	-	ID HUMAN SERVICES				RM APPROVED
		MEDICAID SERVICES				<u>10. 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		TE SURVEY MPLETED
		345171	B. WING		0	C 2/28/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	K MANOR - SHELBY			401 N MORGAN STREET		
WHITE OF	TRANOR - SHELBT			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)	HOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	0		
	conducted on 02/20/2 surveyor returned to f validate the credible a exit date was change was found in complia CFR 483.73, Emerge ID# CB1G11.	ertification survey was 23 through 02/24/23. The the facility on 2/28/23 to allegation and therefore the d to 2/28/23. The facility nce with the requirement ncy Preparedness. Event				
F 000	INITIAL COMMENTS		F 00	0		
	survey was conducte 02/24/23. The survey on 2/28/23 to validate therefore the exite wa Event ID# CB1G11. Intake NC000197425	complaint investigation d from 02/20/23 through or returned to the building the credible allegation as changed to 2/28/23. was investigated. 1 of the 2 resulted in a deficiency.				
	Immediate jeopardy v	vas identified at:				
	of (J)	500 at a scope and severity 510 at a scope and severity				
	The tags F600 and F Quality of Care.	610 constituted Substand				
E 600	was removed on 02/2 survey was conducte					2/24/22
F 600 SS=J	Free from Abuse and CFR(s): 483.12(a)(1)	negleci	F 60			3/24/23
	§483.12 Freedom fro Exploitation	m Abuse, Neglect, and				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					03/21/2023

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.

PRINTED: 04/12/2023

	MENT OF HEALTH AN					FORM	M APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345171	B. WING			C 02/28/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>		
				4	01 N MORGAN STREET			
WHITE O	AK MANOR - SHELBY			5	SHELBY, NC 28150			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's me §483.12(a) The facilit §483.12(a)(1) Not use physical abuse, corpo involuntary seclusion; This REQUIREMENT by: Based on observatio Director and staff inte protect a resident's rig when staff pushed a r wheelchair without sh asked the staff person was hurting, the staff and the resident susta great left toe and an a to her foot being cauge footrest and being dra The left great toe had before it healed. This reviewed for neglect ( Immediate Jeopardy I Transport Driver #1 c Resident #6 in her wh to stop pushing her do was dragging her foo jeopardy was remove facility provided and in credible allegation for	right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced ms, record review, Medical rviews, the facility failed to ght to be free from neglect esident with diabetes in her oes, and when the resident in to stop because her foot kept pushing the wheelchair ained an open area to her abrasion to her left heel due ght under the wheelchair aigged during the transport. to be treated for one month was for 1 of 1 resident Resident #6). began on 11/14/22 when ontinued to transport heelchair after she told him own the hall because he t and it hurt. The immediate d on 02/25/23 when the mplemented an acceptable	F	600	White Oak - Shelby does provide an environment Free from Abuse and Neglect Resident #6 foot dropped off the wheelchair foot pedal and became lod under the foot pedal of the wheelchair. Resident alleges the transport driver w was pushing her failed to stop when sh ask as a result this caused an abrasion her right heel and an open area to her great toe that measured 2x2 cm. On 12/14/22 those areas were healed and treatment was discontinued. An audit of residents that used wheelc transport since November 2022 reveal no other incidents with residents being maneuvered in a wheelchair. This aud was completed on 2/23/23 by Administration and the Corporate Nurs Consultant. Another audit was complet by Nursing Administration on 2/23/23 t ensure residents are transported via th	hair d hair d hair d d hair d d d d d d d d d d d d d d d d d d d		

Facility ID: 943557

If continuation sheet Page 2 of 31

PRINTED: 04/12/2023

	OF DEFICIENCIES	MEDICAID SERVICES		IPLE CONSTRUCTION		NO. 0938-03 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /	IG	· · ·	ATE SURVEY OMPLETED	
			A. BUILDIN	<u> </u>	с		
		345171	B. WING		02/28/202		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF			
				401 N MORGAN STREET			
WHITE O	AK MANOR - SHELBY			SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE	
F 600	Continued From pag	e 2	F 6	:00			
1 000		e z everity level of a "D" (No	Г C	proper device (i.e. standa	ard whoolebair		
		ential for more than minimal		geriatric chair, high back			
		ediate jeopardy) to ensure		stretcher) for their safety.			
		ion and monitoring systems		consisting of resident inte			
	put into place are effe			determine if the facility st			
				providers stop what they			
	The findings included	1:		transporting residents in			
				when asked to stop or if t	the resident is		
		nitted to the facility on		vocalizing that they are in			
	-	ses which included diabetes		was completed by the so	cial services		
	mellitus, and coronar	ry artery disease (CAD).		department on 2/24/23.			
	Review of the quarte	rly Minimum Data Set (MDS)		Interviews with residents	were conducted		
	dated 9/21/22 reveal			asking the question if the	•		
	moderately cognitive			member to stop is their re			
		staff members for transfers.		and is the staff paying att			
		cumented as able to make		request. The interviews w			
	herself clear and und			by the social services dep 2/24/23. Interviewable an			
		have a clear comprehension rs. The assessment revealed		non-interviewable resider			
		skin conditions or needed		audits completed by the I			
		ng the assessment period.		Administration team on 3	-		
		ig the dececement period.		concerns were noted.	112020.110		
	On 2/22/23 at 12:03	PM an interview was					
	conducted with Resid	dent #6. She stated a few		All facility staff including a	agency staff were		
		ort driver came into the		re-educated on the abuse			
		and was dragging her feet		that includes residents ar			
		front lobby. Resident #6		abuse, neglect and explo			
		him to stop, I was telling him		the resident's right to be t			
	• •	never said anything and kept		physical abuse/neglect. T			
		. The interview revealed her		including agency staff wil			
	-	erneath the footrest of the ad dragged her left foot from		educated on ensuring that are being transported in a			
		lobby of the facility. Resident		their body parts are stabi			
		d socks on because shoes		their feet on the foot peda	-		
	-	ated a staff member whom		transported. The education			
		ally stopped him because her		any staff transporting res			
		esident #1 stated a nurse		wheelchair to stop what t			
		d dressed her foot before		when asked by the reside			

Facility ID: 943557

If continuation sheet Page 3 of 31

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		E SURVEY
	CONNECTION	BENTI TOATION NOMBER.	A. BUILDING	3		
		245474	P. MINC			С
		345171	B. WING		02	2/28/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AK MANOR - SHELBY			401 N MORGAN STREET		
				SHELBY, NC 28150		
(X4) ID			ID	PROVIDER'S PLAN OF CORREC		(X5) COMPLETIO
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
F 600	Continued From page	e 3	F 60	0		
	going out to her appo	intment. The interview		circumstance. This education will	be	
		rse #3 and Nurse Aide #5		conducted by the Director of Nurs	ing and	
		d that Transport driver #1		Nursing Administration, and comp		
		underneath the pedal while		2/24/23. All facility staff/transporte		
		p while Nurse #3 was		including agency staff and the oth		
	dressing her foot.			outside transporters were educate		
	On 0/00/00 at 0:00 D			paying attention to the residents		
	On 2/22/23 at 3:39 P	e Aide (NA)#5. She stated on		transporting them in a wheelchair include making sure the resident		
11/14/22 she had gotten Resident #			parts, such as their feet, are secu	-		
	-	side appointment. The		not rubbing against the floor. This		
		esident #6 did not get out of		education also included stopping		
		rsonal preference and did		wheelchair, if a resident complain		
	not want to wear sho	es only socks. She stated		and notifying the facility licensed	nursing	
		s on the resident because		staff in order to conduct an asses		
		ripper socks in her drawer.		and render treatment. This educa		
		pproximately an hour after		completed by the Director of Nurs	-	
	U	lent #6 dressed and in her		the transport company by 2/24/23	i.	
		e she saw Nurse #3 bringing vn the hallway and her foot		All facility staff/transporter includi	20	
		tated Resident #6 was		agency staff and other transporte	-	
	-	transport was rough with her		educated on paying attention to the		
		g her. Resident #6 stated		residents while transporting them		
		NA #5 stated her left great		wheelchair to include making sure		
		nad been lifted or had a		residents body parts, such as the		
		She stated Nurse #3		are secured and not rubbing agai		
		ts sock and told her she was		floor. This education will be comp		
		rector of Nursing. NA #5		the Director of Nursing and the tra	ansport	
	the male transport dr	as very clear in stating it was iver who hurt her foot and		company by 2/24/23.		
		n she was leaving the		The wheelchair van transport con	ıpany's	
		she did not tell anyone else		transporters and the facility		
		cause she knew Nurse #3		staff/transporter (on FMLA or vac		
	was handing the situa	ation.		that are not available for the educ		
	On 2/23/23 at 8:50 A	M an interview was		not start working or care for resid after the education is completed.		
		sport Driver #2. She stated		hired staff will receive this educat	-	
		me employee working for		well prior to caring for residents.		
		scheduling conflicts and the		Human Resources Director will in		

Facility ID: 943557

If continuation sheet Page 4 of 31

TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DA	TE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,			COMPLETED		
					С			
		345171	B. WING		0	2/28/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE			
	K MANOR - SHELBY			401 N MORGAN STREET				
				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 (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE		
F 600	Continued From page	e 4	F 600					
		with appointments the facility		Director of Nursing of ne	ew hires. and the			
	also had to use a con			Director of Nursing will e				
		e interview she stated on		is completed. The Huma	•			
		ancellation and returned to		Director was notified of				
		d when she was coming into		on 2/24/23 by the Admir	nistrator.			
		facility, she saw the contract		<b>_</b>				
	company Transport Driver #1 pushing Resident #6 towards the door. She stated she saw the			The wheelchair transpo				
	#6 towards the door. She stated she saw the resident's foot was bleeding badly and stopped			given a copy of the educ Director of Nursing to educ				
		Resident #6 stated, "he was		transporters, and copies				
	-	Id him to stop." Transport		of this education will be	-			
		asked the secretary to go		on 2/24/23. Transporter				
		cause the resident could not		asked if they received th				
	-	e condition, she was in.		the facility prior to trans				
		tated Resident #6's foot was		a wheelchair by Nursing				
		Ichair and had been dragged		education was not comp				
		1 when he pushed her to the		education will be comple				
		revealed Nurse #3 came to ot Resident #6 to dress her		moment by the Nursing prior to handling the res				
	foot. She stated Tran			a wheelchair.				
		was delaying the transport.						
		, , , , , , , , , , , , , , , , , , , ,		Ongoing monitoring and	l compliance will			
	On 2/22/23 at 3:49 Pl	M a voicemail message was		be achieved by Resider	-			
		evious secretary that was		will be conducted by the				
		ne of the incident. A return		Department and the Tra	-			
	phone call was not re	eceived.		Monitoring Tool that will				
	On 2/22/22 at 4.05 D	M on interview was		Nursing Administration.				
	On 2/22/23 at 4:05 Pl	port Driver #1. He stated he		Department will intervier 10 residents a week for				
		company the facility used		that there are no issues				
		the interview he stated he		residents for 4 weeks ar				
		e incident with Resident #6		residents for 4 weeks. T				
	and was in the facility	to transport one of the		Administration will moni	tor residents that			
	facilities residents to	an appointment. The		are being transported in				
		had continued to transport		outside appointments fo				
		cility following the incident		wheelchair positioning f				
	with Resident #6 on 7	11/14/22.		residents for 4 weeks, th 4 weeks.	nen 3 residents for			

Facility ID: 943557

If continuation sheet Page 5 of 31

		MEDICAID SERVICES	(X2) MULTIE	PIF	CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	MPLETED
				-		с	
		345171	B. WING			02/28/2023	
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				40	1 N MORGAN STREET		
	K MANOR - SHELBY			SF	HELBY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	5	F 60	00			
1 000	11/14/22 revealed on		FO	00	The regults from this monitoring tool	vill	
	Resident #6 returned				The results from this monitoring tool v be discussed during weekly Quality	VIII	
		open area on her left great			Assurance Meetings for its effectiven	ess	
	toe measuring 2 centimeters (cm) by 2 cm. Nurse #3 cleaned the area with normal saline and covered it with a bandage. The Nurse Practitioner				Any identified issues will be corrected		
					the Quality Assurance Team		
					recommendations. Unresolved issues	s will	
(NP) was notified along with the residents Responsible Party (RP). Resident #6 denied pain				be reviewed by the Administrator for f	ollow		
		P). Resident #6 denied pain			up re-education.		
i	and was in no distres						
	also obtained a close			The Administrator and Director of Nur	sing		
		Nurse #3 she had bumped			are responsible for the ongoing		
	•	ould not remember what.			compliance of F600.		
	Interventions to reduc						
	mobility.	high back wheelchair for			Completion date of 3/24/23.		
	On 2/22/23 at 3:16 P						
		e #3. She stated Resident #6					
		out of the facility to an					
		se Aide #5 had gotten her					
		vaiting in her room. Nurse #3					
		er #1 went to the resident's					
		hing her to the front of the e Secretary came to her and					
	said Resident #6's for						
		nen she saw Resident #6,					
		her that she must have hit					
		g but did not know what.					
		Fransport Driver told her he					
		d happened. Resident #6					
		ring regular non grip socks					
		time of the incident. Nurse					
		6 did not normally wear					
		lidn't get out of the bed					
		n appointment. The interview					
		had shoes in her room.					
		took Resident #6 back to her					
	room, removed the sock exposing a 2 cm by 2					1	

Facility ID: 943557

If continuation sheet Page 6 of 31

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/12/2023 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345171	B. WING				C 28/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
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	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	and applied a dry dress end of the sock there area of the residents I had footrests on her w board (device used to from dropped off of the resident's foot had be footrest. The interview issues with Resident is wheelchair on previou incident Nurse #3 and Resident #6 up in her had slid down causing footrest. She stated a resident's foot, she pu- lobby and Transport of scheduled appointme she had made an error stating the incident report Director of Nursing's ( the Nurse Practitioner notified the resident's the incident. A verbal physician order Nurse #3 at 3:45 PM toe with normal saline Cleanse open area to saline and apply antib dry dressing daily. A physician order date Wound Nurse #1 at 9 discontinue the currer toe. Cleanse left great	eel. She cleaned the area ssing. Nurse #3 stated at the was bright red blood at the left great toe. Resident #6 wheelchair along with a prevent the residents foot e footrest), but the come lodged under the v revealed the staff had #6 sliding down in her is occasions and after the d Nurse Aide #5 had to pull wheelchair because she g her foot to drop off the fter she redressed the ushed her back to the front lriver #1 took her to the nt. The interview revealed or on the incident report by courred when the resident Nurse #3 stated she filled t and placed it in the (DON) box, placed a note in "s non emergent folder and Responsible Party following der dated 11/14/22 written by read to, "cleanse left great e, cover with a bandage. left great toe with normal biotic ointment. Cover with a	F 60				

If continuation sheet Page 7 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345171	B. WING				C / <b>28/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	tape daily and as nee normal saline and app with foam daily and a abrasion. The facility weekly we revealed Resident #6 abrasion due to traum measuring 0.9 cm by measuring 1.2 cm by	vith gauze and secure with ded. Cleanse left heel with oly antibiotic ointment. Cover is needed related to an ound report dated 11/30/22 had obtained an acquired ha on the left great toe 1.0 cm and on the left heel 1.0 cm.	F	60	0		
	revealed Resident #6 abrasion due to traum	bund report dated 12/14/22 had obtained an acquired ha on the left great toe 0.5 cm and on the left heel 0.5 cm.					
	Wound Nurse #1 at 1 discontinue current tr	eatment to left great toe and rep daily to the left great toe					
	revealed Resident #6 for having a skin cond	was not listed on the report dition. The report revealed n removed from the report ng healed.					
		ound report dated 2/15/23 was listed as having a new ed on 2/13/23.					
	AM of Resident #6's v Nurse #1. Resident # open area to the left g	onducted on 2/23/23 at 8:56 wound care with Wound 6 was observed to have a great toe and third toe with a jury to the base of the fifth					

Facility ID: 943557

If continuation sheet Page 8 of 31

PRINTED: 04/12/2023

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/12/2023 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345171	B. WING			_		C 28/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WHITE O	AK MANOR - SHELBY				01 N MORGAN STREET HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	orders for wound care infection control proto change. No drainage areas. On 2/23/23 an intervie Director of Nursing (D out about the incident occurred because the the previous day durin meeting. She stated so been informed earlier injury. The interview r was minor at the time meeting they discusse a Geri-chair to keep h her from scooting dow team decided to initia however after discusse Responsible Party (R want the resident in a saw the resident, she back wheelchair in wh stated it was her unde go to the front lobby a her foot was bleeding before she could leav interview revealed she #6 had been seen foll wound care by the Ph On 2/23/23 at 11:32 A conducted with the M stated she recalled be with the resident havin she knew the resident	followed the physicians' e along with following col during the dressing was observed to the open ew was conducted with the OON). She stated she found the day after it had by go over the incidents from ng stand-up morning she normally would not have unless it was a serious evealed she felt the incident . She stated during stand-up ed switching the resident to the rest elevated and prevent win in her wheelchair. The te a therapy evaluation sing with Resident #6's P) she stated she did not Geri chair. Once therapy was transitioned into a high nich she still uses. The DON erstanding Nurse #3 had to and get Resident #6 because and provide wound care e for the appointment. The e did not know if Resident owing the incident for hysician. M an interview was edical Director (MD). She sing notified of the incident ng a minor injury. She stated t's wounds had improved e MD stated it was Resident	F	600				

Facility ID: 943557

If continuation sheet Page 9 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/12/2023 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345171	B. WING			_		C 28/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				4	401 N MORGAN STREET			
WHITE OF	AK MANOR - SHELBY			5	SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	care treatment by the wound from 11/14/22 within a few weeks. On 2/22/23 at 4:10 PM conducted with the Tr During the interview th received any notificated during transport for the The Administrator was jeopardy on 02/23/23 The Credible Allegation 11/14/22 for immediate follows. Identify those recipier are likely to suffer, a sea result of the noncomore a result of the noncomore the identified resident right foot dropped off footrest and became I footrest of the wheelch floor while being rolled transporter on 11/14/22 transporter failed to sther wheelchair from h facility lobby after she her foot was hurting. The abrasion to her right foot was nor resident's right foot was to go to her appointment of the second to the second the second to the second	<ul> <li>oplied with follow up wound nurses. She stated the had healed completely</li> <li>M an interview was ansportation Company. hey stated they had not ion of issues with a resident e date of 11/14/22.</li> <li>s notified of immediate at 4:30 PM.</li> <li>on for noncompliance dated te jeopardy removal as</li> <li>as who have suffered, or serious adverse outcome as npliance.</li> <li>t is Resident #1's and her from the wheelchair foot lodged under the foot hair or rubbed against the d down the hallway by the 22. Resident #1 alleges the top pushing the resident in her room in the facility to the e told him to stop because This caused her to have an heel and an open area at the be that measured 2x2 cm. hotified of the area and the as treated and she was able</li> </ul>	F	600				

If continuation sheet Page 10 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345171	B. WING				C /28/2023
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	audit was completed 2/23/23 to ensure idea neglect are transporte standard wheelchair, wheelchair, stretcher) An audit of residents transport since Nover incidents with residen wheelchair. This audit by Administration and Consultant. Another a Nursing Administratio residents are transpot (i.e. standard wheelch back wheelchair, stree further audit consistin determine if the facilit stop what they are do residents in a wheelch the resident is vocaliz This audit was completed the question if they as is their request honor attention to their requ completed by the soc 2/24/23. Specify the action the process or system fai adverse outcome fror and when the action we All facility staff includi	hsported in a wheelchair. An by nursing administration on ntified residents at risk for ed via the proper device (i.e. geriatric chair, high back of or their safety. that used wheelchair mber 2022 revealed no other its being maneuvered in a t was completed on 2/23/23 I the Corporate Nurse audit was completed by n on 2/23/23 to ensure rted via the proper device hair, geriatric chair, high tcher) for their safety. A g of resident interviews to y staff and outside providers bing while transporting hair when asked to stop or if ting that they are in pain. eted by the social services 3. ents were conducted asking sk the staff member to stop ed and is the staff paying est. The interviews were ial services department on e entity will take to alter the lure to prevent a serious n occurring or reoccurring, will be completed. ng agency staff were eglect protocol that includes	F	600			

Facility ID: 943557

If continuation sheet Page 11 of 31

PRINTED: 04/12/2023

	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY PLETED		
		345171	B. WING		02	C 2/ <b>28/2023</b>		
	ROVIDER OR SUPPLIER		40	REET ADDRESS, CITY, STATE, ZIP COI 1 N MORGAN STREET HELBY, NC 28150	DE			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 600	free from physical new including agency staff ensuring that resident in a wheelchair, that t stabilized including th before being transpor includes any staff tran- wheelchair to stop wh asked by the resident circumstance. This ed by the Director of Nur Administration and co- facility staff/ transport and the other outside on paying attention to transporting them in a making sure the reside their feet, are secured the floor. This education the wheelchair, if a re and notifying the facil order to conduct an a treatment. This education Director of Nursing ar 2/24/23. All facility staff/transporting them in a	g the resident's right to be glect. The nursing staff f will also be educated on ts who are being transported their body parts are beir feet on the foot footrests ted. The education also insporting residents in a nat they are doing when t, no matter the ducation will be conducted rsing and Nursing pompleted by 2/24/23. All ter including agency staff transporters were educated to the residents while a wheelchair to include lent's body parts, such as d and not rubbing against ion also included stopping esident complains of pain ity licensed nursing staff in issessment and render ation was completed by the nd the transport company by orter including agency staff orters will be educated on	F 600					

Facility ID: 943557

If continuation sheet Page 12 of 31

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/12/2023 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345171	B. WING _			-		C 28/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE	•=	
				40	1 N MORGAN STREET			
WHITE OF	AK MANOR - SHELBY			SI	HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	FMLA or vacation) that education will not start residents until after the Newly hired staff will not well prior to caring for Resources Director we Nursing of new hires, will ensure the training Resources Director we responsibility on 2/24/2 The wheelchair transpection to educate the transpect to transporting resident wheelchair. The Administrator and responsible for the on IJ Removal Date is 2/ On 2/28/23, the facilitti immediate jeopardy re was validated by the facility immediate jeopardy re was validated by the facility intervealed they had recompliant abuse and neglect, ere stabilized in their when to observe residents we by outside staff to ensure the to educate the transpection the transpection to the transpection the transpectio	at are not available for the t working or care for e education is completed. receive this education as residents. The Human ill inform the Director of and the Director of Nursing g is completed. The Human as notified of this (23 by the Administrator. bort company was given a by the Director of Nursing orters, and copies of the recation will be given to the ansporters will also be asked ducation by the facility prior nts in a wheelchair by n. If education was not tion will be completed at ursing Administration prior nts' transport in a d Director of Nursing are going compliance of F600. 25/23. y's credible allegation for emoval effective 2/25/23 following: Staff interviews reved education on resident nsuring residents are elchair prior to transport and who are being transported sure they are being handled audits were conducted on	F 6	500				

Facility ID: 943557

If continuation sheet Page 13 of 31

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/12/2023 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345171	B. WING		_		C 28/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WHITE OA	K MANOR - SHELBY			01 N MORGAN STREET HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600 F 610 SS=J	wheelchair for their sa conducted with alert a had been transported no concerns identified transportation inciden November 2022. The facility's action pla completed as of 2/25/ Investigate/Prevent/C CFR(s): 483.12(c)(2)- §483.12(c) In respons neglect, exploitation, of wust: §483.12(c)(2) Have et violations are thoroug §483.12(c)(3) Prevent neglect, exploitation, of investigation is in prog §483.12(c)(4) Report investigations to the a	per device such as a geriatric chair, or high back afety. Interviews were and oriented residents who since November 2022 with d. No additional ts were identified since an was validated to be 23. orrect Alleged Violation (4) se to allegations of abuse, or mistreatment, the facility vidence that all alleged hly investigated. t further potential abuse, or mistreatment while the gress.	F 600		JEFICIENCY)		3/24/23
	accordance with State Survey Agency, withir incident, and if the all appropriate corrective This REQUIREMENT by: Based on record revi interviews the facility	e law, including to the State a 5 working days of the eged violation is verified a action must be taken. is not met as evidenced ew, resident and staff failed to follow their neglect reporting immediately to		White Oak - Shelb Prevent/ Correct Al The Director of Nur	-		

Event ID: CB1G11

Facility ID: 943557

If continuation sheet Page 14 of 31

		MEDICAID SERVICES				DMB NC	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE COMP	SURVEY
						(	С
		345171	B. WING			02/	28/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	K MANOR - SHELBY				1 N MORGAN STREET		
				SI	HELBY, 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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIC DATE
F 610	Continued From page	2 14	F 6	10			
		ecting residents. Transport			resident #6 on 2/24/23 regarding the		
		ident #6 from her room to			occurrence with the transporter pushing		
		facility with her foot caught			her in the wheelchair on 11/14/22.		
	underneath the footre				Resident #6 was reassessed for		
	Resident #6 stated to	Transport driver #1 to stop			transportation device on 11/14/22 and		
		ning despite the resident			new order was implemented for geriatric	2	
		g in an injury to the resident's			chair, and further evaluation and		
		s not immediately reported			preference from resident resulted in an		
		f. The lack of reporting,			order for a high back wheelchair with		
	investigating and prot			foam wedge cushion, elevating leg rests	5		
		This occurred for one of			and drop leg pad. The wheelchair		
	one resident reviewed	d for abuse (Resident #6).			transport company was notified on 2/23/23 to inform the owner that the		
	Immediate Jeonardy	began on 11/14/22 an			identified transporter will no longer be al	hle	
		as allowed to continue to			to transport residents from facility.	510	
	work without any corr				Resident #6 has voiced no more		
		vas removed on 02/25/23			concerns.		
		ided and implemented an					
	acceptable credible a	llegation for Immediate			Interviews with residents were conducte	ed	
	· ·	ne facility remains out of			asking the question if they ask the staff		
		r scope and severity level of			member to stop is their request honored	ł	
	•	with potential for more than			and is the staff paying attention to their	_	
		not immediate jeopardy) to			request. The interviews were completed	1	
	ensure completion of systems put into place	education and monitoring e are effective.			by the Social Services department on 2/24/23.		
					An audit of residents that used wheelch	air	
	The findings included	:			transport since November 2022 by the		
	<u> </u>				wheelchair van transport company and	by	
					the facility staff\transporter revealed no	-	
		s "Abuse, neglect and			other incidents with residents being		
		ated 10-1-22 revealed in part			maneuvered in a wheelchair. This audit		
		entify, correct, and intervene			was completed on 2/23/23 by		
		abuse, neglect, exploitation			administration and the corporate nurse		
		on of resident property was			consultant. Another audit was completed		
		The policy read to respond			by Nursing Administration on 2/23/23 to		
		t the alleged victim by he alleged perpetrator and			ensure residents are transported via the proper device (i.e. standard wheelchair,		
	to immediately report				proper device (i.e. standard wheelchall,		

Facility ID: 943557

If continuation sheet Page 15 of 31

CENTER		MEDICAID SERVICES				IO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED	
		345171	B. WING		C		
	ROVIDER OR SUPPLIER	545171		STREET ADDRESS, CITY, STATE, ZIP (		2/28/2023	
	ROVIDER OR SUFFLIER			401 N MORGAN STREET	JODE		
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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 610	Continued From page	a 15	F 6 <sup>2</sup>	10			
1 010	administration. The fa		FU	stretcher) for their safety.			
	investigation into the	•					
	5	5		All facility staff including ag	gency staff were		
	Resident #6 was adm	•		re-educated on the abuse	neglect protocol		
	-	ses which included diabetes		that includes how to identit	-		
	mellitus, and coronar	y artery disease (CAD).		reportable, to report imme			
	Deview of the environment	h Minimum Data Oat (MDO)		administration if they see a			
	dated 9/21/22 reveale	rly Minimum Data Set (MDS)		how to assess other reside protective measure in plac	•		
	moderately cognitivel			immediately remove and/o			
		staff members for transfers.		perpetrator, while facility is			
		umented as able to make		thorough investigation.	, considering s		
	herself clear and und	erstood. She was					
	documented to also h	nave a clear comprehension		This education consists of	the following:		
		rs. The assessment revealed		how to identify what is rep			
		kin conditions or needed		report immediately to adm			
	special footcare durin	ig the assessment period.		see abuse/neglect; how to			
				residents and put protectiv			
	11/14/22 revealed on	initial allegation report dated		place; to immediately remo			
	Resident #6 returned			suspend the perpetrator; fa			
		open area on her left great		ensure that residents are p	•		
		imeters (cm) by 2 cm. Nurse		any care, services and situ			
		with normal saline and		what they are doing while			
	covered it with a band	d aid. The Nurse Practitioner		and services to a resident	-		
	(NP) was notified alo	ng with the residents		the resident to stop; to stop	p care and		
		P). Resident #6 denied pain		services, if a resident com			
		s per the report. Resident #6		and notify the facility licens	•		
		d abrasion to her left heel.		in order for them to conduc			
		Nurse #3 she had bumped		assessment and render tre			
	Interventions to reduce	ould not remember what.		the overall need to pay atte residents while providing of			
		high back wheelchair for		services that the resident a			
	mobility.			staff does stop. This educa			
				completed by the Corporat			
	On 2/22/23 at 12:03 I	PM an interview was		Services Consultant for the			
		lent #6. She stated a few		on 2/23/23. Then it was co			
		ort driver came into the		Administrator for the Direc			
	facility to pick her up	and was dragging her feet		and Nursing Administration	n. All facility		

Facility ID: 943557

If continuation sheet Page 16 of 31

		MEDICAID SERVICES				0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING			
						С
		345171	B. WING		02/	28/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AK MANOR - SHELBY			401 N MORGAN STREET		
				SHELBY, NC 28150		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETIC DATE
			-			
F 610			F 61			
		front lobby. Resident #6		staff including agency staff were the		
		nim to stop, I was telling him		educated by the Director of Nursing	and	
		never said anything and kept		Nursing Administration on 2/24/23.		
		The interview revealed her		The wheelebair ven transport comp	anv's	
	foot was caught underneath the footrest of the wheelchair and he had dragged her left foot from			The wheelchair van transport comp transporters and the facility	arry 5	
	her room to the front lobby of the facility. Resident			staff/transporter (on FMLA or vacati	on)	
	#6 stated she just had socks on because shoes			that are not available for the educat		
		ted a staff member whom		not start working or care for residen		
	she did not know fina	lly stopped him because her		after the education is completed. No		
		esident #1 stated a nurse		hired staff will receive this education	-	
	came and got her and	d dressed her foot before		well prior to caring for residents. Th	е	
		intment. The interview		Human Resources Director was no		
		rse #3 and Nurse Aide #5		on 2/24/23 by the Administrator to in		
		d that Transport Driver #1		the Director of Nursing of new hires		
		underneath the pedal while		Director of Nursing will ensure train	ing is	
	she asked him to stop	o while Nurse #3 was		completed.		
	dressing her foot.					
	On 2/22/23 at 3:39 Pl	M an interview was		The wheelchair transport company given a copy of the education by the		
		e Aide (NA)#5. She stated on		Director of Nursing to educate the		
		ten Resident #6 dressed		transporters, and copies of the com	pletion	
		ide appointment. The		of this education will be given to the		
		esident #6 did not get out of		on 2/24/23. Transporters will also b		
		rsonal preference and did		asked if they received this educatio		
		es only socks. She stated		the facility prior to transporting resid	-	
		on the resident because		a wheelchair by Nursing Administra		
		ripper socks in her drawer.		education was not completed, the		
		mately an hour had lapsed		education will be completed at that		
		Resident #6 dressed and in		moment by the Nursing Administrat		
		time she saw Nurse #3		prior to handling the residents' trans	sport in	
		back down the hallway and		a wheelchair.		
	-	NA #5 stated Resident #6		The Director of Nursing also read	cated	
		rom transport was rough s pushing her. Resident #6		The Director of Nursing also re-edu the current licensed nursing includir		
		n and NA #5 stated her left		agency nurses on completing occur	-	
		ike it had been lifted or had a		reports as soon as possible after ar		
	-	She stated Nurse #3		incident occurs. Occurrence reports		
						1

Facility ID: 943557

If continuation sheet Page 17 of 31

						<u>38-039</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURV COMPLETED		
			A. BUILDING	3			
		345171	B. WING		C 02/28/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		JZ3	
				401 N MORGAN STREET			
WHITE O	AK MANOR - SHELBY			SHELBY, NC 28150			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	MPLETIO DATE	
F 610	Continued From page	e 17	F 61	10			
		ector of Nursing. NA #5		and appropriate treatment	rendered. This		
		as very clear in stating it was		education included the pro			
		river who hurt her foot and		out an occurrence report th	•		
		n she was leaving the		following: generate occurre	-		
		she did not tell anyone else		form; give description of the			
		cause she knew Nurse #3		circumstances surrounding			
	was handing the situa	ation.		occurrence; provide emerg	-		
	On 2/23/23 at 8:50 Al	Manintonyiowywaa		the resident if needed; cha the clinical record and ente			
		port Driver #2. She stated		board; notify the physician			
		me employee working for		representative; document a			
		scheduling conflicts and the		observations; obtain individ			
	-	with appointments the facility		statements for current shift			
	also had to use a con			two previous shifts for any/			
	transports. During the	e interview she stated on		not witnessed; investigate	occurrence;		
	11/14/22 she had a ca	ancellation and returned to		and licensed nursing staff t	o complete		
		d when she was coming into		report and submit complete			
		facility, she saw the contract		report form to nursing adm			
		Priver #1 pushing Resident		soon as possible during the			
		She stated she saw the		This education was comple			
		eeding badly and stopped Resident #6 stated, "he was		The facility licensed nursin FMLA or vacation) that are			
		Id him to stop". Transport		for this education will not s			
		asked the Secretary to go		care for residents until afte	5		
		cause the resident could not		is completed. The Director			
	-	e condition, she was in.		maintain a listing of staff th	-		
		tated Resident #6's foot was		education. Newly hired lice			
	underneath the whee	lchair and had been dragged		staff will receive this educa	tion as well		
		1 when he pushed her to the		prior to caring for residents			
		revealed Nurse #3 came to		Resources Director will not			
		ot Resident #6 to dress her		of Nursing of the new hires			
	foot. She stated Trans	•		notified of responsibility on	2/24/23 by the		
	The interview reveale	was delaying the transport.		administrator.			
		se she thought Nurse #3		Occurrence reports are co	mpleted by the		
		ation. She stated she was		floor license nurse staff wh			
	never asked about the			occurs. At that point, licens			
				nurse will report daily, Mon	-		
	On 2/22/23 at 3:16 Pl			Friday during morning mee			

Facility ID: 943557

If continuation sheet Page 18 of 31

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	LE CONSTR	RUCTION	(X3) DATE	D. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G		<b>N</b> /	PLETED
							С
		345171	B. WING				28/2023
NAME OF P	ROVIDER OR SUPPLIER			STREETAD	DDRESS, CITY, STATE, ZIP CODE	02/	20/2020
				401 N MOF	RGAN STREET		
WHITE O	AK MANOR - SHELBY			SHELBY,	NC 28150		
(X4) ID			ID				(X5) COMPLETIO
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
F 610	Continued From page	e 18	F 6 <sup>2</sup>	0			
		#3. She stated Resident #6		deter	mined by the Director of Nursing	and	
		out of the facility to an			dministrator if further investigation		
		Nide #5 had gotten her ready,			ed. This will be conducted by Nur		
		in her room. Nurse #3 stated			nistration and reported to the	-	
	Transport Driver #1 w	ent to the resident's room		admir	nistrator. During the weekends an	d	
	and began pushing h	er to the front of the facility.		off ho	ours, the director of nursing and		
	She stated the Secret	tary came to her and said		admir	nistrator are contacted by phone a	and	
		s bleeding. The interview		the de	etermination is made for		
		aw Resident #6, the resident		inves	tigation.		
		must have hit her foot on					
		t know what. Nurse #3			sidents and resident representativ		
		er #1 told her he did not			rovided information and education		
		ened. Resident #6 was noted			esident rights that include the righ	t to	
		non grip socks with no			ee from abuse and neglect by the		
		he incident. Nurse #3 stated			ssions department on or prior to		
	Resident #6 did not n	•			ssion to the facility. All staff memb ding agency staff are provided	Ders	
		et out of the bed unless she ent. The interview further			nation and education on resident		
		bes in her room. Nurse #3			that include the right to be free fr	om	
		lent #6 back to her room,		<b>–</b>	e and neglect by the Social Service		
		posing a 2 centimeter (cm)			irtment and/or staff development		
		her left great toe and an			linator upon hire and at least year	lv	
		eel. She cleaned the area			after. All staff members including	· <b>y</b>	
		ssing. Nurse #3 stated at the			cy staff are responsible for the		
		was bright red blood at the			ction of residents and the immedi	ate	
		left great toe. Resident #6			val of any harm to residents. This		
		wheelchair along with a			ation is provided by the Social		
	board (device used to	prevent the residents foot			ces Department and/or Staff		
	from dropped off of th	e footrest), but the			lopment Coordinator upon hire ar	nd	
	resident's foot had be	come lodged under the		at lea	ast yearly thereafter.		
		v revealed the staff had					
		#6 sliding down in her			Administrator and Director of Nurs	ing	
	-	us occasions and after the			ved additional coaching and		
		d Nurse Aide #5 had to pull			ucation of F610 by the corporate		
		wheelchair because she			e consultant and the Corporate So	ocial	
		g her foot to drop off the		Servi	ces Consultant on 2/23/23.		
		fter she redressed the					
	resident's foot, she pu lobby and Transport [	ushed her back to the front			bing monitoring and compliance w chieved by resident interviews tha		

Facility ID: 943557

If continuation sheet Page 19 of 31

TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /	j		MPLETED
						С
		345171	B. WING			2/28/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 610	Continued From page	e 19	F 61	0		
	-	ent. The interview revealed		will be conducted by the Soc	al Services	
		or on the incident report by		Department and the Audit of		
		ccurred when the resident		Reports Tool that will be con		
	-	. Nurse #3 stated she filled		Nursing Administration. Soci	•	
	out the incident repor	-		Department will interview a r		
		(DON) box, placed a note in		10 residents a week for 4 we		
		r's non emergent folder and		there are no issues noted. T	-	
		Responsible Party following rview revealed she had not		residents for 4 weeks and th		
		from the staff members		residents for 4 weeks. The N Administration will monitor re	-	
	involved.	nom the stan members		auditing of Occurrence Repo	-	
				Occurrence Reports will be i		
	On 2/22/23 at 4:05 Pl	M an interview was		any concerns that need to be		
	conducted with Trans	port Driver #1. He stated he		for 4 weeks. Then 5 resident		
		company the facility used		reviewed for 4 weeks, then 3	3 residents will	
		the interview he stated he		be reviewed for 4 weeks.		
		e incident with Resident #6		The sum of the factor that a second to		
	-	/ to transport a resident. The had continued to transport		The results from this monitor be discussed during weekly		
		cility following the incident		Assurance Meetings for its e	•	
	with Resident #6 on 2			Any identified issues will be		
				the Quality Assurance Team	•	
	On 2/22/23 at 4:10 P	M an interview was		recommendations. Unresolv		
		ransportation Company.		be reviewed by the Administ	rator for follow	
		hey stated they had not		up re-education.		
		ion of issues with a resident			f Nixona in	
	during transport for th	ie date of 11/14/22.		The administrator, Director of Social Social Social Social	•	
	0n 2/23/23 an intervi	ew was conducted with the		Social Services Director is re the ongoing compliance of F		
		DON). She stated she found			010.	
	out about the inciden	-		Completion date of 3/24/23.		
		2 because they go over the				
	incidents from the pre	evious day during stand-up				
		e stated she normally would				
		ed earlier unless it was a				
		terview revealed she felt the				
		the time. She stated during				
		y discussed switching the chair to keep her feet				

If continuation sheet Page 20 of 31

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/12/2023 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION			LETED
		345171	B. WING		_		C 28/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WHITE OA	K MANOR - SHELBY			401 N MORGAN STREET SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	her wheelchair. The te therapy evaluation ho Resident #6's Respor she did not want the r She stated Resident # not be transported by following the incident. looking back the facilit transportation driver fu protection of other rest the resident, she was back wheelchair in wh stated it was her unde go to the front lobby a her foot was bleeding before she could leav interview revealed she #6 had been seen foll wound care by the Ph not obtain statements interview Resident #6 on the floor that file th obtaining the stateme involved. The interview should have been invo resulted in an injury to stated Transport Drive pushing the resident was jeopardy on 02/23/23 The Credible Allegatio	her from scooting down in earn decided to initiate a wever after discussing with sible Party (RP) she stated esident in a geriatric chair. 46's RP also requested she the contract company again The interview revealed ty should have removed the rom the facility to ensure sidents. Once therapy saw transitioned into a high sich she still uses. The DON erstanding Nurse #3 had to nd get Resident #6 because and provide wound care e for the appointment. The e did not know if Resident owing the incident for ysician. She stated she did regarding the incident or , further stating the nurses e incident report should be nts from all staff members w revealed the incident estigated more since it o Resident #6. The DON er #1 should have stopped when he asked him to.	F 61	D			
	a result of the noncon						

Facility ID: 943557

If continuation sheet Page 21 of 31

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					FORM	): 04/12/2023 APPROVED 0. 0938-0391	
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
	345171	B. WING		_	C 02/28/2023		
NAME OF PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
WHITE OAK MANOR - SHELBY			101 N MORGAN STREET				
			SHELBY, NC 28150				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
rubbed against the floor the hallway by the trans alleges the transporter f resident in her wheelcha facility to the facility lobb stop because her foot w her to have an abrasion open area at the end of measured 2x2 cm. Licer the area and the resider and she was able to go facility failed to identify t abuse situation and staf administration immediat failed to assess other re measures in place, and investigation. The facility corrective actions for the identified as the perpetr. The Director of Nursing on 2/24/23 regarding the transporter pushing her 11/14/22. Resident # 1 v transportation device or was implemented for ge evaluation and preferen in an order for a high ba wedge cushion, elevatir pad. The wheelchair tra notified on 2/23/23 to int identified transporter wil transport residents from	s Resident #1 and on ght foot dropped off the nd became lodged or edal of the wheelchair or while being rolled down sporter. Resident #1 failed to stop pushing the air from her room in the by after she told him to vas hurting. This caused to her right heel and an the left great toe that nsed nurse was notified of nt's right foot was treated to her appointment. The that this incident was an ff failed to report to tely. The facility further esidents, put protective conduct a thorough y also failed to provide e named transporter as rator. interviewed resident #1 e occurrence with the in the wheelchair on was reassessed for n 11/14/22 and new order eriatric chair, and further ice from resident resulted ack wheelchair with foam ng leg rests and drop leg insport company was form the owner that the II no longer be able to	F 610					

Facility ID: 943557

If continuation sheet Page 22 of 31

	-	D HUMAN SERVICES				FORM	): 04/12/2023 MAPPROVED
STATEMENT O	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345171	B. WING		_		C 28/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•=	
			4	01 N MORGAN STREET			
WHITE OF	K MANOR - SHELBY		s	HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	22	F 610				
	the question if they as is their request honor attention to their requ	ed and is the staff member to stop ed and is the staff paying est. The interviews were ial Services department on					
	van transport compar staff/transporter revea residents being mane audit was completed of and the corporate nur was completed by Nu 2/23/23 to ensure res the proper device (i.e	nber 2022 by the wheelchair and by the facility aled no other incidents with uvered in a wheelchair. This on 2/23/23 by administration se consultant. Another audit rsing Administration on idents are transported via					
	process or system fai	entity will take to alter the lure to prevent a serious n occurring or reoccurring, vill be completed.					
	how to identify what is immediately to admin how to assess other r	eglect protocol that includes s a reportable, to report istration if they see neglect, esidents and put protective mmediately remove and/or tor, while facility is					
	identify what is report to administration if the assess other resident measures in place; to	ts of the following: how to able; to report immediately ey see neglect; how to s and put protective immediately remove and/or tor; facility conducting a					

Facility ID: 943557

If continuation sheet Page 23 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345171	B. WING				C 28/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE O	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 PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 610	thorough investigation protected during any to stop what they are and services to a resi resident to stop; to sto resident complains of licensed nursing staff an assessment and re overall need to pay at while providing care a resident ask to stop, t education was comple Services Consultant f 2/23/23. Then it was of Administrator for the I Nursing Administratio agency staff were the of Nursing and Nursin The wheelchair van tr transporters and the f FMLA or vacation) that education will not star residents until after th Newly hired staff will well prior to caring for Resources Director w the Administrator to in of new hires. The Direct the training is complet The wheelchair transp copy of the education to educate the transp completion of this edu facility on 2/24/23. Tra- if they received this en-	h; ensure that residents are care, services and situation; doing while providing care dent when asked by the op care and services, if a pain and notify the facility in order for them to conduct ender treatment; and the tention to the residents and services that the that staff does stop. This eted by the Corporate Social for the Administrator on completed by the Director of Nursing and n. All facility staff including n educated by the Director ng Administration on 2/24/23. ansport company's facility staff/transporter (on at are not available for the t working or care for the education is completed. receive this education as residents. The Human vas notified on 2/24/23 by nform the Director of Nursing ector of Nursing will ensure ted. port company was given a by the Director of Nursing orters, and copies of the ucation will be given to the ansporters will also be asked ducation by the facility prior	F	610			

Facility ID: 943557

If continuation sheet Page 24 of 31

PRINTED: 04/12/2023

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	): 04/12/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345171	B. WING		_	( 02/:	) 28/2023
NAME OF P	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WHITE O	AK MANOR - SHELBY			01 N MORGAN STREET SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	that moment by the N to handling the reside wheelchair. The Director of Nursir current licensed nurse on completing occurre possible after an incid reports to be complete assessed and approp The education include an occurrence report generate occurrence of the circumstances provide emergency ca chart occurrence in th on acute board; notify representative; docun observations; obtain i for current shift and a for any/all occurrence occurrence; and licen complete report and s occurrence report forr as soon as possible d education was complet licensed nursing staff are not available for th working or care for re- education. Newly hire receive this education residents. The Humar notify the Director of N	tion will be completed at ursing Administration prior ints' transport in a and also re-educated the est including agency nurses ence reports as soon lent occurs. Occurrence ed after the resident is riate treatment rendered. ed the process of filling out that entails the following: report form; give description surrounding the occurrence; are to the resident if needed; e clinical record and enter it the physician and resident nent all pertinent individual staff statements t least two previous shifts s not witnessed; investigate sed nursing staff to submit completed in to nursing administration uring the specific shift. This eted on 2/24/23. The facility (on FMLA or vacation) that his education will not start	F 610				

If continuation sheet Page 25 of 31

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/12/2023 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345171	B. WING		_		C 28/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
WHITE O	AK MANOR - SHELBY			01 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	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Occurrence reports a license nurse staff wh that point, the license daily, Monday through meetings. Then it is d Nursing and the Admi investigation is neede Nursing Administratio administrator. During hours, the director of are contacted by phot made for investigation All residents and resid provided information a resident rights that ind from abuse and negled department on or prio All staff members incl provided information a rights that include the and neglect by the So and/or staff developm and at least yearly the including agency staff protection of residents removal of any harm is provided by the So and/or Staff Developm and at least yearly the including agency staff protection of residents removal of any harm is provided by the So and/or Staff Developm and at least yearly the including agency staff protection of residents removal of any harm is provided by the So and/or Staff Developm and at least yearly the The Administrator and received additional co F610 by the corporate Corporate Social Sem	re completed by the floor ien an incident occurs. At d safety nurse will report in Friday during morning etermined by the Director of inistrator if further ed. This will be conducted by n and reported to the the weekends and off nursing and administrator ne and the determination is n. dent representatives are and education on the clude the right to be free ext by the admissions or to admission to the facility. uding agency staff are and education on resident oright to be free from abuse bocial Services Department nent coordinator upon hire ereafter. All staff members f are responsible for the s and the immediate to residents. This education cial Services Department nent Coordinator upon hire ereafter.	F 610				

If continuation sheet Page 26 of 31

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	D: 04/12/2023 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345171	B. WING		_		C 28/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WHITE OF	K MANOR - SHELBY			401 N MORGAN STREET SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page		F 61	0			
F 686 SS=D	On 2/28/23, the facility immediate jeopardy re- was validated by the f revealed they had rec- reporting resident abu- residents are stabilized transport and to obset transported by outside being handled approp- educated on notifying any resident in an abu- Nursing staff received the process of filling of The facility's action pl- completed as of 2/25/ Treatment/Svcs to Pre CFR(s): 483.25(b)(1)( §483.25(b) Skin Integ §483.25(b)(1) Pressur Based on the compre- resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indiv demonstrates that the (ii) A resident with pre- necessary treatment a with professional stan promote healing, prev- new ulcers from deve This REQUIREMENT by:	y's credible allegation for emoval effective 2/25/23 following: Staff interviews eived education on use and neglect, ensuring ed in their wheelchair prior to rve residents who are being e staff to ensure they are riately. All staff were Administration if they see use or neglect situation. Heducation which included out an occurrence report. an was validated to be 23. event/Heal Pressure Ulcer i)(ii) rity re ulcers. hensive assessment of a nust ensure that- ocare, consistent with s of practice, to prevent oes not develop pressure vidual's clinical condition by were unavoidable; and ssure ulcers receives and services, consistent dards of practice, to rent infection and prevent	F 68	16 White Oak - Shelb	y does		3/24/23

Event ID: CB1G11

Facility ID: 943557

If continuation sheet Page 27 of 31

		MEDICAID SERVICES					NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			<b>I Y Y</b>	ATE SURVEY DMPLETED
		345171	B. WING				C 02/28/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
					01 N MORGAN STREET		
WHITE O	AK MANOR - SHELBY			S	HELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 686	Continued From page	o 97		686			
1 000	staff, Nurse Practition			000	Treatments/Services to Prevent/Heal		
	Director (MD), the fac	cility failed to provide wound			Pressure Ulcers		
		ble sacral pressure ulcer on 3			Desident #454 was found to have an		
		/08/22, 12/09/22, and sidents (Resident #154)			Resident #154 was found to have an unstageable acquired pressure ulcers	on	
	reviewed for pressure			her sacral area on 12/07/22 by the	UII		
					Treatment Nurse. Treatment Nurse die	d	
	The findings included	1:			not write the order for wound care unt		
					12/11/22. As a result of the Treatment		
	Resident #154 was a			Nurse not following policy and proced	ure		
	09/08/22 and was dis			because she forgot to write the order.			
	12/11/22. Her admitt			Resident #154 did not receive wound	care		
	fibrillation, hypertensi			to her sacral wound one 12/08/22,			
	renal disease on dial	ysis.			12/09/22, and 12/10/22. Resident did		
					receive wound care on 12/11/22 as		
		ission Minimum Data Set			documented by the nurse. Resident w		
	. ,	ated 09/14/22 revealed she t with no behaviors and			discharged to the hospital on 12/11/22 and is no longer a resident.	2	
		total assistance with all			and is no longer a resident.		
		g except eating in which she			Skin audits were completed on all		
	-				residents by the Nursing Administratio	n	
	required set up only. The assessment also revealed Resident #154 had a pressure reducing				Team. These audits were completed of		
		id chair and was at risk of			3/07/23. All new residents will have a		
	developing pressure ulcers but had none on				audit on admission. A review of treatm		
	admission. The MDS	S further revealed the			order was conducted by the Nursing		
	resident was currently	y receiving dialysis.			Administration Team, to assure that al		
					pressure areas have a timely wound o		
		ulcer report dated 12/07/22			order on the Treatment Administration		
		atment Nurse revealed			Record (TAR), this was completed on		
		n unstageable wound to the sified as pressure ulcer with			3/16/23.		
		It was described as soft with			Treatment nurse along with other licer	nsed	
		kin and smooth and regular			nursing staff were re-educated on time		
		exudate (fluid that leaks out			writing/transcribing and initiating of	- ' J	
	-	nearby tissue). According to			treatment order and completion of a s	kin	
		ent plan was to cleanse with			assessment sheet. The re-education v		
		septic used to cleanse			conducted by the Director of Nursing		
	wounds) and apply sl	kin prep (liquid film that			(DON) and was completed on 3/13/23	5.	
	shields delicate and v	vulnerable skin).			Newly hired staff will receive this		

Facility ID: 943557

If continuation sheet Page 28 of 31

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG			
		345171	B. WING			02	C 2/28/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AK MANOR - SHELBY				01 N MORGAN STREET HELBY, NC 28150		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIO
F 686	Continued From page	e 28	F 6	86			
					education during the orientation period		
		n's order written 12/11/22			prior to beginning work on the floor.		
		tten by the Treatment Nurse					
	for Resident #154's s			Nursing staff which included Registere	d		
	cleansed with Dakin's around the wound an			Nursing, licensed nurses, and nursing assistants was provided inservice			
	dressing daily and pri			education on pressure ulcers by Direct	or		
		very 2 hours, and daily skin			of Nursing. Inservice education was		
	audit by the nurse.				completed on 3/13/23. Education		
					included: risk identifiers/risk factors		
	Review of Resident #			commonly associated with pressure			
		d (TAR) revealed the sacral			ulcers; standards of care for promoting		
		e ulcer wound dressing had 2/11/22 and daily wound care			healthy skin, including use of support services and pressure reduction/		
		essure wound was not done			positioning/ transferring devices; and		
	12/08/22 through 12/				proper procedure for reporting and		
					documenting noted skin concerns and		
	Interview on 02/22/23	at 12:05 PM with the			initiation of appropriate treatments. Ne	wly	
		ealed Resident #154 had a			hired staff will receive this education		
		on of her skin. She stated on			during the orientation period prior to		
	12/07/22 she found th				beginning work on the floor. A pressure		
		cquired pressure ulcer on an odor. The Treatment			ulcer monitoring tool has been created with education provided by Director of		
		ident #154's RP had visited			Nursing to treatment nurse on proper		
	· ·	/22 and observed the wound			completion of tool on 3/24/2023.		
		e on that date and after					
	seeing the wound the	RP requested the resident			Ongoing monitoring and compliance w	ill	
		spital for evaluation and			be achievable by a Pressure Ulcer		
	treatment of the wour	nd.			monitoring tool. This tool will be		
	Dhono inton <i>ii</i>	0/00/00 at 0.06 ANA			completed by the Nursing Administration		
	Nurse #2 who cared f	2/23/23 at 8:26 AM with for Resident #154 on			Pressure Ulcer Reports will be reviewe by the Nursing Administration which wi		
		2 on 1st shift revealed she			then follow up to make sure a treatmer		
		id had worked at the facility			order has been completed timely. All		
		ould not recall the resident			residents that have pressure areas will	be	
	or her wound.				monitored for 90 days.		
	Interview on 02/23/23	3 at 11:48 AM with the			The results from this monitoring tool wi	11	
		) revealed she didn't look at			be discussed during weekly Quality		

Facility ID: 943557

If continuation sheet Page 29 of 31

		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	OMB NO. (X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	·	COMPL	
					с	
		345171	B. WING		02/2	8/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE O	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 686	all the wounds at the Nurse was monitoring was infected she wou wound. The MD expl venting PEG tube, en diabetes and atrial fib calorie malnutrition ar resident had a Kenne explained she had no not be certain that wa resident had when dis Phone interview on 00 Nurse Practitioner (NI was at the end of her comorbidities includin the development of a stated the rapid devel the wound was likely obstruction, malnutriti there was no way to a skin. Follow up phone inter AM with the Medical I Resident #154's prote comorbidities there w done to prevent or av ultimately pressure ul Follow up interview of the Treatment Nurse the order for wound c would not have flagge Treatment Administra #154 needed wound	facility, but if the Treatment g an area that she thought ald contact the MD to see the ained Resident #154 had a d stage renal disease, rillation as well as protein and it was possible the ady ulcer. She further t seen the wound and could as the type of wound the scharged. 2/24/23 at 11:29 with the P) revealed Resident #154 life with multiple ag what she believed to be Kennedy ulcer. The NP lopment and deterioration of due to her gastric outlet ion and malabsorption and avoid the breakdown of her rview on 02/24/23 at 11:57 Director (MD) revealed given ein malnutrition and other as nothing that could be oid skin breakdown and cers. n 02/24/23 at 1:08 PM with revealed she had not written are until 12/11/22 and it ed the nurses on the tion Record (TAR) Resident care. She stated she could mentation that indicated	F 68		ected per ssues will r for follow nsible for	

Facility ID: 943557

If continuation sheet Page 30 of 31

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 04/12/2023 FORM APPROVEI OMB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345171	B. WING		_	C 02/28/2023
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
WHITE OAK MANOR - SHELBY				401 N MORGAN STREET		
				SHELBY, NC 28150		(10)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	
F 686		e 30 care on 12/11/22 as	F 6			

Event ID: CB1G11

Facility ID: 943557

If continuation sheet Page 31 of 31