iill be tor of udits 100 venty and

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN			(X3) DATE SURVEY COMPLETED
		345171	B. WING _		-	C 06/29/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150		33/20/23 11
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FREGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S I ((EACH CORREC' CROSS-REFEREN DI		
F 253	Continued From page	e 7	F2	(b) The Maintenance oversee weekly aud paper holders in all four weeks (beginning Ongoing compliance the Maintenance Sundministrator by congoing audits compliance of the Maintenance of	lits of checking toile resident rooms for ng June 27, 2017). e will be monitored upervisor and the mpleting/reviewing pleted monthly and er forms will also to communicate arneeds. Any newly worker will be rientation on regula of toilet paper holder be completed by the tenance Supervisor Nurse. Newly hired to be trained during ring Maintenance et paper holders. The pleted by the Staff et This training will us necessary to ensure the staff Development diministrator. The Facility Plans to ensure the staff Development diministrator. The Facility Plans to ensure the staff of the complete to F253 will worked the complete to F253 will worked the staff these will be reviewed by etings Monday-Fridate the staff of these will be reviewed by etings Monday-Fridate the staff of the staff of these will be reviewed by etings Monday-Fridate the staff of the staff of the staff of these will be reviewed by etings Monday-Fridate the staff of the staff of the staff of the staff of these will be reviewed by etings Monday-Fridate the staff of the sta	by as ny rly rs. ne r, or l his ure s tte.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER		•	40	TREET ADDRESS, CITY, STATE, ZIP CODE 11 N MORGAN STREET HELBY, NC 28150		
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F 253 F 272 SS=D	Continued From page 483.20(b)(1) COMPR ASSESSMENTS			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 responsifor ongoing compliance to F253.	ng	7/21/17
	(b) Comprehensive A (1) Resident Assessr must make a comprehensive A (1) Resident Assessr must make a comprehensive A (2) resident's needs, street preferences, using the instrument (RAI) speciassessment must include assessment must include (ii) Identification and (ii) Customary routin (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behave (vii) Psychological were (viii) Physical fun problems. (ix) Continence.	ment Instrument. A facility hensive assessment of a ngths, goals, life history and e resident assessment cified by CMS. The lude at least the following: demographic information le. lis. lior patterns. ell-being. ctioning and structural lis and health conditions. lional status. lit. list and procedures.					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	: :	00/20/2011	
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F 272	regarding the addition on the care areas of the Minimum Data (xviii) Documentar assessment. The assinclude direct observation the resident, as well a licensed and non-licensed on all shifts. The assessment prodobservation and compass well as communic non-licensed direct chifts. This REQUIREMENT by: Based on record revision facility failed to compassed on involving cogresidents (Resident # The findings included Resident #230 was a 06/09/17 for rehability	tringered by the completion Set (MDS). Ition of participation in sessment process must an and communication with as communication with as communication with as communication with as communication with the resident, ation with licensed and are staff members on all are staff members on all is not met as evidenced iew and staff interview, the lete the Minimum Data Set inition for 1 of 33 sampled (230).	F 2		f a pals, life the RAI. pe ent Found to ficient		
	coded him as "not as Interview for Mental S assessed Resident # term or long term me	num Data Set dated 06/16/17 sessed" for the Brief Status (BIMS). The staff 230 has having no short mory impairments and being sision making. The Care		29, 2017.2. How Corrective Action will the Accomplished for Those Resided Having a Potential to be Affect Same Deficient Practice.	lents		

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE		
WHITE O	AK MANOR - SHELBY			401 N MORGAN STREET			
WHILE OF	KK MANOK - SHELDT			SHELBY, NC 28150			
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F 272			F 2	An audit of current resident completed on June 30, 20 BIMS were completed appadmitted and readmitted rewill be conducted/completer resident as appropriate. Reeducation/reinserving were Coordinators was completed 2017 and conducted by the Coordinator. This reinservaddressed that staff assess not be conducted in place interview, and completing and during the MDS observations. Address What Measure Into Place or Systemic Cheensure that the Deficient Frecur. Reeducation/reinserving were Coordinators was completed 2017 and conducted by the Coordinator. This reinservaddressed that staff assess not be conducted in place interview, and completing interview, and completing interview, and completing interview, and completing interview.	ats was 17, to ensure propriately. A esidents' BIM ed with the with current M ed on July 21 e Corporate B wicing esments shou of the BIMS these timely vation period es Will be Put anges Made Practice Will I with current M ed on July 21 e Corporate B wicing esments shou of the BIMS these timely	DS I, RAI ID DS I, RAI ID DS I, RAI ID ID S I, RAI ID ID S I, RAI ID ID S II, RAI ID ID S II II ID S I	
				and during the MDS obser This inservicing will also be any new MDS Coordinator Corporate RAI Coordinato Compliance to F272 will be the Corporate RAI Coordir Administrator. The Corpor Coordinator will complete of BIMS completion on six weekly for four weeks, the monthly for three months,	e completed r by the r. e monitored the rate RAI random audit residents n six resident	oy s	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION IG	(X3) DATE SURVE COMPLETED	B) DATE SURVEY COMPLETED	
		345171	B. WING		C 00/20/20	47	
	ROVIDER OR SUPPLIER	343771		STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	06/29/20	17	
(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 CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED TO THE APPR	OULD BE COME	(X5) PLETION DATE	
F 272 F 309 SS=D	FOR HIGHEST WELL 483.24 Quality of life Quality of life is a fund applies to all care and residents. Each resid	PROVIDE CARE/SERVICES BEING damental principle that diservices provided to facility lent must receive and the ne necessary care and	F 2	needed. The Administrator will revithese random audits. 4. Indicate How the Facility Plans Monitor Its Performance to Make That Solutions are Sustained and When Corrective Action will be Co. Ongoing compliance to F272 will monitored by the review of the rar audits for the BIMS completion on MDS. The results of these audits reviewed by in the Morning QI me Monday-Friday for any additional discussion/recommendations. The of these audits/observations will a reviewed during the monthly QA in for any further discussion and recommendations, if needed. The Administrator and Director of are responsible for ongoing comp F272.	s to Sure Dates Da	17	
	well-being, consistent comprehensive asses 483.25 Quality of care	sment and plan of care.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	COMF	(X3) DATE SURVEY COMPLETED	
		345171	B. WING			C / 29/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	1 00.	23/2017
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	facility residents. Basessessment of a residents received accordance with propractice, the compressive plan, and the resident facility must ensprovided to residents consistent with profest the comprehensive pland the residents' god (I) Dialysis. The faci residents who requires revices, consistent of practice, the composite plan, and the residents who requires revices, consistent of practice, the composite plan, and the residents who requires revices. This REQUIREMEN by: Based on observation interview and staff in follow the physician of 2 sampled resider (Resident #230). The findings included Resident #230 was a 06/09/17. His diagnorenal disease, enception.	ent and care provided to seed on the comprehensive ident, the facility must ensure e treatment and care in fessional standards of hensive person-centered esidents' choices, including following: Int. Bure that pain management is so who require such services, essional standards of practice, person-centered care plan, eals and preferences. It must ensure that e dialysis receive such with professional standards prehensive person-centered esidents' goals and T is not met as evidenced ens, record review, resident terviews, the facility failed to ordered fluid restriction orders	F 30	White Oak Manor-Shelby does services to maintain the highes and care for the residents. 1. How Corrective Action will be Accomplished for Each Reside Have Been Affected by the Deferactice. Staff removed the water pitcher Resident #230's room when ide being on a fluid restriction. Reswas discharged home on June Re-education/inservicing was in	t well-being e nt Found to icient r from entified as sident #230 29, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345171	B. WING			C 06/29/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	00/29/2017	
				401 N MORGAN STREET	0022		
WHITE OA	AK MANOR - SHELBY			SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	DATE	
F 309	Continued From page	e 13	F 3	809			
F 309	determined by nephrodialysis. Since under encephalopathy had better. He was admit term rehabilitation. Physician orders date cubic centimeters (corestriction diet which 90 milliliters (equaling times daily and dietar the trays. The Minimum Data S 06/16/17 noted he haindependent with dea a therapeutic diet and supervision. It was alidialysis. The admission nutrition oted he received a lidiet, no added salt ar was distributed by 27 day and 730 cc from day. On 06/25/17 at 12:48 observed eating in his water pitcher with wa On 06/27/17 at 12:37 observed eating in his pitcher by his side in	plogy that he required regoing dialysis, his cleared and he felt much ted to the facility for short and 06/16/17 included a 1000 pper 24 hours fluid stated nursing would provide 270 cc) with med pass 3 py would provide 730 cc on et, an admission dated intact cognition and was a sision making skills, received at ate with set up and so coded that he received and was on a 1000 cc which of cc for medication pass per the dietary department per the dietary department per PM Resident #230 was a room. On his table was a ter in it.	F 3	the Nursing Department of July 18, 2017 by the Direct during Nurse's Meetings. Assistant Meetings. This re-education/inservicing a following physician's order placing a water pitcher in room who is on fluid restromation. Accomplished for Those I Having a Potential to be A Same Deficient Practice. An audit was conducted or residents with physician or restrictions and there is or resident did not have, nor water pitcher in the room. The re-education/inservice physician orders and not pitcher in a resident's roor restrictions was initiated work. Department on July 17 are by the Director of Nursing Meetings and Nursing As Staff members who are or leave of absences/vacation their inservicing complete back to work. 3. Address What Measure.	ctor of Nursing and Nursing and Nursing and Nursing addressed ers and not a resident's rictions. In will be Residents Affected by the orders for fluid one current ers. That is does have a coing on following a water on fluid with the Nursing July 18, 20 g during Nurse is sistant Meeting an approved on/etc. will have dupon reporters Will be Puters and Nurse will be Puters will be Puters and Nurse will be Puters will be Puters will be Puters and Nurse will be Puters wi	ng er ng 17 's gs. ve ing	
	doesn't drink a lot fro	stated at this time that he m the water pitcher. #1 stated during interview		Into Place or Systemic Cl Ensure that the Deficient Recur.	-		
		PM that she normally filled		Current Nursing Staff hav	e been		

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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			C 6/29/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	0/29/2017	
TO UNE OF TH	TO VIDER OR GOTT EIER			401 N MORGAN STREET	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
WHITE OA	K MANOR - SHELBY						
				SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	Continued From page	e 14	F 3	09			
F 309	the water pitchers aft residents on fluid resiwater pitcher and that unit was currently on Resident #230 was opitcher on 06/27/17 a he poured water from plastic cup he had at that he was unaware restriction diet. He stapitcher two times a description of the poured water from plastic cup he had at that he was unaware restriction diet. He stapitcher two times a description of the pitcher two times and fluid Nurse #1 entered the did not see the water yesterday (06/27/17) Resident #230 asked informed of his fluid in NA #2 was interviewed she stated she had fipitcher on first shift of know he was on a fluid stated that normally the nurse aides of fluid reask. The Director of Nursin 06/29/17 at 10:52 AN	er supper. She stated those trictions should not have a t no one on the rehabilitation a fluid restriction. bserved with a full water at 4:25 PM. He stated that a the pitcher into the small bedside. He further stated of being in any fluid ated staff filled his water ay. PM, NA #2 was interviewed. Was unaware of Resident restriction diet. At this time a conversation and stated he pitcher in his room and he stated this morning of for a water pitcher and was estriction. ed on 06/29/17 at 9:37 AM. A silled Resident #230's water in 06/27/17 as she did not id restriction. She further he nurses will inform the estrictions and she forgot to any stated during interview on that she expected staff to	F3	inserviced on following physicand not placing a water pitch room of a resident on fluid reaching. This re-education/inservicing with the Nursing Department and July 18, 2017 by the Dir Nursing during Nurse's Mee Nursing Assistant Meetings. The members who are on approvabsences/vacation/etc. will be inservicing completed upon to work. This inservicing will repeated with newly hired storientation by the Staff Dev Nurse. This training will also reinforced as necessary to ecompliance by the Staff Dev Nurse and/or the Director of Compliance to F309 will be the Administrator and Direct by reviewing observations of on fluid restriction and not his pitcher in the room (currently resident). These will be confor fourteen days, then three for four weeks, then once a months, then twice monthly quarters, and then as needed 4. Indicate How the Facility Monitor Its Performance to 19.	her in the estrictions. It is g was initiated at on July 17 rector of tings and Staff wed leave of have their reporting back all also be easift during elopment in Nursing. The monitored by or of Nursing f any resident aving a water by one enpleted daily estimes a week week for three for three ed. Plans to Make Sure		
	care guide in the com communication. Tho restriction should not	se residents on a fluid receive a water pitcher. ated on 06/29/17 at 11:51 AM		That Solutions are Sustaine When Corrective Action will Ongoing compliance to F30 monitored by the review of t observations of any resident restriction and not having a	be Complete. 9 will be he t on fluid		

1 ' '		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345171	B. WING _			l	C / 29/2017	
	ROVIDER OR SUPPLIER			40	TREET ADDRESS, CITY, STATE, ZIP CODE O1 N MORGAN STREET HELBY, NC 28150	1 00/	23/2017	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 309	restriction diet via the	e 15 care guide and those receive a water pitcher.	F3	809	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 a be reviewed during the monthly QA meeting for any further discussion and recommendations, if needed. The Administrator and Director of Nursi are responsible for ongoing compliance F309.	s. Iso		
	activities of daily living services to maintain generonal and oral hygomers and oral hygomers. This REQUIREMENT by: Based on observation resident and staff interprovide scheduled should residents (Residents trim chin hairs for 2 or	is unable to carry out greceives the necessary good nutrition, grooming, and giene. is not met as evidenced ans, record review and erviews the facility failed to owers for 2 of 5 sampled #160 and #18) and failed to f 5 sampled residents #132) reviewed for activities	F3	3312	White Oak Manor-Shelby does provide ADL /care for dependent residents. 1. How Corrective Action will be Accomplished for Each Resident Found Have Been Affected by the Deficient Practice. (a) Scheduled showers are being provider Resident #160 and #18 as they are	d to	7/27/17	
	02/10/16 with diagnost Parkinson's disease a respiratory failure. Review of the quarter	s admitted to the facility on sees of heart failure, and acute and chronic ally Minimum Data Set dated seident #160 was cognitively			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.	ed e		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345171	B. WING		<u> </u>	06#		
NAME OF P	ROVIDER OR SUPPLIER	0.0		9.	TREET ADDRESS, CITY, STATE, ZIP CODE	06/2	29/2017	
NAME OF T	COVIDEIX OIX OOI 1 EIEIX				O1 N MORGAN STREET			
WHITE OA	K MANOR - SHELBY				HELBY, NC 28150			
				_	·			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Continued From page	e 16	F;	312				
		tensive assistance with			(b) Residents #24 and #132's chin hairs	s		
	toileting, personal hyg				were removed by the Director of Nursir			
	, percentage	,			when these were identified.	3		
	Review of the care plant	an dated 06/01/2017			Re-education/reinservicing was			
	· ·	60 required varying degrees			immediately initiated on June 28, 2017	for		
	of assistance with act	tivities of daily living related			the Nursing Department (Nurses and			
	to Parkinson's diseas	e and recent exacerbation			Nursing Assistants) on Removal of Fac	ial		
		pulmonary disease and			Hair. This was conducted by the Direct			
	congestive heart failu	•			of Nursing and addressed removing fac			
	•	form hygiene tasks with			hair during ADL cares, and if the reside	nt		
		ne interventions included			refuses, notifying the supervisor.			
		, hygiene, dressing and			2. Have Carractive Action will be			
		ne interventions stated the nale Nurse Aide (NA) or			How Corrective Action will be Accomplished for Those Residents			
	older female NA for b			Having a Potential to be Affected by the				
	older lemale Witter b	atiming addictance.			Same Deficient Practice.			
	Review of the facility	shower schedules revealed						
	· · · · · · · · · · · · · · · · · · ·	vers were scheduled for			(a) Re-education/reinservicing on			
	Monday and Thursda	y on the 7:00 AM to 3:00 PM			providing residents showers as schedu	led		
	shift. Review of the fa	icility shower sheet			and/or requested, and addressing refus	sals		
	documentation reveal	led Resident #160 received			by residents was initiated with the Nurs			
		and 06/27/17. There was			Department on July 17 and July 18, 20			
		on of showers being given			by the Director of Nursing during Nurse			
	or refused by Resider				Meetings and Nursing Assistant Meetin	gs.		
	06/05/17, 06/08/17, 0	6/12/17 or 06/15/17.			Staff members who are on approved			
	An intension conducts	ad an 06/20/17 at 0:22 ANA			leave of absences/vacation/etc. will have	-		
		ed on 06/28/17 at 9:22 AM she worked on Resident			their inservicing completed upon report back to work. The Administrator and the			
		nrough Friday. She stated			Social Services Director also reviewed	ie		
	•	vers were scheduled for			any concerns/grievances and there we	re		
		y on the day shift. NA #5			no other residents who have expressed			
		so short staffed for the past			concern with their bathing/shower	-		
		sn't enough time for showers			schedule.			
		ys there were only two to						
		. She stated a shower sheet			(b) An immediate audit was conducted	by		
	should be completed	with each shower and if			Nursing to identify any resident(s) that			
	there wasn't a showe	r sheet the shower most			may have any unwanted facial hair.			
	likely wasn't done.				Re-education/reinservicing was also			
					immediately initiated on June 28, 2017	for		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII	NG			С	
		345171	B. WING _				/ 29/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	12312011	
					01 N MORGAN STREET			
WHITE OA	AK MANOR - SHELBY				HELBY, NC 28150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	<u> </u>			(X5)	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 312	Continued From pa	ge 17	F S	312				
	An interview conduc	cted on 06/28/17 at 10:03 AM			the Nursing Department (Nurses and			
	with the Director of	Nursing revealed it was her			Nursing Assistants) on Removal of Fa	cial		
	expectation for show	wers to be given to residents			Hair. This was conducted by the Dire	ctor		
	on their scheduled	shower day. She stated the			of Nursing and addressed removing fa	acial		
	facility had been sh	ort staffed but showers should			hair during ADL cares, and if the resid	ent		
	_	er stated she had not found			refuses, notifying the supervisor.			
		Resident #160 had received			Re-education/reinservicing on remova			
		on 06/22/17 and 06/27/17.			facial hair was also continued with the			
		at #160 was out of the facility			Nursing Department on July 17 and J			
		ould not have received a			18, 2017 by the Director of Nursing du	•		
		t she felt sure he received his			Nurse's Meetings and Nursing Assista			
		owers but could not find a staff			Meetings. Staff members who are on			
	Interriber that recalls	ed giving him a shower.			approved leave of absences/vacation, will have their inservicing completed u			
	An interview conduc	cted on 06/28/17 at 2:27 PM			reporting back to work.	роп		
		ed she worked with Resident			roporting back to work.			
		ne stated there had been			3. Address What Measures Will be P	ut		
	_	ast few months when showers			Into Place or Systemic Changes Made			
		ed due to having two to three			Ensure that the Deficient Practice Will			
		e stated the facility had been			Recur.			
		October 2016 and staffing						
	wasn't improving. S	he further stated if a shower			(a) Current staff have been inserviced	d on		
	sheet wasn't comple	eted for Resident #160 the			providing showers to residents as			
	shower was not give	en.			scheduled and/or requested by the			
					resident. This was initiated with the			
		s admitted to the facility on			Nursing Department on July 17 and J			
	_	oses of non-Alzheimer's			18, 2017 by the Director of Nursing du	•		
	dementia, anxiety a	ind depression.			Nurse's Meetings and Nursing Assista			
	5				Meetings. Staff members who are on			
	I -	erly Minimum Data Set dated			approved leave of absences/vacation			
		Resident #18 was severely			will have their inservicing completed unreporting back to work. This inservicing			
		I and required extensive ing, personal hygiene and			will also be repeated with newly hired	•		
	bathing.	ing, personal hygiene and			during Orientation by the Staff	staii		
	Danning.				Development Nurse. This training wil			
	Review of the care	plan dated 06/08/17 revealed			also be reinforced as necessary to en			
		red assistance with activities			compliance by Staff Development Nui			
	-	limited mobility, secondary to			Director of Nursing, and/or Assistant	- - ,		
		cognitive impairment and			Director of Nursing. In addition to this			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			С	
		345171	B. WING _			06/	29/2017	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				40	01 N MORGAN STREET			
WHITE OA	K MANOR - SHELBY			s	HELBY, NC 28150			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 312	Continued From page	e 18	F3	312				
	· -	erventions included assist			training, the facility has also added an			
		e, dressing and grooming			additional function in the Nursing			
	daily and as needed.				Assistants' Smart Charting for			
	dany and do noodod.				documenting showers or whirlpool bath	ıs		
	Review of the facility	shower schedules revealed			The Nursing Assistants will now have a			
	•	ers were scheduled for			specific question populate for daily Sm			
		ay on the 7:00 AM to 3:00 PM			Charting on ADL cares provided for			
	shift. Review of the fa				residents that asks if the resident recei	ved		
		lled Resident #18 received a			a shower or whirlpool bath based on th	е		
	shower on 06/22/17	and 06/27/17. There was no			resident's shower/whirlpool bath sched	ule.		
	other documentation	of showers being given or			Inservicing on this new Smart Charting			
	refused by Resident	#160 for 06/01/17, 06/05/17,			function was initiated by the Assistant			
	06/08/17, 06/12/17 o	r 06/15/17.			Director of Nursing on July 21, 2107 ar	ıd		
					the function will populate in Smart			
		ed on 06/28/17 at 9:22 AM			Charting as of July 24, 2017. Staff			
		she worked on Resident			members who are on approved leave of	of		
	· ·	rough Friday. She stated			absences/vacation/etc. will have their			
		ers were scheduled for			inservicing completed upon reporting b	ack		
	_	ay on the day shift. NA #5			to work. This inservicing will also be			
	_	so short staffed for the past			repeated with newly hired staff during			
		sn't enough time for showers			Orientation by the Staff Development			
	_	ys there were only two to . She stated a shower sheet			Nurse. This training will also be			
		with each shower and if			reinforced as necessary to ensure compliance by Staff Development Nurs	•		
	-	er sheet the shower most			Director of Nursing, and/or Assistant	ᠸ,		
	likely wasn't done.	JIOSE LIIC SHOWEI HIUSE			Director of Nursing, And/or Assistant Director of Nursing. Nursing			
	mony waon't done.				Administration (DON, ADON, SDC, Un	it		
	An interview conduct	ed on 06/28/17 at 10:03 AM			Coordinators) will monitor any			
		ursing revealed it was her			documented "No" by the Nursing			
		ers to be given to residents			Assistants about residents			
	-	nower day. She stated the			showers/whirlpool baths to determine			
		rt staffed but showers should			cause (such as refusal). These review	s		
	•	stated she had not found			will be completed three times a week for			
	_	Resident #18 had received			two weeks, then weekly for six weeks,			
	shower's other than (06/22/17 and 06/27/17. She			then monthly for three months, and the	n		
	stated she felt sure s	he received her showers but			as needed thereafter.			
	could not find a staff	member that recalled giving						
	her a shower.				(b) Current Nursing staff have been inserviced on Removal of Facial Hair.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345171	B. WING			C / 29/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	129/2017	
				401 N MORGAN STREET			
WHITE OA	AK MANOR - SHELBY			SHELBY, NC 28150			
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 312	with NA #13 revealed #18 most days. She stimes in the past few couldn't be completed NAs on the hall. She short staffed since Od wasn't improving. She sheet wasn't complet shower was not giver 3. Resident #24 was 7/13/15 with diagnost disease, and dement disturbance. A review of the annual dated 4/11/17 revealed severely cognitively in assistance with person revealed no rejection A care plan reviewed Resident #24 require activities of daily livin	ed on 06/28/17 at 2:27 PM If she worked with Resident stated there had been many months when showers diducted the facility had been ctober 2016 and staffing the further stated if a shower ed for Resident #18 the final staffing the facility on the state of the facility of of the	F 31	,	ne sing 18, 2017 g Nurse's Meetings. oved will have reporting will also be luring ment re nt Nurse, stant mpliance strator and random air. These epartment least 100 eted east twenty		
	Review of the showe Resident # 24 receive on Tuesday and Frida On 6/25/17 at 1:13 P observed with multipl scattered across her On 6/26/17 at 9:55 A	ed showers on the day shift ays. M Resident #24 was the chin hairs ½ inch in length chin. M Resident #24 was the chin hairs ½ inch in length the chin hairs ½ inch in length		then ten per month for three quathen as needed. Compliance to F312 will be monthe Administrator and Director of by review of the newly added question of the audits on facial and review of the audits on facial 4. Indicate How the Facility Plar Monitor Its Performance to Make That Solutions are Sustained an When Corrective Action will be Conserved.	itored by f Nursing lestion for t Charting al hair. Ins to e Sure d Dates		

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345171	B. WING			C 06/29/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150		33/23/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	observed with multip scattered across her On 6/27/17 at 2:35 F observed with multip scattered across her On 6/28/17 at 8:01 A observed with multip scattered across her On 6/28/17 at 2:25 F the nursing assistant shave the men and vneeded. Nurse aide: #24 had received a sanother nurse aide. On 6/28/17 at 9:50 A the nursing assistant remove facial hair foon shower days but indicated Resident # and facial hair removindicated Resident # and would allow staff On 6/28/17 at 9:53 A (DON) asked Reside of the chin hairs and you remove the chin well? I used to go do see anything now. I wook them from us." On 6/28/17 at 9:56 A revealed her expectation would be seen anything now. I wook them from us."	le chin hairs ½ inch in length chin. M Resident #24 was le chin hairs ½ inch in length chin. M Resident #24 was le chin hairs ½ inch in length chin. M Resident #24 was le chin hairs ½ inch in length chin. M Nurse Aide #6 revealed stresponsibilities were to women on shower days if #6 indicated that Resident shower earlier that day by M Nurse Aide #7 revealed stresponsibilities were to men and women not only as needed. Nurse Aide #7 24 should have been shaved wed. The nurse aide further 24 was not resistive to care	F 3-	Ongoing compliance to F312 monitored by the Administrato Director of Nursing by review added question for Showers/w bath in SmartCharting and revaudits on facial hair. The result of these audits/reviews will be the Morning QI meetings Monfor any additional discussion/recommendations. of these observations will also reviewed during the monthly of for any further discussion and recommendations, if needed. The Administrator and Directorare responsible for ongoing confidence.	r and of the newly whirlpool riew of the Its from both reviewed in day-Friday The results be DA meeting		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345171	B. WING			C 06/29/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150		00/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	would shave the resi On 6/28/17 at 10:16 Administrator stated be offered daily and resident was not refu 4. Resident #132 wa 11/21/16 with diagno hypertension and de disturbance. A review Data Set dated 12/6/had moderately imparequired total assista and had no rejection Review of the showe Resident # 132 receion Wednesday and I	e DON further stated she dent. AM an interview with the she expected for ADL care to as needed as long as the sing or declining care. As readmitted to the facility on ses that included mentia without behavioral of the annual Minimum 16 revealed Resident # 132 sired decision making skills, nce with personal hygiene, of care. The schedule revealed wed showers on the day shift	F 3				
	scattered across her On 6/27/17 at 9:22 A observed with multip scattered across her On 6/28/17 at 8:02 A observed with multip scattered across her On 6/28/17 at 9:31 A the nursing assistant remove facial hair for on shower days but a stated Resident #132	chin. M Resident #132 was le chin hairs ¼ in length chin. M Resident #132 was le chin hairs ¼ in length					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY	
		345171	B. WING				C / 29/2017
	ROVIDER OR SUPPLIER		<u>. I</u>	4	TREET ADDRESS, CITY, STATE, ZIP CODE 01 N MORGAN STREET SHELBY, NC 28150	1 00/	23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353 SS=E	Resident #132 was now would allow staff to castated she would share she returned from the one of the control of	rse aide further indicated of resistive to care and are for her. Nurse Aide #7 we the resident's face when grapy. M an interview with the DON tions were for men and of be removed every day and ys. The DON stated hould be performed daily AM an interview with the she expected for ADL care to as needed as long as the sing or declining care. FICIENT 24-HR NURSING LANS The sufficient nursing staff with etencies and skills sets to elated services to assure that or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care		312			7/27/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ICATION NUMBED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345171	B. WING				29/ 2017
	ROVIDER OR SUPPLIER			40	TREET ADDRESS, CITY, STATE, ZIP CODE 01 N MORGAN STREET HELBY, NC 28150	1 001	23/2011
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	of personnel on a 24- nursing care to all res resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides (a)(2) Except when w this section, the facilit nurse to serve as a cl duty. (a)(3) The facility mus nurses have the spec sets necessary to car identified through res described in the plan (a)(4) Providing care assessing, evaluating resident care plans at needs. This REQUIREMENT by: Based on observatio resident and staff inte provide assistance wi due to insufficient nur residents (Residents The findings included	each of the following types hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not aived under paragraph (e) of ty must designate a licensed harge nurse on each tour of et ensure that licensed iffic competencies and skill e for residents' needs, as ident assessments, and of care. includes but is not limited to an includes but is not limited to an includes but is not limited to an include planning and implementing and responding to resident's is not met as evidenced ans, record review and arviews the facility failed to the activities of daily living sing staff for 2 of 5 sampled #160 and #18).	F	353	White Oak Manor-Shelby does provide sufficient 24-hour Nursing Staff Per Ca Plans. 1. How Corrective Action will be Accomplished for Each Resident Foundary Been Affected by the Deficient Practice. Nursing staff are available to provide	re	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345171	B. WING			C	
NAME OF D	DOVIDED OD CUDDUED	040171	1 2:		TREET ARRESCO CITY STATE ZIR CORE	06/	29/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE OA	K MANOR - SHELBY				01 N MORGAN STREET		
				S	HELBY, NC 28150		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 353	353 Continued From page 24		F3	353			
	Parkinson's disease and acute and chronic respiratory failure.				scheduled showers for Residents #160 and #18 as they are scheduled and/or requested (if requested on a)	
		rly Minimum Data Set dated			non-scheduled shower day) by the		
		esident #160 was cognitively			residents. The Day Shift LPN is ensuring	ng	
	•	ktensive assistance with			Residents #160 and #18 showers are		
	toileting, personal hyg	giene and batning.			being provided as scheduled and/or	_	
	Davious of the care al	an 06/01/2017 revealed			requested. Additionally, there is nothin to indicate either resident experienced		
		ed varying degrees of			negative change in condition.	а	
		ties of daily living related to			negative change in condition.		
		and recent exacerbation of			2. How Corrective Action will be		
		ulmonary disease and			Accomplished for Those Residents		
	congestive heart failu				Having a Potential to be Affected by the	.	
	_	form hygiene tasks with			Same Deficient Practice.		
	limited assist. The inte						
		, hygiene, dressing and			Re-education/reinservicing on providing	a	
	_	esident preferred a male			residents showers as scheduled and/o	-	
		Ider female NA for bathing			requested, and addressing refusals by		
	assistance.	is a remain of the real seasons			residents was initiated with the Nursing		
					Department on July 17 and July 18, 20		
	Review of the facility	shower schedules revealed			by the Director of Nursing during Nurse		
	·	vers were scheduled for			Meetings and Nursing Assistant Meeting		
		y on the 7:00 AM to 3:00 PM			Staff members who are on approved	-	
	shift. Review of the fa	acility shower sheet			leave of absences/vacation/etc. will have	ve	
		led Resident #160 received			their inservicing completed upon report	ting	
	a shower on 06/22/17	7 and 06/27/17. There was			back to work.		
		on of showers being given			The Administrator and the Social Servi	ces	
	or refused by Resider	nt #160 for 06/01/17,			Director also reviewed any		
	06/05/17, 06/08/17, 0	6/12/17 or 06/15/17.			concerns/grievances and there were no)	
					other residents who have expressed		
		ed on 06/28/17 at 9:22 AM			concern with their bathing/shower		
		she worked on Resident			schedule. The daily Nursing schedule		
		nrough Friday. She stated			that was referenced did not reflect daily	/	
		vers were scheduled for			facility occupancy has been averaging		
		y on the day shift. NA #5			approximately fifteen percent under full		
	_	so short staffed for the past			occupancy. The Administrator, Directo		
		sn't enough time for showers			Nursing, and Scheduler continue to rev		
	to be given on the days there were only two to				daily staffing schedules to ensure nurs	е	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		345171	B. WING			C
NAME OF DE	ROVIDER OR SUPPLIER	343171		STREET ADDRESS, CITY, STATE, ZIP CODE		5/29/2017
NAME OF F	NOVIDER OR SUFFLIER				-	
WHITE OA	K MANOR - SHELBY			401 N MORGAN STREET		
				SHELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	Continued From page	e 25	F 38	53		
	should be completed there wasn't a showe likely wasn't done.	. She stated a shower sheet with each shower and if r sheet the shower most		staffing attains or maintains the practical physical, mental, and psychosocial well-being of each as determined by resident ass and individual plans of care.	ch resident,	
	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			3. Address What Measures W Into Place or Systemic Change Ensure that the Deficient Prac Recur.	es Made to	
				Current staff have been inserv providing showers to residents scheduled and/or requested by resident. This was initiated wi Nursing Department on July 1 18, 2017 by the Director of Nu Nurse's Meetings and Nursing	s as y the th the 7 and July rsing during	
				Meetings. In addition to this in the facility has also added an a function in the Nursing Assista Charting for documenting show whirlpool baths. The Nursing will now have a specific questifor daily Smart Charting on AD provided for residents that ask resident received a shower or	nservicing, additional ints' Smart wers or Assistants on populate DL cares is if the	
	sheet wasn't complet shower was not giver A follow up interview 2:44 PM revealed the staffing since the first they had made salary did not feel that new at The DON stated that agencies in the past I staffing got better. Sh	ed for Resident #160 the		bath based on the resident's shower/whirlpool bath schedul Inservicing on this new Smart function was initiated by the As Director of Nursing on July 21, the function will populate in Sn Charting as of July 24, 2017. If these inservices, staff member on approved leave of absences/vacation/etc. will have inservicing completed upon reto work. Inservicing will also be	charting ssistant 2107 and nart or both of rs who are ve their porting back	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
				B. WING			C 06/29/2017
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	23/2017
					01 N MORGAN STREET		
WHITE OA	K MANOR - SHELBY				HELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 353	Continued From page	e 26	F3	353			
	for some reason the orientation. The DON (11:00 PM-7:00 AM) ask the Nurses to he cover, and if that did instructed the staff to assure safety. Interview with the Ad 3:03 PM that reveale staffing issues in the stated that the facility agencies because the stated the facility offecame in or stayed over she was made aware that they were short of the Ad 100 AM) shift and she bonuses to get staff that they called her between the they could not get an instructed them to called them to c	new staff did not stay after I stated when third shift had only 2 NAs they would Ip out or ask other shifts to not happen then they "buddy up together" to "buddy up together" to ministrator on 06/29/17 at d she was aware of the facility. The Administrator or did not utilize staffing ey were not needed. She ered bonuses to staff who er. The Administrator stated e on Friday night (06/23/17) with staffing at 3 Nurses and g for the third (11:00 PM to ne directed them to offer o cover the shift. She stated ack and informed her that yone to stay and she rry on the best they could.			with newly hired staff during Orientation the Staff Development Nurse. These trainings will also be reinforced as necessary to ensure compliance by St. Development Nurse, Director of Nursing and/or Assistant Director of Nursing. Nursing Administration (DON, ADON, SDC, Unit Coordinators) will monitor at documented "No" by the Nursing Assistants about residents showers/whirlpool baths to determine cause (such as refusal). These review will be completed three times a week fit two weeks, then weekly for six weeks, then monthly for three months, and the as needed thereafter. From June 26 to July 24, 2017, the fact has hired twelve Nursing Assistants, to LPNs, and four RNs. To assist with Nursing staff recruitment and retention new programs have also been implemented. These programs are: no Nursing Staff Sign-On Bonus programthe new employee receives monetary incentives at 30 days of employment, 90 days of employment; new November 10 to	aff ng, ny 's or en illity vo ,	
	revealed Resident #1	rly Minimum Data Set 8 was severely cognitively d extensive assistance for			Nursing Staff Referral program where a staff member referring a hired nursing staff member will receive monetary incentives at 30 days of employment, 90 days of employment at then at 6 months of employment; and a	and	
	Review of the care pl Resident #18 require of daily living due to I	an dated 06/08/17 revealed d assistance with activities imited mobility, secondary to gnitive impairment and			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	he ; ude	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345171	B. WING _	B. WING			29/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		20.2011	
				40	01 N MORGAN STREET			
WHITE OA	AK MANOR - SHELBY			s	HELBY, NC 28150			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 353	Continued From page	e 27	F:	353				
	incontinence. The inte	erventions included assist			and a new Nursing Scheduler in place.			
	with bathing, hygiene	, dressing and grooming			The Administrator, HR Manager, and			
	daily and as needed.				other Administrative staff attended an			
					in-service on staff retention that was			
	-	shower schedules revealed			conducted by White Oak Management			
		ers were scheduled for			Inc. on July 20, 2017. The Administrat			
	_	y on the 7:00 AM to 3:00 PM			DON, and HR Manager will evaluate th			
	shift. Review of the fa				effectiveness of retention and recruitme	ent		
	documentation revealed Resident #18 received a shower on 06/22/17 and 06/27/17. There was no				by reviewing how many sign-on and referral bonuses are paid in a payperio	d		
		of showers being given or			as well as how many additional shifts	u,		
	refused by Resident #160 for 06/01/17, 06/05/17,				were worked for the points forgiveness			
	06/08/17, 06/12/17 or				program, and how many new Nursing			
					department hires there were. These			
	An interview conducte	ed on 06/28/17 at 9:22 AM			reviews will be completed each payper	iod		
	with NA #5 revealed s	she worked on Resident			(every two weeks) times four, then			
	· ·	ough Friday. She stated			monthly for three months, and then as			
		ers were scheduled for			needed (as well as the continued daily			
	_	y on the day shift. NA #5			reviews of the Nursing Department			
	-	so short staffed for the past			schedules).			
		sn't enough time for showers ys there were only two to			Compliance to E252 will be menitored	b) (
	_	She stated a shower sheet			Compliance to F353 will be monitored the Administrator and Director of Nursii	-		
		with each shower and if			by review of the newly added question	•		
		r sheet the shower most			Showers/whirlpool bath in Smart Chart			
	likely wasn't done.				and reviews completed on recruitment			
					and retention.			
	An interview conducte	ed on 06/28/17 at 10:03 AM						
		ursing revealed it was her			4. Indicate How the Facility Plans to			
		ers to be given to residents			Monitor Its Performance to Make Sure			
		ower day. She stated the			That Solutions are Sustained and Date	-		
	-	t staffed but showers should			When Corrective Action will be Comple	te.		
	_	stated she had not found			Ongoing compliance to ESES will be			
		esident #18 had received 6/22/17 and 06/27/17. She			Ongoing compliance to F353 will be			
		ne received her showers but			monitored by the Administrator and Director of Nursing by review of the ne	why		
		nember that recalled giving			added question for Showers/whirlpool	wiy		
	her a shower.				bath in Smart Charting and the reviews	i		
					completed on recruitment and retention			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345171	345171 B. WING			C 06/29/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 401 N MORGAN STREET SHELBY, NC 28150	•	23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 353	with NA #13 revealed #18 most days. She stimes in the past few couldn't be completed NAs on the hall. She short staffed since Of wasn't improving. She sheet wasn't complet shower was not giver A follow up interview 2:44 PM revealed the staffing since the first they had made salary did not feel that new The DON stated that agencies in the past staffing got better. She had been 2 orientation for some reason the orientation. The DON (11:00 PM-7:00 AM) ask the Nurses to he cover, and if that did instructed the staff to assure safety.	ed on 06/28/17 at 2:27 PM If she worked with Resident stated there had been many months when showers in the due to having two to three stated the facility had been ctober 2016 and staffing in the further stated if a shower the facility that the stated for Resident #18 the	F 38	as well as any concerns with staff/resident care. The resident care. The resident care in these reviews will be review. Morning QI meetings Monday additional discussion/recommendation of these reviews will also be during the monthly QA meet further discussion and recording reeded. The Administrator and Directors are responsible for ongoing F353.	ults from yed in the ay-Friday for as. The results addressed ting for any mmendations,		
	3:03 PM that reveale staffing issues in the stated that the facility agencies because the stated the facility offe came in or stayed ov she was made aware that they were short was the stated that the stated that they were short was the stated that they were short was the stated that the stated tha	d she was aware of the facility. The Administrator of did not utilize staffing ey were not needed. She ered bonuses to staff who er. The Administrator stated e on Friday night (06/23/17) with staffing at 3 Nurses and g for the third (11:00 PM to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345171	B. WING		C 06/29/2017
	NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 101 N MORGAN STREET SHELBY, NC 28150	1 00/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 353	bonuses to get staff that they called her I they could not get at instructed them to call and the could not get at instructed them to call a conducted with NA # employed with the fat that sometime the w 17 residents and wa care done. She state you could do. On 06/27/17 at 2:47 revealed she had be stated that staffing w unusual for a NA to provide all of their call was impossible to comprove the work but she had to the county of the county of the call of the	he directed them to offer to cover the shift. She stated back and informed her that myone to stay and she arry on the best they could. 45 PM an interview was #5 who stated she had been acility for years. NA #5 stated fork load for 1 NA was 16 or is impossible to get all of the ed you just had to do the best PM an interview with NA #9 teen at the facility for years and was so low that it was not be assigned 17 residents to the are for them. NA #9 stated it complete all of her assigned do the best she could. AM an interview with NA #10 teen employed with the facility she had never seen the all of her years here. NA #10 the last month she had to	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		345171	B. WING _			C 06/29/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 401 N MORGAN STREET SHELBY, NC 28150	E	00/23/2017	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 353	were to call the Sche respond they were to (DON). Nurse #4 stat DON the night of 06/2 the DON told them to On 6/28/17 at 9:40 A conducted with Nurse to 7:00 AM shift state (06/23/17) the facility building and there we that would not allow respond care to then get the care they need morale was bad because working short. On 06/28/17 at 2:46 (06/27/17) she was a provide care for and on the state of the care they need the	duler and if she did not call the Director of Nursing sed that when they called the 23/17 to report the staffing do the best they could. M an interview was e #5 who worked 11:00 PM dd that Friday night worked with 4 NAs in the ere several female residents male NAs to provide a so those residents do not dd. Nurse #5 stated the euse people were tired of PM NA #11 stated yesterday ssigned 14 residents to one resident fell in the early	F3	553			
	she already was. She a work load that large their proper baths an assist them with the as brushing teeth twice. On 06/29/17 at 10:39 conducted with the S started working on fir schedule 6 weeks be Scheduler stated the direct care staff in ord schedule: 7:00 AM-3:00 PM	er even more behind than e continued to state that with e the residents did not get d she did not have time to activities of daily living such ce a day or toileting them. AM an interview was cheduler who explained she ading coverage for the fore it was posted. The facility needed the following der to complete the daily 3:00 PM-11:00 00 PM-7:00 AM					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*		IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345171	B. WING		C 06/29/2017	
	NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - SHELBY		4	STREET ADDRESS, CITY, STATE, ZIP CODE 101 N MORGAN STREET SHELBY, NC 28150	00/23/2017	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 353	sheets for as far back facility had been shot calculations) the major the nursing staff time time frame of compla	8 Nurses 17 Nurse 12 Nurse Aides g staff schedules and time (as 01/2017 revealed the rt staffed (according to their ority of the days. A focus of sheets from the most recent ints of short staffing from vealed the approximate	F 353			
	06/26/17 06/24/17 7:00 AM-3:00 PM 7:00 AM-3:00 PM PM 9 Nurses 8 Nurses 16.5 Nurse Aides 13 Nurse Aides 3:00 PM-11:00 PM 3:00 PM-11:00 PM PM 6 Nurses 3 Nurses 9 Nurse Aides 13 Nurse Aides 11:00 PM-7:00 AM 11:00 PM-7:00 AM AM 3 Nurses 2 Nurses 8 Nurses	06/25/17 06/23/17 7:00 AM-3:00 PM 7:00 AM-3:00 7.5 Nurses 8 Nurses 16.5 20 Nurse Aides 3:00 PM-11:00 PM 3:00 PM-11:00 3.5 Nurses 7 Nurses 16 Nurse Aides 8 Nurse Aides 11:00 PM-7:00 AM 11:00 PM-7:00 4 Nurses 5 Nurses 4 Nurse Aides				

PRINTED: 07/25/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		345171	B. WING _			C 06/29/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	1 00/	23/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 353	Continued From page	: 32	F3	353			
F 356 SS=C	revealed the facility has since the first of this y had made salary adjuted that staff had a go DON stated that the fagencies but stopped better. She stated that orientations a month freason the new staff of DON stated that when AM) had only 2 NAs thelp out or ask others did not happen then to "buddy up together" to Interview with the Adra 3:03 PM that revealed staffing issues in the facility agencies because the stated that the facility offer came in or stayed over she was made aware that they were short was to get staff to that they called her battey could not get any instructed them to car	ministrator on 06/29/17 at d she was aware of the facility. The Administrator did not utilize staffing ey were not needed. She red bonuses to staff who er. The Administrator stated on Friday night (06/23/17) with staffing at "3 Nurses and g for the third (11:00 PM to e directed them to offer to cover the shift. She stated ack and informed her that	F3	356		7/18/17	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345171	B. WING		C 06/29/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	00/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 356	(g) Nurse Staffing In (1) Data requireme the following informat (i) Facility name. (ii) The current date. (iii) The total number by the following cate unlicensed nursing s resident care per shi (A) Registered nurse (B) Licensed practice vocational nurses (a) (C) Certified nurse a (iv) Resident census (2) Posting requirem (i) The facility must p specified in paragraph daily basis at the bes (ii) Data must be pos (A) Clear and readal (B) In a prominent por residents and visitor (3) Public access to The facility must, up	formation ints. The facility must post ation on a daily basis: If and the actual hours worked regories of licensed and staff directly responsible for ifft: If an	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345171 B. WING			C 06/29/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/29/2017	
MUUTE 0.	WANDS OUT BY			401 N MORGAN STREET		
WHITE OF	AK MANOR - SHELBY			SHELBY, NC 28150		
(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 APPROPRIA DEFICIENCY)	DATE	
F 356	Continued From page	e 34	F 356	3		
	for review at a cost no standard.	ot to exceed the community				
	(4) Facility data reten facility must maintain staffing data for a mir required by State law This REQUIREMENT by: Based on observatio facility failed to post to the beginning of the finde the survey and failed weekends. The findings included The annual recertificate began on 06/25/17 the Observation on 06/25 noted the posted nurs for 06/23/17 (Friday).	ation survey for the facility		White Oak Manor-Shelby does post D Nurse Staffing Information per requirements. 1. How Corrective Action will be Accomplished for Each Resident Foun 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. Write reeducation/reinservicing was initiated by 5th 2017 with the Nursing Staffing	d to of ten	
	(DON) was observed hours from 06/23/17 from 06/25/17. *On 06/26/17 at 8:11 for 06/25/17 were pos *On 06/26/17 at 10:25 hours for 06/26/17 at 8:19 10:55 AM nurse staffistill posted. *On 06/28/17 at 8:20 nurse staffing hours frosted.	3 AM the nurse staffing ere correctly posted. AM, at 9:38 AM and at ng hours for 06/26/17 were AM and at 10:40 AM the		July 5th, 2017 with the Nursing Staff Scheduler and with Weekend Supervis on July 8, 2017. The Director of Nursin also verbally discussed with third shift LPN assigned to update the Daily Nurs Staffing Board and written reeducation/reinservicing was completed July 18, 2017. This reeducation/inservicing was completed 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.	ng se ed I by	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
				401 N MORGAN STREET			
WHITE OA	AK MANOR - SHELBY			SHELBY, NC 28150			
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				BEITGIENE	'')		
F 356	posted.	e 35 for 06/28/17 were still ursing Staff Coordinator	F 3	The Director of Nursing did Daily Nurse Staffing Board 2017. Written reeducation/	on June 25,		
	(NSC) on 06/28/17 a posted the nurse state the census every day of a specific time the required to be posted that she did not think were posted over the was no one in the factollected the residen posted the nurse staffing hours. Interview with the Ad 11:30 AM revealed the supposed to be posted by the Nurse Supervision.	t 11:00 AM revealed she ffing hours after she received y and that she was unaware nurse staffing hours were d. The NSC further added the nurse staffing hours weekends because there cility over the weekend who t census and when she ffing hours on Monday's, the for Friday were still posted. ministrator on 06/29/17 at ne nurse staffing hours were ed every day by the NSC and isor (NS) on the weekends.		2017. Written reeducation/was initiated on July 5th, 20 Nursing Staff Scheduler and Weekend Supervisor on July The Director of Nursing also discussed with third shift LF update the Daily Nurse State written reeducation/reinsencompleted July 18, 2017. Treeducation/inservicing was the Administrator and the Discussing. 3. Address What Measures Into Place or Systemic Chalensure that the Deficient Princeton.	o17 with the d with ly 8, 2017. o verbally PN assigned to ffing Board and vicing was This is completed by birector of s Will be Put nges Made to		
	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.			Current staff members assi the Daily Nurse Staffing Bo reinserviced by the Administ Director of Nursing and was July 18, 2018. This inservice repeated with any newly hir appointed to update the Da Staffing Board during Orient Administrator or Director of training will also be reinforced necessary to ensure completed Administrator and/or the Director of the Administrator and/or the Director of the Administrator and/or the Director of the Administrator, Director of the Administrator of the Admin	ard have been strator and the scompleted on cing will be red staff illy Nurse station by Nursing. This red as iance by the rector of monitored by of Nursing, r(s) by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED	
		345171	B. WING _			C 06/29/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	I	00/23/2017	
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F 356 F 367 SS=E		RAPEUTIC DIET	F3	Staffing Board that will be compl for 14 days (beginning July 5, 20 three times a week for four week once a week for three months, the monthly for three quarters, then needed. 4. Indicate How the Facility Plan Monitor Its Performance to Make That Solutions are Sustained and When Corrective Action will be CO Ongoing compliance to F356 will monitored by the Administrator, Nursing, and/or Weekend Super by completing the observations of Daily Nurse Staffing Board. The from these reviews will be review Morning QI meetings Monday-Frany additional discussion/recommendations. To f these observations will also be reviewed during the monthly QA for further discussion and recommendations, if needed.	17), then s, then s, then len twice as s to Sure d Dates omplete. be Director ovisor(s) of the results yed in the iday for the results?	f	
	(e) Therapeutic Diets						
	the attending physicia						
	registered or licensed prescribing a resident						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, , ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345171	B. WING_			C	
NAME OF D	ROVIDER OR SUPPLIER	040171	5: 11::10 _	STREET ADDRESS, CITY, STATE, ZIP CODE		6/29/2017	
NAME OF PI	ROVIDER OR SUPPLIER						
WHITE OA	AK MANOR - SHELBY			401 N MORGAN STREET SHELBY, NC 28150			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 367	by: Based on observation interviews and staff in served the correct the added salt to 3 of 5 stafor a no added salt diand #232). The findings included 1. Resident #231 wa 06/08/17. Her diagnot congestive heart failur hypertension. Her 06/08/17 diet ord added salt diet. The history and physishe had been in the hulmonary opacities at She was diuresed with marked improvement facility for rehabilitation. The admission Minim coded her with intact having trouble concersupervision for eating diet. The nutritional screen was currently on a daweighed daily for contents.	is not met as evidenced ns, record review, resident derviews, the facility failed to erapeutic diet including no ampled residents with orders et (Residents #230, #231, : s admitted to the facility on eses included acute diastolic re, dementia, and ers included a regular no cal dated 06/14/17 stated espital for bibasilar and congestive heart failure. h intravenous lasix with . She was admitted to the en and strengthening. um Data Set dated 06/15/17 cognition, being tired, entrating, requiring set up and and receiving a therapeutic i dated 06/15/17 noted she ily diuretic and was being gestive heart failure. The	F 3	White Oak Manor-Shelby does the residents with a therapeutic prescribed by a physician. 1. How Corrective Action will be Accomplished for Each Reside Have Been Affected by the Def Practice. Residents #230, #231, and #23 their meal trays corrected upon identification of having salt add on their trays. Resident #230 verification of discharged on June 29, 2017 at Resident #232 was discharged 2017. The Corporate RD initiated insequence 28, 2017 to the Dietary standerssed tray accuracy. All concepts Dietary staff have completed the inservicing. 2. How Corrective Action will be Accomplished for Those Resident Having a Potential to be Affected Same Deficient Practice. The Corporate RD initiated insequence 28, 2017 to the Dietary standerssed tray accuracy, including packet being placed on a tray of resident on a no added salt diese.	c diet as De ent Found to ficient 32 all had n ded items was and d on July 4, ervicing on taff that current ne De ents ed by the ervicing on taff that ding no salt of a et. All		
	was possibly due to a Resident #231 was no	experienced since admission decrease in edema. oted to make food choice endently with tray set up.		current Dietary staff have comp inservicing. An audit of current residents with the comp inservicing.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		345171	B. WING _				C 29/2017
	ROVIDER OR SUPPLIER			40	REET ADDRESS, CITY, STATE, ZIP CODE 11 N MORGAN STREET HELBY, NC 28150	, 00.	
(X4) ID PREFIX TAG	· ·		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	fluctuations due to did of edema. The goal of significant weight chain included a therapeuti. On 06/25/17 at 12:31 received her noon may was on a regular not a observations at this tis salt packet. Two numbers of the proof of the salt packet. Two numbers of the packet is salt packet. Two numbers of the packets. Family presendementia. On 06/25/17 at 3:14 If interviewed. She was state the year or the packets. Family presendementia. On 06/27/17 at 12:40 received her tray white saltine crackers. She not pay attention to we packets routinely. On 06/28/2017 at 7:1 stated that salt and packets routinely. Resident #231 was of tray by NA #2 on 06/2 tray included a salt path is time that the resident without	eloped on 06/22/17 for weight curetic therapy and a history was to not experience larges. Interventions of diet. PM, Resident #231 real. The tray card noted she ladded salt diet and large me revealed she received a see aides entered and reto her starting to eat. PM, Resident #231 was so noted to not be able to bresident of the United lat at this time stated she had	F	367	therapeutic diet of no added salt has be completed and the Dietary department 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 to 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 Pullinto Place or Systemic Changes Made Ensure that the Deficient Practice Will Recur. Current Dietary Staff have been inserviced on ensuring tray accuracy, to include not adding a salt packet to the of a resident on a no added salt diet. A 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 complet of audits of residents' trays prior to delivery to the resident to ensure no sa packets are placed on the tray for a resident receiving a no added salt diet. This monitoring is being completed for 3 meals daily for fourteen days, then all three meals three days a week for four	is ee een, t to Not o tray	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		PLETED
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	ROVIDER OR SUPPLIER			40	TREET ADDRESS, CITY, STATE, ZIP CODE D1 N MORGAN STREET HELBY, NC 28150	,	
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F 367	On 06/28/2017 2:12 F stated that for those r diet, no salt packets s trays. Dietary staff ha the diet was listed on Staff in the kitchen we	PM, the Dietary Director residents on a no added salt should be added to their d been educated on this and each resident's tray ticket. Ere to complete a final check acy at the end of the tray line	F	367	weeks, and then ten random trays monthly for three months, and as need 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 Date When Corrective Action will be Comple	s	
	2:25 PM that the faciliance residents were a are planning a short to not permit the liberalistated no added diets packets. On 06/29/2017 10:51 stated that before a tresident, staff should confirm the tray is being resident and the correlative with the Adr 11:51 AM revealed stone added salt diet whom the tray. 2. Resident #230 was 06/09/17 with end state encephalopathy and at the admission Minimunoted he had intact states.	review the tray ticket to fing delivered to the correct ect diet was being followed. ministrator on 06/29/17 at aff were expected to follow a ich meant no salt packets admitted to the facility on ge renal disease, anemia. um Data Set dated 06/16/17 thort and long term memory ng impairments. He ate			Ongoing compliance to F367 will be monitored by the review of the tray and by the Dietary Manager and the Administrator. The results of these and will be reviewed in the Morning QI meetings Monday-Friday for any additional discussion/recommendations. The results of these audits/observation will also be reviewed during the monthl QA meeting for any further discussion a recommendations, if needed. The Administrator and Dietary Manage are responsible for ongoing compliance F367.	dits s. s y and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 401 N MORGAN STREET SHELBY, NC 28150	DDE	00/29/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 367	therapeutic diet. The nutritional screet was on a regular low added slat diet with fl noted to receive dialy had a pacemaker. An interim care plan on a regular low condadded salt. On 06/25/17 at 12:48 served his meal and concentrated sweet robserved with a salt plant the could not receive that he could not receive that he could not receive that the factor of the trays. On 06/28/2017 2:12 I stated that for those is diet, no salt packets strays. Dietary staff hat the diet was listed on Staff in the kitchen wo for the trays for accura as the trays are loaded. The corporate dieticia 2:25 PM that the facilionce residents were are planning a short in not permit the liberalii	n dated 06/16/17 noted he concentrated sweet and no uid restrictions. He was visis three times a week and dated 06/22/17 noted he was centrated sweet diet with no seen trated sweet diet with no seen tray card stated low no added salt diet. He was backet on his tray. If on 12/27/17 at 12:37 PM all if he received salt with his expected in the properties of the properties	F3	367			
	On 06/29/2017 10:51	AM, the Director of Nursing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED C		
		345171	B. WING			06/29/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	<u> </u>	00/23/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 367	resident, staff should confirm the tray is be resident and the corr Interview with the Ad 11:51 AM revealed s no added salt diet whon the tray. 3. Resident #232 wa 06/22/17 with diagnor chronic kidney disealimb, pulmonary hypother admission physical included a regular local added salt diet. Her Minimum data S Nursing notes dated she was alert with concorrect on 06/25/17 at 12:42 received her tray whoting she was on a tray was a salt packet time stated her orien. On 06/27/17 at 1:20 was noted to be alernoted. Resident #23 extremity edema. On 06/28/2017 2:12 stated that for those diet, no salt packets trays. Dietary staff has	ray was delivered to a direview the tray ticket to being delivered to the correct eect diet was being followed. ministrator on 06/29/17 at taff were expected to follow a nich meant no salt packets s admitted to the facility on uses including hypertensive se, cellulitis of the left lower ertension and diabetes. cian orders dated 06/22/17 we concentrated sweet no et was not complete. 06/25/17 at 12:43 PM noted onfusion. 2 PM, Resident #232 ich included the tray card no added salt diet. On this et. Family present at this	F 36	67			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345171	B. WING		C 06/29/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	1 00/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 367	of the trays for accur as the trays are load The corporate dietici 2:25 PM that the faci once residents were are planning a short not permit the liberal stated no added diet packets. On 06/29/2017 10:5 stated that before a tresident, staff should confirm the tray is be resident and the corr Interview with the Ad 11:51 AM revealed s no added salt diet whon the tray. 483.45(b)(2)(3)(g)(h) LABEL/STORE DRU The facility must prodrugs and biologicals them under an agree §483.70(g) of this paunicensed personnel aw permits, but only supervision of a licer (a) Procedures. A far pharmaceutical servithat assure the accurdispensing, and admits a state of the correction of th	rere to complete a final check racy at the end of the tray line ed on the cart. an stated on 06/28/2017 at a complete a final check racy at the end of the tray line ed on the cart. an stated on 06/28/2017 at complete diets admitted but for those who term stay, time usually did distation of diets. She further is should not receive salt AM, the Director of Nursing tray was delivered to a fireview the tray ticket to being delivered to the correct rect diet was being followed. Aministrator on 06/29/17 at the taff were expected to follow a mich meant no salt packets DRUG RECORDS, GS & BIOLOGICALS wide routine and emergency is to its residents, or obtain the ement described in complete the diet of the diet of the complete diet of the complete diet of the salt of the complete diet of the complete	F 4		7/27/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345171	B. WING		C 06/29/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	1 00/20/20 11	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 431	Continued From pag	e 43	F 43	1		
	1 7 7	tion. The facility must services of a licensed				
	disposition of all con-	etem of records of receipt and trolled drugs in sufficient occurate reconciliation; and				
	(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.					
	labeled in accordance professional principle appropriate accesso	s used in the facility must be se with currently accepted es, and include the				
	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.					
	permanently affixed controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when package drug distrib quantity stored is mit be readily detected.	provide separately locked, compartments for storage of d in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345171	B. WING _				29/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/		
				40	01 N MORGAN STREET			
WHITE OA	AK MANOR - SHELBY			S	HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 431	Continued From pag	e 44	F4	431				
F 431	Based on observation facility failed to remo medication from 1 of The findings included A review of the facilit "Medication Storage # 9. Outdated, conta medications and those cracked, soiled, or wimmediately removed according to procedu destruction, and reor a current order exists An observation of the 6/25/17 at 10:45 AM Sulfate inhalation 0.0 in the box. The vials An interview on 6/25 #3 indicated the nurs the medications and rem from the cart. Nurse was administered on medication was expirated on the control of the control of the cart. Surse was administered on medication was expirated on the control of the control of the cart. Surse was administered on medication was expirated on the control of the	ons and staff interviews, the ve 3 vials of expired 8 medication carts. d: y policy dated 5/31/17 titled In The Facility" read in part, minated, or deteriorated se in containers that are ithout secure closures are d from stock, disposed of ares for medication dered from the pharmacy, if s. e 100 hall medication cart on revealed a box of Albuterol 183% 2.5 mg/3 ml with 3 vials expired February 2017. //17 at 10:45 AM with Nurse ses were supposed to check periodically for expired above expired medications #3 stated the medication 5/14/17 at 6:20 AM and the red at the time it was AM an interview with the DON) stated her expectation in date to be checked prior to	F 2	431	White Oak Manor-Shelby does provide routine and emergency drugs and biological to its residents, or obtain the under an agreement and stores drugs biological in accordance with State and Federal laws. 1. How Corrective Action will be Accomplished for Each Resident Foun Have Been Affected by the Deficient Practice. The 3 Vials of Albuterol Sulfate inhalati were immediately removed from the medication cart. The resident used Albuterol twice in May and it was not u at all the month of June. The Albutero 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.	m and I d to on sed		
	shifts for expired med stated the pharmacy	medication and the checked by nurses between dications. The DON also was supposed to check the onthly for expired medications.			A Pharmacy Representative completed 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.			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		345171	B. WING _			C 06/29/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	_	00/25/2017	
				401 N MORGAN STREET			
WHITE OA	K MANOR - SHELBY			SHELBY, NC 28150			
(X4) ID PREFIX TAG			PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 431	431 Continued From page 45		F 4	J31			
F 431	On 6/27/17 at 11:57 A Administrator stated if the medication carts t	AM an interview with the ner expectations were for o be checked every shift by and to remove out dated	F 4	Formal reeducation/inservicing checking medication carts for medications/inhalers was corthe Director of Nursing at a Nameting on July 17, 2017. The reeducation/inservicing will continue to be completed upon reporting basences and will have the completed upon reporting basences and will have the completed upon reporting basences and will have the completed upon reporting basences. Current Nurses have been in checking medication carts for medications/inhalers prior to administration and on each seeducation/inservicing will continue to be completed upon reporting basences and will have the completed upon reporting basences and will have the completed upon reporting basences and will be repeated upon reporting basences and will be re	r expired mpleted by Nurses his ontinue for oproved leave eir inservicing ick to work. Will be Put ges Made to actice Will No deserviced on r expired shift. This ontinue for oproved leave eir inservicing ick to work, atted with a monitored by the dor the laso a monthly ted to the	t t	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		345171	B. WING _			C 06/29	/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	00/25	12011
				401 N MORGAN STREET			
WHITE OA	AK MANOR - SHELBY			SHELBY, NC 28150			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 431	Continued From page	÷ 46	F 4	audits will be conducted by Se Medication Nurses and the Nu document on an audit tool. The be completed daily for each M Cart for 14 days, then three tin for 6 weeks, then once weekly weeks, then as needed. 4. Indicate How the Facility PI Monitor Its Performance to Ma That Solutions are Sustained a When Corrective Action will be Ongoing compliance to F431 v monitored by review of the Nur for medication carts to ensure inhalers/medication. The result audits will be reviewed by the Nursing and Administrator, as review of the results in the Momeetings Monday-Friday for an additional discussion/recomme The results of these audits will reviewed during the monthly C for any further discussion and recommendations, if needed.	urses will his audit v ledication mes a wer for six lans to ake Sure and Dates e Comple will be rse audits no expire lts of thes Director of well as rning QI ny endations I also be	ek ste. sed	