STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor-Shelby	**401 N Morgan Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation was conducted on 08/25/25 through 08/28/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: 1D44C7.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/25/25 through 08/28/25. Event ID: 1D44C7. The following intakes were investigated: 2590410 and 2589982. 3 of 3 complaint allegations did not result in deficiency.	F0000		
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641	White Oak Manor – Shelby will ensure Minimum Data Set (MDS) Assessments accurately reflects the resident's status, including in the areas of restraints, infections and falls with major injury. Resident #8's MDS Assessment dated 05/29/25 was modified on 08/27/25 by the Corporate Consultant to reflect that Resident #8 did not use restraint (bedrails) on daily basis. Resident #15's MDS Assessment dated on 06/05/25 was modified on 08/27/25 by the Corporate Consultant to reflect that Resident #15 did not have active tuberculosis (TB). Resident #35's MDS Assessment dated on 06/10/25 was modified on 09/15/25 by the Corporate Consultant to reflect that Resident #35 did sustain a major injury with a fall. An audit was completed by the Corporate Consultant on current residents to ensure restraints (bedrails) accurately reflecting the residents' status. This audit was completed on 08/27/25. An audit was completed on 09/15/25 by the Corporate Consultant on current residents in the last 30 days coded with active infections to ensure infections, including TB, accurately reflect the residents' status.	09/17/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0641 SS = E	Continued from page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of restraints (Resident #8), infections (Resident #15), and falls with major injury (Resident #35). This deficient practice was identified for 3 of 5 sampled residents. The findings included: 1. Resident #8 was admitted to the facility on 01/04/2018 with diagnoses that included epilepsy (seizure disorder). Review of Resident #8's quarterly MDS assessment dated 05/29/2025 revealed Resident #8 was cognitively intact and used restraints (bedrails) on a daily basis. Review of the Bed Rail Assessment dated 05/29/2025 completed by the Safety Nurse revealed Resident #8 utilized two upper bed rails for positioning and mobility. An observation and interview were conducted with Resident #8 on 08/27/2025 at 12:35 PM. Resident #8 was observed in his room sitting up in his chair beside his bed. Resident #8's hands were contracted with bilateral palm guards in place. Resident #8's bed had no side rails in use. Resident #8 stated he was not able to help staff turn and position him in bed and he did not need the rails on his bed. An interview was conducted with the Nurse Assessment Coordinator on 08/27/2025 at 1:50 PM. The Nurse Assessment Coordinator stated that Resident #8's MDS	F0641	Continued from page 1 An audit was completed on 09/15/25 by the Corporate Consultant on current residents to ensure residents that sustained a major injury with a fall in the last 30 days are coded accurately and reflect the residents' status. Current and newly admitted residents will have their MDS Assessments accurately reflect their status. The Nurse Assessment Coordinator (NAC) and the Interdisciplinary Care Team (IDT) were re-educated by the Corporate Consultant by 09/16/25 regarding the importance of the MDS Assessments accurately reflecting the residents' status including restraints (bedrails), infections (TB) and falls with major injury. The IDT team members are a social worker, a registered dietician, and an activity representative. Newly hired NAC nurses and IDT will receive this education during their job specific orientation with their Corporate Consultant. The Director of Nursing (DON) and/or Corporate Consultant will monitor 3 MDS Assessments weekly for 12 weeks to ensure the MDS Assessments accurately reflect the resident's status, including in the areas of restraints, infections and falls with major injury. The identified trends will be discussed weekly during the Morning Quality Improvement (QI) meetings for 12 weeks. The identified issues or trends will further be discussed at the monthly Quality Assurance (QA) meetings with the care team for recommendations as indicated. The DON is responsible for the ongoing compliance of F641.	

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F0641 SS = E	Continued from page 2 was coded inaccurately and that she had made a mistake when completing Resident #8's MDS assessment. The Nurse Assessment Coordinator explained that she did not mean to click "restraints" used daily. The Nurse Assessment Coordinator further explained that she was new to the MDS role and was still learning the MDS process. An interview was conducted with the Safety Nurse on 08/27/2025 at 2:10 PM. The Safety Nurse stated that Resident #8 had previously used two upper rails for positioning and bed mobility but Resident #8's last bed rail assessment revealed he was unable to use the side rails for any type of repositioning or support. An interview was conducted with the DON on 08/27/2025 at 2:30 PM. The DON stated that she expected all MDS assessments be completed accurately based on the resident's clinical status. An interview was conducted with the Administrator on 08/27/2025 at 2:46 PM. The Administrator stated that she expected the MDS to be reflective of the resident's clinical condition and completed accurately. 2. Resident #15 was admitted to the facility on 06/29/2022 with diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes mellitus (DM), and latent tuberculosis (TB). Review of the Electronic Medical Record revealed Resident #15 had received no treatment for TB since she was admitted to the facility on 06/29/2022. Review of Resident #15's quarterly MDS assessment dated 06/05/2025 revealed Resident #15 was cognitively intact and was coded for active TB. An observation and interview were conducted with Resident #15 on 08/27/2025 at 10:04 AM. Resident #15 was observed in her room sitting up in her wheelchair. Resident #15 was alert and oriented and stated that she did not have TB, but she had smoked for many years and had lung disease. An interview was conducted with the Nurse Assessment Coordinator on 08/27/2025 at 10:07 AM. The Nurse	F0641		

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F0641 SS = E	Continued from page 3 Assessment Coordinator stated that Resident #15's MDS entry for TB was made in error. The Nurse Assessment Coordinator explained that she did not mean to select "tuberculosis". The Nurse Assessment Coordinator further explained that she was new to the MDS role and was still learning the MDS process. An interview was conducted with the Administrator on 08/27/2025 at 10:28 AM. The Administrator stated the Nurse Assessment Coordinator was new to the role and miscoded the TB on Resident #15's MDS. The Administrator also stated that she expected the MDS to accurately reflect the resident's clinical assessment including active diagnoses. An interview was conducted with the Nurse Practitioner (NP) on 08/28/2025 at 11:31 AM. The NP stated that Resident #15 had latent TB, not active TB. The NP further explained that Resident #15 had not received any treatment for TB and had no respiratory issues. 3. Resident #35 was initially admitted to the facility on 03/01/24 and was readmitted to facility on 12/31/24. Resident #35's diagnoses included unspecified dementia, generalized muscle weakness, and unsteadiness on feet. Resident #35's progress note dated 03/18/25 at 8:26 AM revealed Resident #35 had an assisted fall when lowered to the ground during transfer from toilet to wheelchair. Swelling and bruising were immediately noted to Resident #35's left pinky finger after the fall. An x-ray of Resident #35's left hand was ordered at that time. Resident #35's physician orders dated 03/18/25 revealed the following orders: 1. Refer to orthopedics (physicians who treat bone fractures) for proximal (fracture is closer to hand than the fingertip) 5th finger comminuted (a fracture where bone breaks into three or more fragments) fracture. 2. Wrap left hand with ACE (all cotton elastic) wrap daily to support left pinky due to broken finger until follow-up with orthopedics. A review of Resident #35's quarterly MDS assessment dated 06/10/25 revealed Resident #35 was coded to have sustained no falls with major injury.	F0641		

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F0641 SS = E	Continued from page 4 An interview with the MDS Coordinator on 08/28/25 at 10:59 AM revealed that Resident #35's quarterly MDS assessment had been completed on 06/10/25 but was not correctly coded for fall with major injury after the fall on 03/18/25 which resulted in a finger fracture. The MDS Coordinator stated the miscoding was an error due to an oversight. An interview with the DON on 08/28/25 at 10:13 AM revealed that she expected the resident's MDS assessments would be accurate and reflect the resident's care needs. An interview with the Administrator on 08/28/25 at 11:29 AM revealed that it was important that MDS assessments were completed accurately.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656	White Oak Manor – Shelby ensures the development and implementation of individualized person-centered comprehensive care plans for each resident, including the areas of wounds and constipation. Resident #30's comprehensive care plan was updated with actual wounds to the left foot on 8/28/25 by the Nurse Assessment Coordinator (NAC). The Corporate Consultant updated Resident #30's comprehensive care with risk for recurring episodes of constipation on 09/15/25. An audit was completed by the Corporate Consultant on current residents with wounds, and risk for and diagnosis of constipation to ensure comprehensive care plans are developed and implemented. This audit was completed on 9/16/25. Current and newly admitted residents will an individualized person-centered comprehensive care plans that are developed and implemented, including wounds and constipation as indicated. The NAC and the Interdisciplinary Care Team (IDT) were re-educated by the Corporate Consultant by 9/16/25 regarding the development and implementation of individualized person-centered comprehensive care plans for each resident, including for wounds and constipation. The IDT team members are a social worker, a registered dietician, and an activity representative. Newly hired NAC Nurses and IDT will receive this education during their job specific orientation with their Corporate Consultant.	09/17/2025

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F0656 SS = D	Continued from page 5 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, resident and staff interviews, the facility failed to develop an individualized person-centered comprehensive care plan for 1 of 6 residents whose comprehensive care plans were reviewed (Resident #30). · Findings included: Resident #30 was admitted to the facility on 5/30/25 with diagnoses which included type 2 diabetes and constipation. An admission Minimum Data Set (MDS) assessment dated 6/06/25 revealed Resident #30 was cognitively intact, had no reports of constipation on look back period, and had no pressure or vascular ulcers on admission. A review of Resident #30's comprehensive care plan initiated 6/02/25 and last revised 8/06/25 did not reveal a care plan for wounds to left foot or constipation. Physician's orders for Resident #30 revealed the following orders: A current order initiated on 5/30/25 for polyethylene glycol (a laxative) 17 grams twice daily. A current order initialed on 05/30/25 for Senna (a laxative) 8.6 mg tablet, take 2 tablets by mouth twice	F0656	Continued from page 5 The Director of Nursing (DON) will monitor newly admitted residents or current residents with newly ordered wound care and interventions for constipation to ensure their comprehensive care plans are developed and implemented for wounds and constipation. The monitoring will be completed weekly for 12 weeks to assure compliance. The identified trends will be discussed weekly during the Morning Quality Improvement (QI) meetings for 12 weeks. The identified issues or trends will further be discussed at the monthly Quality Assurance (QA) meetings with the care team for recommendations as indicated. The DON is responsible for the ongoing compliance of F656. Compliance date is 09/17/25.	

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F0656 SS = D	Continued from page 6 daily. An order dated 06/20/25 for daily treatment of left great toe wound. A current order initiated on 06/21/25 for lactulose (a laxative) 45 milliliters daily. An order dated 08/04/25 for daily treatment of left foot wound. A review of Resident #30's Gastroenterologist consult for constipation dated 08/14/25 revealed recommendations were for metoclopramide to assist with clearing stool from Resident #30's colon. A physician order was entered on 8/16/25 for metoclopramide (a medication that increases intestinal movement) 5 mg daily. An interview with the MDS Coordinator on 08/28/25 at 10:59 AM revealed that Resident #30's comprehensive care plan should have been updated when Resident #30 developed two separate wounds on his left foot which required daily treatment. The MDS Coordinator stated a care plan for constipation should have been initiated when Resident #30 was admitted due to constipation. The MDS Coordinator would be notified of resident changes in the daily team meeting. The MDS Coordinator stated the lack of care plan initiation was an error due to an oversight. An interview with the Director of Nursing (DON) on 08/28/25 at 11:13 AM revealed that she expected the resident's care plans to be accurate and reflect the resident's care needs. If a resident's condition changes, a new care plan should be initiated by the MDS Coordinator. An interview with the Administrator on 08/28/25 at 11:29 AM revealed that it was important that care plans were completed accurately. The Administrator stated the care plan should reflect the clinical condition of the residents, including constipation and wounds.	F0656		