

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Kings Mountain		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Sipes Street Kings Mountain, NC 28086	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006</p> <p>Based on record review, observation, resident, and staff interviews, the facility failed to develop an individualized person-centered comprehensive care plan in the areas of urinary catheter use and opioid (pain medication) use (Resident #89). This deficient practice was for 1 of 5 residents whose comprehensive care plans were reviewed.</p> <p>Findings included:</p> <p>Resident #89 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM), chronic pain, peripheral vascular disease, and obstructive uropathy.</p> <p>a. A review of Resident #89's physician orders revealed an order dated 11/29/2023 for the placement of a urinary catheter due to urinary retention.</p> <p>b. A review of Resident #89's medication orders revealed:</p> <ol style="list-style-type: none"> 1. Tramadol (an opioid) 50 milligrams (mg) twice a day for pain; start date: 11/27/2023. 2. Tramadol 50 mg three times a day for pain; start date: 12/21/2023 3. Tramadol 100 mg every 8 hours for pain; start date: 04/29/2024 <p>A review of Resident #89's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #89 was cognitively intact. The MDS also revealed Resident #89 had an indwelling urinary catheter and received scheduled pain medications.</p> <p>Review of Resident #89's comprehensive care plan dated 02/01/2024 revealed no care plan was developed related to opioid use or a urinary catheter.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation and interview was conducted with Resident #89 on 04/29/2024 at 3:43 PM. Resident #89 was lying in bed watching television. Resident #89 appeared comfortable and did not verbalize any complaints of pain or discomfort. Resident #89 had an indwelling urinary catheter with a privacy bag attached to his bed frame. The catheter bag was off of the floor and draining without difficulties. Resident #89 stated he has had issues with pain for a very long time because he had chronic back pain and bad circulation in his legs. He also stated that he had been working with his doctor who had adjusted his pain medications.</p> <p>Interviews were conducted with the MDS Nurse #1 and MDS Nurse #2 on 05/01/2024 at 2:30 PM. MDS Nurse #1 stated Resident #89's MDS dated [DATE] noted he had a urinary catheter and received opioids (pain medication). MDS Nurse #2 indicated Resident #89 should have been care planned for the use of an indwelling urinary catheter and opioid use. MDS Nurse #1 further stated that she was not sure how the care plans for opioid use and the urinary catheter were overlooked.</p> <p>An interview was conducted with the Regional MDS Coordinator on 05/01/2024 at 2:51PM. The Regional MDS Coordinator stated that the quarterly MDS was accurate, and the Care Area Assessment (CAA) was triggered to proceed to care plan. She further stated that the MDS nurses were relatively new to their roles. She further stated Resident #89's care plan would be updated, and she would work on a process to capture an accurate and correct clinical picture of residents relating to the care plan process.</p> <p>An interview was conducted with the Administrator on 05/01/2024 at 3:10 PM. The Administrator stated she expected the care plan to reflect the resident's clinical condition and care needs.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>37019</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and staff interviews, the facility failed to follow their Hand Hygiene policy and procedure when Nurse #1 failed to sanitize her hands after doffing gloves used to clean stool smears from a resident's rectum and before donning clean gloves to apply treatment to the resident's rectum and then failed to doff her gloves, sanitize her hands and don clean gloves before refastening the resident's brief for 1 of 3 residents (Resident #21) reviewed for incontinence care.</p> <p>The findings included:</p> <p>Review of the facility's Hand Hygiene Policy and Procedure with no date revealed the following statement: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:</p> <p>Before and after assisting a resident with toileting;</p> <p>After contact with a resident's mucous membranes and body fluids or excretions;</p> <p>After removing gloves or aprons;</p> <p>An observation on 04/30/24 at 12:40 PM revealed Nurse #1 came into Resident #21's room to apply hemorrhoid cream to the resident. The resident turned onto her left side, Nurse #1 unfastened her brief and the resident had smears of stool on her rectum. Nurse #1 cleaned the stool from Resident #21's rectal area, doffed her gloves and without sanitizing her hands donned a clean pair of gloves and applied the hemorrhoid cream to Resident #21's rectal area. Nurse #1 without doffing her gloves, sanitizing her hands, and donning new gloves, proceeded to refasten the residents brief and the resident turned back on her back. Nurse #1 then doffed her gloves, sanitized her hands and left the room.</p> <p>An interview on 05/01/24 at 4:38 PM with Nurse #1 was conducted. Nurse #1 stated she should have sanitized her hands after doffing her gloves and before donning clean gloves to apply the hemorrhoid cream to Resident #21. She further stated she should have doffed her gloves, sanitized her hands, and donned clean gloves after applying the treatment and before fastening the resident's brief and positioning her in the bed. Nurse #1 indicated she knew she was supposed to sanitize her hands after doffing her gloves and when moving from a dirty to clean procedure but was nervous and just forgot to do so.</p> <p>An interview on 05/02/24 at 10:52 AM with the Infection Preventionist was conducted. The Infection Preventionist stated Nurse #1 should have doffed her gloves after cleaning the resident, sanitized her hands and donned clean gloves prior to applying hemorrhoidal cream to the resident. She further stated Nurse #1 should have doffed her gloves, sanitized her hands, and donned clean gloves prior to refastening the resident's brief and positioning her for comfort in the bed. The Infection Preventionist indicated this should happen anytime when moving from a dirty to clean procedure and anytime you change your gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 05/02/24 at 10:58 AM with the Director of Nursing (DON) revealed it was her expectation that Nurse #1 sanitized her hands after doffing her dirty gloves and before donning clean gloves to proceed with resident treatment. She stated she also expected Nurse #1 to doff her gloves after applying treatment, sanitize her hands and don clean gloves prior to refastening her brief and positioning Resident #21 in bed. The DON indicated she expected Nurse #1 to sanitize her hands anytime she doffed her gloves and when moving from a dirty to clean procedure with residents.</p>		

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<p>F 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643</p> <p>Based on observations, resident, and staff interviews, the facility failed to provide a privacy curtain for 1 of 14 rooms on the memory care unit reviewed for privacy (room [ROOM NUMBER]).</p> <p>The findings included:</p> <p>Resident #48 was admitted to the facility on [DATE].</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #48 was severely cognitively impaired.</p> <p>An observation of room [ROOM NUMBER] was conducted on 04/29/24 at 10:00 AM and revealed a semi-private room with and the bed next to the door had no privacy curtain hanging.</p> <p>An observation and interview were conducted with Nurse #3 on 04/30/24 at 10:15 AM revealed room [ROOM NUMBER] did not have a privacy curtain hanging. Nurse #3 further revealed housekeeping was responsible for cleaning and changing out curtains in residents' rooms. Nurse #3 indicated she was unable to recall how long room [ROOM NUMBER] had gone without a privacy curtain.</p> <p>An observation and interview conducted with Nurse Aide (NA) #3 on 04/30/24 at 10:20 AM revealed the privacy curtain for the bed next to the door had been torn down by a resident about two to three weeks ago. NA #3 further revealed she had not completed a work order and was going to do it now. NA #3 indicated a work order was completed by entering on the computer and it was sent straight to the Maintenance Director.</p> <p>An interview conducted with Housekeeping Aide #1 on 04/30/24 at 11:35 AM revealed she was aware the privacy curtain in room [ROOM NUMBER] had been torn down. It was further revealed she thought maintenance was aware and was going to fix Resident #48's privacy curtain and had not completed a work order.</p> <p>An interview conducted with the Director of Maintenance on 05/01/24 at 2:30 PM revealed he was not aware the privacy curtain in room [ROOM NUMBER] had been torn down because no staff had completed a work order. It was further revealed a work order can be completed by any staff and should have been completed and the curtain would have been put back up immediately.</p> <p>An interview conducted with the Administrator on 05/01/24 at 11:15 AM revealed she expected residents to have privacy and privacy curtains to be in place. It was further revealed a work order should have been completed and the privacy curtain should have been put back up in a timely manner.</p>		