STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. Building B. Wing	05/23/2024

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

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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review, resident interview, and staff interviews the facility failed to safely transfer a resident when Nurse Aide (NA) #3 and NA #4 transferred Resident #240 resident from the bed to the wheelchair. During the transfer the resident reported pain and stated her knee had popped. Resident #240 was sent to the emergency room (ER) and x-ray results indicated a right horizontal fracture involving the superior patella (a break in the upper part of the kneecap) with large knee joint effusion. Resident #240 was discharged back to the facility the same day with an immobilizer and a follow up appointment with .This occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #240). The findings included: Resident #240 was admitted to the facility on [DATE] with diagnoses which included dementia. Review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #240 was moderately cognitively impaired and was dependent for transfer and required two people assist. Review of Resident #240's Kardex which explained the resident's transfer status indicated the resident was a two person assist with a gait belt since admission on 04/25/24. Review of Resident #240's physical therapy note dated 04/26/24 revealed Resident #240 was dependent for chair to bed and bed to chair transfers and required maximal assistance for sit to stand transfers. Interview conducted with the Director of Therapy on 05/22/24 at 10:10 AM revealed Resident #240 was admitted from the hospital as a two people assist with a gait belt and was assessed on 04/26/24 by therapy and was dependent for transfers. The Director of Therapy stated the resident was limited weight bearing and continued to require two people assist with a gait belt or a Hoyer lift. The Director of Therapy further revealed transferring Resident #240 without a gait belt was unsafe and nursing staff had been educated on how to properly transfer residents. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A written statement completed by NA #3 on 05/03/24 revealed on 05/02/24 NA #3 and NA #4 entered Resident #240's room and the resident was sitting on the side of the bed with family wanting to assist the resident to the bedside commode. The statement further revealed Resident #240 was okay to be transferred from the bed to the wheelchair to be weighed. NA #3 indicated before Resident #240 sat in the wheelchair she plotted down, and her leg was under the wheelchair. The statement revealed NA #3 and NA #4 took Resident #240 to be weighed and then put her back in the bed. NA #3's written statement revealed Resident #240 stated her knee was hurting and they had received a footrest for the resident's wheelchair before going to be weighed. Interview conducted with NA #3 on 05/21/24 at 4:20 PM revealed on 05/02/24 she and NA #4 went into Resident #240's room to get the resident to be weighed. Resident #240 was sitting in the side of the bed with family present with the bedside commode nearby when they entered the room. NA #3 indicated the family left the room and they assisted the resident from the bed to the wheelchair to be taken to get her weight. NA #3 revealed she and NA #4 stood Resident #240 by the arms without a gait belt and started to turn the resident to be able to sit down but the resident lost her balance and fell back in the wheelchair. NA #3 stated Resident #240's right foot ended up behind and underneath the chair. NA #3 revealed Resident #240 started to scream in pain and stated that her knee popped. The NA indicated Nurse #4 was notified and assessed Resident #240 and instructed NA #3 to get a leg rest for the wheelchair to put the resident ' s right leg on. NA #3 revealed Resident #240 continued to complain of pain, but they were instructed by Nurse #4 to weigh the resident after she was assessed. NA #3 indicated Resident #240 was weighed and assisted back into bed by Nurse #4 and Nurse #3. NA #3 indicated Resident should have had a gait belt when transferred and they failed to do so because they were in a hurry. A phone interview conducted with Nurse Aide (NA) #4 on 05/21/24 at 1:50 PM revealed on 05/02/24 she and NA #3 were instructed by Nurse #4 to get Resident #240's weight. NA #4 further revealed the resident was sitting on the side of the bed with family present when they entered the room. NA #4 indicated the family left the room and NA #3 and NA #4 changed Resident #240's brief and transferred the resident from the bed to the wheelchair. NA #4 stated Resident #240 stood up assisted by both NAs and when the resident went to turn the resident fell back into the chair and Resident #240's right leg was bent back behind. NA #4 indicated Resident #240 stated my knee hurts bad, and something popped. Nurse #4 assessed the resident and placed Resident #240's right leg on a wheelchair leg rest and instructed for the NAs to weigh the resident after she was assessed. NA #4 indicated Resident #240 continued to complain of pain while being weighed. NA #4 revealed Nurse #4 and Nurse #3 put the resident back to bed. NA #4 stated she and NA #3 did not use a gait belt to transfer Resident #240 because they were in a hurry and should have because the resident was unable to hold her own weight and her Kardex required a two person transfer with a gait belt. A phone interview conducted with Nurse #4 on 05/22/24 at 8:55 AM revealed on 05/02/24 a NA reported Resident #240 was complaining of leg pain and heard a pop in her leg. Nurse #4 stated she observed Resident #240 in her wheelchair and was complaining of pain in both of her legs. Nurse #4 indicated she assessed Resident #240 but could not recall if she instructed NA #3 and NA #4 to obtain a footrest, the outcome of the assessment, or if she assessed the resident before or after she was weighed. Nurse #4 indicated she did not complete an incident report but did notify the Assistant Director of Nursing (ADON) due to being at shift change. Nurse #4 was unable to share any further details of what occurred on 05/02/24 with Resident #240. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A written statement completed by Nurse #3 on 05/03/24 revealed on 05/02/24 Resident #240 stated that her right knee hurt, and the RR indicated it occurred during a transfer. The statement indicated the on call was notified and a STAT (immediate) x-ray was ordered, and a lidocaine patch was placed on the resident ' s knee for pain. Nurse #3's statement indicated the family requested for Resident #240 to be sent out to the ER and the on call provided an order for the resident to be sent out. Review of progress note dated 5/2/24 completed by Nurse #3 revealed Resident #240's resident representative (RR) reported the resident had complained of knee pain and that her knee popped when being transferred from the bed to the wheelchair. The on-call provider was contacted, and a STAT x-ray was ordered for Resident #240's right knee and the RR was notified. The note indicated Resident #240 received pain medication and a lidocaine patch that was applied to the knee for pain. Nurse #3 documented an estimated time of an hour and half later Resident #240's RR was concerned about the results and wanted the resident to be sent out to the hospital. The on-call was contacted again and an order was obtained to send out Resident #240 to the emergency room (ER) per RR request. A phone interview conducted with Nurse #3 on 05/22/24 at 8:30 AM revealed on 05/02/24 she arrived at the facility after the incident at shift change. Nurse #3 indicated Nurse #4 shared to monitor Resident #240's knee due to the resident stating her knee felt tight during a transfer. Nurse #3 recalled being on shift for about 45 minutes and Resident #240's RR asked her to assess Resident #240 right leg. Nurse #3 indicated Resident #240's right knee was swollen, and the resident had complained of pain. Nurse #3 further revealed she contacted and notified the on-call provider and a STAT order for an x-ray was put in. Nurse #3 revealed Resident #240's RR did not want to wait any longer and requested the resident go out to the hospital. Nurse #3 revealed on call was contacted again and the resident was sent to the ER per family request. Review of the ER report dated 05/02/24 revealed Resident #240 arrived from the facility with a right knee pain she sustained from the facility while being transferred from bed to a wheelchair. The note further revealed it was reported the resident heard a pop, and the family would like an x-ray to be completed. It was documented Resident #240 had history of osteopenia but no significant degenerative joint disease. Results of x-rays revealed an acute appearing horizontal fracture involving the superior patella (a break in the upper part of the kneecap) with large knee and joint effusion (fluid built up in between joints causing swelling). Resident #240 was discharged back to the facility on [DATE] with an immobilizer. The note indicated a referral was completed for the resident to follow up with an orthopedic provider. Review of the occurrence reported completed by Nurse #5 on 05/03/24 revealed Resident #240 went to the emergency room (ER) to have right knee evaluated which resulted in a non-displaced fracture to the right patella per report. The resident returned wearing an immobilizer and the Program of All-Inclusive Care for the Elderly (PACE) to schedule an ortho appointment. Recommended interventions revealed Resident #240 was to be changed to a total lift with two people assisting. A phone interview conducted with Resident #240 on 05/21/24 at 10:30 AM revealed she had dementia and sometimes got confused but recalled two staff members helping her get in her wheelchair from her bed. The resident stated when staff transferred her it happened fast and when she sat down in her wheelchair her knee hurt bad. The resident indicated staff pushed her out the room after it happened. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A phone interview conducted with Resident #240's resident representative (RR) on 05/21/24 at 10:40 AM revealed family had visited the resident, and two staff members came into the resident ' s room to take her to get weighed. The RR further revealed he was out in the hall and heard Resident #240 yell oh, my leg. When Resident #240 exited her room, it was observed the resident's right leg was placed in a leg rest on the wheelchair with staff pushing her to be weighed. The RR indicated staff reported that the resident's leg was not straight when she sat down, and her leg went back behind the wheelchair. The RR indicated they observed Resident #240 to have facial expressions of being in pain. The resident continued to complain of pain while they took the resident to get weighed. The RR revealed after the staff weighed Resident #240, they put the resident into bed and a Nurse assessed the resident. The Nurse stated she would keep an eye on the resident's knee to make sure it was not swelling. Interview conducted with the Assistant Director of Nursing (ADON) on 05/21/24 at 2:15 PM revealed she was not in the facility on 05/02/24 at the time of the incident and Nurse #3 contacted her and told her that Resident #240 had complained of knee pain and the RR wanted the resident sent out to the ER. The ADON advised Nurse #3 to contact the on call and provide the information. The ADON indicated she was not aware that the injury could have been as a possible result of the transfer until Monday 05/06/24 after speaking to staff. The ADON stated when Resident #240 was transferred staff should have been aware if Resident #240 ' s legs and feet were straight, and the resident legs should have not been bent behind. Interview conducted with the Director of Nursing (DON) on 05/21/23 at 2:30 PM revealed she was not present at the facility at the time of the incident and was not aware of Resident #240 was sent out to the ER until 05/03/24 during morning meeting. The DON further revealed she was not aware the NAs did not use a gait belt during the transfer. The DON stated Resident #240 was a dependent two person assist with gait belt and a gait belt should have been used. The DON indicated if a gait belt was used and used properly the resident wouldn't have fallen in the wheelchair. The DON revealed no in service or education was conducted with staff after the incident because she was not aware the transfer was not done correctly.