

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

PRINTED: 08/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2018
NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150	
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F 610 SS=D	<p>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff and physician interviews, the facility failed to thoroughly investigate a resident's femur fracture by not interviewing all pertinent staff members. This affected one of one residents reviewed with an injury of unknown injury (Resident #172).</p> <p>The findings included:</p> <p>Resident #172 was originally admitted to the facility on 03/25/09. Her diagnoses included anxiety disorder, chronic obstructive pulmonary disease, and dementia.</p> <p>Review of the most recent Safe Resident Handling Data Collection Form, dated 04/30/18, noted Resident #172 required the use of a total</p>	F 610	<p>White Oak- Shelby does Investigate/ Prevent/ Correct Alleged Violators.</p> <p>The Investigation was conducted on this injury of unknown origin beginning 7/4/18. The DON conducted the investigation, this was the first investigation she had done since her date of hire 6/18/18. When the investigation revealed that the sitter transferred the resident from the bed to the wheelchair via pivot transfer, the investigation also revealed that the private duty sitter knew the resident was to be transferred via a total lift. The DON concluded the sitter's transfer must have caused the injury. The DON did not continue to interview any additional staff.</p>	8/30/18

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

TITLE

(X6) DATE

Electronically Signed

08/10/2018

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

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F 610	<p>Continued From page 1</p> <p>lift during transfers with a divided leg sling, size small and required 1 person to transfer.</p> <p>The most recent Minimum Data Set, a quarterly dated 07/05/18 noted she had long and short term memory impairments and severely impaired decision making skill, required extensive to total assistance with all activities of daily living skills, had range of motion impairment on one side, and she was under Hospice care.</p> <p>Review of nursing notes dated 07/03/18 at 12:07 PM revealed a physician's order was received for a 2 view X-ray of Resident #172's right knee related to increase swelling and pain.</p> <p>The X-ray dated 07/03/18 stated there was no prior study available for comparison. There was narrowing of the lateral knee compartment consistent with osteoarthritis. There was an acute or subacute oblique fracture at the junction of the middle and distal thirds of the femur with approximately 6 centimeters of overriding of the fracture fragments with medial displacement of the distal fracture fragment. There was also osteopenia.</p> <p>Nursing notes dated 07/04/18 at 10:19 AM revealed the physician was in the facility and ordered a right knee immobilizer to be applied. The responsible party did not wish to consult orthopedics at this time.</p> <p>The facility began their investigation of the injury of unknown origin on 07/04/18. Review of the investigation revealed the police were notified on 07/04/18. The Director of Nursing (DON) began to interview staff, (a nurse, and a nurse aide), and the supervisor from the agency where the family</p>	F 610	<p>the DON thought she had completed the investigation and since this was her first investigation she did not fully understand that all pertinent staff member be interviewed.</p> <p>The Director of Nursing and other identified staff that may be involved with an investigation was re-educated to the Abuse and Neglect Investigation policy on 8/8/18 by the Administrator. Newly hired identified staff will be educated during orientation.</p> <p>There have been no allegations to investigate since 7/4/18.</p> <p>Ongoing monitoring and compliance will be achieved by completion of "Investigation Monitoring Tool" this tool will be utilized to monitor that all pertinent staff members be interviewed when an investigation is being conducted. This tool will be completed by the Social Service Director or designee to assure compliance of F610. This will be completed on a weekly basis for 3 months.</p> <p>The results from this monitoring tool will be discussed during weekly Quality Assurance Meetings for its effectiveness. Any identified issues will be corrected per the Quality Assurance Team recommendations. Unresolved issues will be reviewed by the Administrator for follow up re-education.</p> <p>The Administrator, Director of Nursing and Social Services Director is responsible for</p>		

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F 610	<p>Continued From page 2</p> <p>had gotten the resident's private sitters. The DON found out that Resident #172 had a private sitter who was suspected of transferring her on 07/01/18. The DON's report revealed staff saw the resident up in the wheelchair being pushed by the sitter and no staff had transferred her. The sitter who worked with Resident #172 on 07/01/18 was interviewed by the DON on 07/05/18. The statement taken at that time revealed the sitter transferred the resident from the bed to the wheelchair via pivot transfer even though she knew the resident was to be transferred via a total lift. The documented interview revealed there were no signs or symptoms of any injury or trauma during this transfer. The investigation concluded on 07/06/18 at which time the sitter was not permitted to return to the facility and the facility concluded there had been neglect by the sitter.</p> <p>Interview with Resident #172's physician was conducted on 08/01/18 at 10:39 AM. The physician stated that Resident #172 was a very elderly and very frail lady with bad bones. He stated that he could not conclude that the fracture occurred on 07/01/18 due to a sitter using a pivot transfer versus a lift transfer as no injury was reported for several days after that particular transfer.</p> <p>Interview with the DON on 08/01/18 at 11:34 AM revealed that she learned in stand up meeting on 07/03/18 that Resident #172's leg was turned inward. She stated there was no bruising and a small amount of swelling. She had no pain and it was noted she was receiving morphine already. Once the leg was determined to be fractured, the DON began investigating via interviewing staff working that day. At that time she learned there</p>	F 610	the ongoing compliance of F610.		

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F 610	Continued From page 3 had been a sitter who sat with the resident 07/01/18 from 7 AM to 3 PM and was suspected of transferring the resident, although sitters were not permitted to provide any personal care. Once the sitter was interviewed and admitted she had transferred Resident #172 herself without a lift, the DON stated she naturally concluded this was where the fracture originated from and made arrangements for the sitter to not return to the facility. The DON further stated that once she concluded the sitter's transfer must have caused the injury, she did not continue to interview any additional staff who worked with the resident during the next several days, evenings and/or nights of 07/01/18 through 07/03/18 when the injury first was detected.	F 610			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, staff interviews, family interview and agency interview, the facility failed to ensure orientation and supervision was provided for private duty sitters to prevent unsafe transfers for 1 of 3 residents sampled for accidents (Resident #172). The findings included:	F 689	White Oak- Shelby is free of Accident Hazards/ Supervision/ Devices. Resident #172 had private sitters, one of the private sitters failed to go through the orientation for private duty sitters and transferred the resident which is not following the private duty sitter policy. The communication between the family and	8/30/18	

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F 689	<p>Continued From page 4</p> <p>Review of the Private Duty Personnel (Sitter) policy, revised 10/25/16, revealed the following key points:</p> <p>*Requirements prior to employment included that the sitter must attend the facility orientation prior to first day of employment and annually.</p> <p>*Facility approved duties included: may feed resident upon completion of the Feeding Assistants program, may assist resident to common areas after helped out of bed by facility staff, may polish resident's nails, and may hand the resident personal items for self use. No other personal care or other duties may be rendered (effective for those hired on or after 07/26/05). This policy was to be signed by the sitter, resident/responsible party and facility representative.</p> <p>Resident #172 was originally admitted to the facility on 03/25/09. Her diagnoses included anxiety disorder, chronic obstructive pulmonary disease, and dementia.</p> <p>Review of the most recent Safe Resident Handling Data Collection Form, dated 04/30/18, noted Resident #172 required the use of a total lift during transfers with a divided leg sling, size small and required 1 person to transfer.</p> <p>The most recent Minimum Data Set, a quarterly dated 07/05/18 noted she had long and short term memory impairments and severely impaired decision making skill, required extensive to total assistance with all activities of daily living skills, had range of motion impairment on one side, and she was under Hospice care.</p> <p>Review of nursing notes dated 07/03/18 at 12:07 PM revealed a physician's order was received for</p>	F 689	<p>private duty sitter with the appropriate facility staff member failed and it was not communicated to the appropriate staff. Therefore the orientation of the private duty sitter was not completed.</p> <p>There are no private duty sitters currently sitting with any residents. White Oak-Shelby has developed a No Private Duty Sitter Policy. All current residents will be informed of this new policy as well as all new admissions. Current and newly hired staff will be inserviced by the Staff Development Coordinator concerning this new policy.</p> <p>Ongoing monitoring and compliance will be achieved by facility staff rounds, discussions with residents and families and observation of visitors to assure the No Private Duty Sitter Policy is followed. A No Private Duty Sitter Policy tool will be completed to monitor that no private duty sitters are working in the building. This will be monitored weekly for 3 months.</p> <p>Results from this monitoring will be discussed during weekly Quality Assurance meeting for its effectiveness. Any identified issues will be corrected per the Quality Assurance Team recommendations. Unresolved issues will be received by the DON/ Administrator for follow up re-education.</p> <p>The Director of Nursing and Administrator are responsible for the ongoing compliance of F689.</p>		

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F 689	<p>Continued From page 5</p> <p>a 2 view X-ray of Resident #172's right knee related to increase swelling and pain.</p> <p>The X-ray dated 07/03/18 stated there was no prior study available for comparison. There was narrowing of the lateral knee compartment consistent with osteoarthritis. There was an acute or subacute oblique fracture at the junction of the middle and distal thirds of the femur with approximately 6 centimeters of overriding of the fracture fragments with medial displacement of the distal fracture fragment. There was also osteopenia.</p> <p>Nursing notes dated 07/04/18 at 10:19 AM revealed the physician was in the facility and ordered a right knee immobilizer to be applied. The responsible party did not wish to consult orthopedics at this time.</p> <p>The facility began their investigation of the injury of unknown origin on 07/04/18. The Director of Nursing (DON) began to interview staff, (a nurse, and a nurse aide), and the supervisor from the agency where the family had gotten the resident's private sitters. The DON found out that Resident #172 had a private sitter who was suspected of transferring her on 07/01/18. The DON's report revealed staff saw the resident up in the wheelchair being pushed by the sitter and no staff had transferred her. The sitter who worked with Resident #172 on 07/01/18 was interviewed by the DON on 07/05/18. The sitter's statement taken at that time revealed the sitter transferred the resident from the bed to the wheelchair via pivot transfer even though she knew the resident was to be transferred via a total lift. The documented interview revealed there were no signs or symptoms of any injury or trauma during</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>this transfer. In addition, the statement indicated that she providing multiple types of personal care to the resident, had not had any orientation, background checks, or signed the sitter policy.</p> <p>An interview with Nurse Aide #1 on 08/01/18 at 10:02 AM revealed that Resident #172 had private duty sitters 7 days a week. She stated she never saw sitters provide care but that she suspected sitters often provided care as she would go to the room to provide a care or transfer assistance and the resident would already be up.</p> <p>The responsible party was interviewed via telephone on 08/01/18 at 10:12 AM. He stated that he has hired sitters through the agency for years and with other family members. He stated he expected the paid sitters to provide any needed activity of daily livings skills she needed because they were certified nurse aides.</p> <p>Interview with Resident #172's physician was conducted on 08/01/18 at 10:39 AM. The physician stated that Resident #172 was a very elderly and very frail lady with bad bones. He stated that he could not conclude that the fracture occurred on 07/01/18 due to a sitter using a pivot transfer versus a lift transfer as no injury was reported for several days after that particular transfer.</p> <p>A telephone interview was conducted on 08/01/18 at 10:42 AM with the private Sitter #1 who worked with Resident #172 on 07/01/18. Per this interview, the sitter #1 stated that she had been working with Resident #172 for over a year at the facility on Sundays. She stated that she had been instructed at the beginning of employment that staff did not use the lift to move this resident.</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>She then stated that she was told by the nurse to transfer Resident #172 from bed to the wheelchair on 07/01/18 which she said she did while the nurse and nurse aide were in the room helping the roommate. Sitter #1 stated she transferred her from bed to the wheelchair holding her under the arms and pivoting her to the wheelchair. she denied observing the resident in pain, hearing anything unusual or having any problems during the transfer.</p> <p>Nurse #1 was interviewed on 08/01/18 at 11:08 AM. Nurse #1 stated she was working with another nurse aide on 07/01/18 when the sitter transferred Resident #172. Nurse #2 denied being in the room during this transfer and denied instructing the sitter to transfer the resident. Nurse #1 stated she observed no injuries or pain of the resident following the transfer.</p> <p>Interview with the DON on 08/01/18 at 11:34 AM revealed that she learned in stand up meeting on 07/03/18 that Resident #172's leg was turned inward. She stated there was no bruising and a small amount of swelling. She had no pain and it was noted she was receiving morphine already. Once the leg was determined to be fractured, the DON began investigating via interviewing staff working that day. At that time she learned there had been a sitter who sat with the resident 07/01/18 from 7 AM to 3 PM and was suspected of transferring the resident. Once the sitter was interviewed and admitted she had transferred Resident #172 herself without a lift, the DON stated she naturally concluded this was where the fracture originated from and made arrangements for the sitter to not return to the facility. The DON further stated the facility had a sitter policy that was specific regarding the sitter's not being able</p>	F 689			

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F 689	<p>Continued From page 8</p> <p>to provide personal care. Per the DON, the facility stopped allowing private sitters years ago but Resident #172 already had a sitter in place and was permitted to continue. She stated she learned through her investigation that Sitter #1 had not signed the sitter policy or completed any orientation. The DON stated the social worker normally handled making sure the sitter had the appropriate orientation, training and checks since families often came to her to inquire about a sitter.</p> <p>The Social Worker (SW) was interviewed on 08/01/18 at 12:04 PM. SW stated that the facility phased out private duty sitters except for Resident #172 who had employed the sitters for years. She stated that she was aware of the 2 regular sitters but because the weekend sitters came on the weekends when the SW was not present she did not know there was a change in sitters and therefore the need for orientation, training, etc. SW stated the agency where the sitters came from was aware of the policy.</p> <p>Interview with the agency's owner who provided the private sitters was conducted via telephone on 08/01/18 at 1:02 PM. She stated she was aware about 4 years ago the facility stopped permitting sitters in the facility, however, because Resident #172's family insisted, the facility permitted her to keep her sitters. The agency stated they sent 3 sitters routinely, one Monday through Friday 7 AM to 3 PM, one on Saturday from 7 AM to 3 PM and one on Sunday 7 AM to 3 PM. The agency stated they instruct the sitters to do what the facility staff tells them to do.</p> <p>Nurse Aide #2 was interviewed on 08/01/18 at 2:37 PM. She confirmed she worked on 07/01/18</p>	F 689			

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F 689	Continued From page 9 but denied being in the room when the sitter transferred Resident #172. She further denied ever seeing the sitter provide personal care or transfer the resident. Interview with the Administrator in Training and the DON was conducted on 08/02/18 at 1:44 PM. Per the DON, sitters learn they are to sit and not provide personal care during orientation. She stated that Sitter #1 confirmed with her during the investigation that she knew not to provide personal care. DON found out during the investigation that Sitter #1 did not attend any orientation or sign the sitter policy. The DON further stated that when she went to interview the Monday through Friday Sitter #2, she found the sitter in the process of preparing to give Resident #172 a bed bath and stopped her. DON stated that Sitter #2 had been through the orientation and signed the policy. The AIT stated that all staff were expected to stop the sitter when they observed providing personal care. The DON stated she had not interviewed any staff about if they noticed or suspected that sitters were providing care.	F 689			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		8/30/18	

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F 812	<p>Continued From page 10</p> <p>facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to remove expired food from 1 of 1 walk in coolers, date potentially hazardous food after opening for 1 of 1 walk in coolers, and remove dented cans from use for 1 of 1 kitchen storage rooms.</p> <p>The findings included:</p> <p>1. a. Initial observation of the walk in cooler on 07/30/18 at 10:01 AM revealed 2 bags of shredded cabbage with an expiration date of 07/29/18.</p> <p>b. Initial observation of the walk in cooler on 07/30/18 at 10:10 AM revealed an opened and undated 128 ounce container of mayonnaise.</p> <p>c. Initial observation of the kitchen storage room on 07/30/18 at 10:27 AM revealed the following dented cans of food were on shelves and available for use:</p> <ul style="list-style-type: none"> 2 cans of cream style corn 1 can of whole potatoes 1 can of vanilla pudding 1 can of cheddar cheese sauce 1 can of tomato soup 1 can of vegetable beef soup 	F 812	<p>White Oak- Shelby does store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>On 7/27/18 2nd shift dietary aides failed to follow proper procedure for putting away dented cans that arrived with our delivery on 7/27/18. There were seven dented cans placed on the can rack for use. These cans should have been placed in the designated dented can area. The dietary staff failed to pay close attention to the cans they were putting away. Dietary staff also failed to discard out of date shredded cabbage on 7/30/18 with an expiration date of 7/29/18 due to not monitoring expiration dates. Dietary staff failed to label opened date on mayonnaise, 7/30/18 due to lack of application of job effort.</p> <p>The 2 bags of shredded cabbage with an expiration date of 7/29/18 was removed on 7/30/18; the undated open mayonnaise was removed on 7/30/18, these items were thrown away. The 7 dented cans of food that were on the shelf were removed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2018
NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 401 N MORGAN STREET SHELBY, NC 28150		
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F 812	Continued From page 11 An interview with the Assistant Dietary Manager (ADM) on 07/30/18 at 10:32 AM revealed the 2 bags of expired shredded cabbage in the walk in cooler should have been discarded or used on or before the expiration date. The ADM discarded the bags of expired shredded cabbage. The ADM stated the container of mayonnaise in the walk in cooler should have been dated when opened. The ADM discarded the opened and undated container of mayonnaise. The ADM also stated there should be no dented cans on the shelves available for use. The ADM removed the dented cans from the shelves and stated they would be returned to the food supply company for credit. An interview with the Dietary Manager (DM) on 07/31/18 at 9:10 AM revealed it was her expectation for all food to be used or discarded on or by the expiration date, all food to be dated when opened, and no dented cans be available for use. An interview with the Administrator In Training on 08/02/18 at 2:15 PM revealed it was her expectation that dietary staff use or discard all food on or by the expiration date, date food when opened, and return dented cans to the food supply company.	F 812	on 7/30/18 and placed in the dented can section to be returned to the food supply company. There is no other food stored in the building with expired expiration dates and all dented cans are stored in the appropriate area. Dietary Staff was re-educated on 8/3/18 by the Dietary Director regarding dating 1. All opened food 2. disposing of all out of date foods 3. labeling expiration dates and 4. proper procedure for dented cans and the proper area to store dented cans. Newly hired staff will receive the education during their specific orientation in the dietary department. Ongoing monitoring and compliance will be achieved by completion of a store, distribute and serve food safely monitoring tool. This tool will be utilized to monitor proper procedure for dented cans, dating all opened foods and discarding of all out of date foods. This tool will be completed by the Dietary Director or designee to assure compliance of F812. This will be monitored weekly for 3 months. Results from the monitoring will be discussed during weekly Quality Assurance Meetings for its effectiveness. Any identified issues will be corrected per the Quality Assurance Team recommendations. Unresolved issues will be reviewed by the Dietary Director or designee for follow-up reeducation. The Dietary Director is responsible for the		

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

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F 812	Continued From page 12	F 812	on going compliance of F812.		