

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Shelby		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045</p> <p>Based on observations, record review, resident, and staff interviews the facility failed to provide nail care for a dependent resident for 1 of 3 residents (Resident #2) reviewed for activities of daily living (ADL).</p> <p>The findings included:</p> <p>Resident #2 was readmitted to the facility on [DATE] with diagnoses which included dementia and muscle weakness.</p> <p>Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was moderately cognitively impaired, required maximum assistance for bathing and supervision for personal hygiene.</p> <p>A care plan dated 9/4/2024 revealed Resident #2 required assistance for all activities of daily living (ADL) related to weakness secondary to non-traumatic intracranial hemorrhage.</p> <p>An observation and interview were conducted on 10/17/2024 at 9:10 am of Resident #2. Resident #2 was observed with 1/4 inch long jagged fingernails on all ten fingers with a brown substance underneath all ten nails. Resident #2 stated the only time her nails were trimmed or cleaned, was when she went to activities.</p> <p>An observation was conducted on 10/17/2024 at 3:25 pm of Resident #2. Resident #2's fingernails remained 1/4 inch long, jagged, with a brown substance underneath all ten fingernails.</p> <p>An interview was conducted on 10/18/2024 at 11:19 am with Nurse Aide (NA) #2. NA #2 stated she worked first shift, 7:30 am to 3:00 pm, on 10/17/2024. NA #2 stated that she was not assigned Resident #2, however, she had assisted NA #3 with giving a bed bath. NA #2 stated that NAs were allowed to perform nail care, including cleaning and cutting, and stated that she had not provided fingernail care for Resident #2 because she was only assisting with bathing the resident.</p> <p>An interview was conducted on 10/18/2024 at 12:22 pm with NA #3. NA #3 stated that she worked first shift, 7:00 am to 3:00 pm, on 10/17/2024 and was assigned Resident #2. NA #3 stated she had only worked at the facility for a few weeks. NA #3 stated NA #2 assisted her in giving Resident #2 a bed bath on 10/17/2024. NA #3 stated she had not performed fingernail care for Resident #2 because she had not been taught/instructed to perform fingernail care since she started at the facility.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Shelby		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 10/18/2024 at 12:04 pm with the Director of Nursing (DON). The DON stated that NAs were responsible for performing fingernail care for residents on an as needed basis. The DON stated that she was not aware that Resident #2 had 1/4 inch, jagged fingernails with a brown substance underneath. The DON stated her fingernails should have been cut and cleaned.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Shelby		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50045</p> <p>Based on observations, record review, and staff interviews, the facility failed to establish policies and procedures for standard and transmission-based precautions and failed to implement Enhanced Barrier Precautions (EBP) when providing urinary catheter care for 1 of 3 staff members reviewed for infection control practices (Nurse Aide #1).</p> <p>The findings included:</p> <p>A review of the facility's Infection Control policies and procedures revealed no policy and procedure for Enhanced Barrier Precautions (EBP).</p> <p>Review of a care plan dated 9/12/2024 revealed Resident #1 had an indwelling catheter with interventions which included to utilize Enhanced Barrier Precautions (EBP) per facility protocol.</p> <p>An observation was conducted on 10/17/2024 at 3:35 pm. Resident #1 had an EBP sign which stated everyone should clean their hands before entering and after leaving the room. All healthcare personnel must wear gloves and gown for the following high-contact activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of a central line/urinary catheter/feeding tube/tracheostomy, and/or wound care (any skin opening requiring a dressing). A personal protective equipment (PPE) caddy was hanging outside of the door. Nurse Aide (NA) #1 was observed sanitizing her hands prior to entering Resident #1's room. NA #1 washed her hands, put on clean gloves, and proceeded to provide urinary catheter care.</p> <p>An interview was conducted on 10/17/2024 at 3:45 pm with NA #1. NA #1 stated she was trained on infection control when she was hired. NA #1 stated EBP were used when a resident had a common cold and sometimes for a wound. NA #1 stated that she had seen the EBP sign and caddy on the outside of Resident #1's door but was not sure why it was there. NA #1 stated Resident #1 did not have a wound and did not have any respiratory symptoms which is why she did not wear a gown when providing indwelling urinary catheter care. NA #1 was unaware that EBP was utilized for residents with an indwelling urinary catheter. NA #1 stated that she had received education about EBP.</p> <p>An interview was conducted on 10/17/2024 at 3:48 pm with Nurse #1. Nurse #1 stated EBP was utilized when a resident had an indwelling urinary catheter or a wound. Nurse #1 stated staff should wear a gown, mask, and gloves when providing direct care including indwelling urinary catheter care. Nurse #1 stated Resident #1 had an indwelling urinary catheter and a wound. Nurse #1 stated a mask, gown, and gloves should have been worn when providing indwelling urinary catheter care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Shelby		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview was conducted on 10/18/2024 at 8:32 am with the Assistant Director of Nursing (ADON). The ADON stated that she was also the Staff Development Coordinator (SDC) and the Infection Preventionist (IP). The ADON stated that during orientation, staff were educated about EBP. The ADON stated staff were taught to look for precaution signage on the outside of the resident's room and were to follow what the signage said. The ADON stated staff was taught to ask for clarification if they had any questions regarding EBP. The ADON stated she had not performed audits of donning/doffing PPE and would provide additional training for staff if there were any issues. The ADON stated gloves and a gown, should be worn when providing direct care to a resident with an indwelling urinary catheter or a wound. The ADON stated NA #1 should have worn a gown and gloves when she provided indwelling urinary catheter care for Resident #1.</p> <p>An interview was conducted on 10/18/2024 at 10:45 am with the Director of Nursing (DON). The DON stated EBP were new, and staff were educated when the facility began to implement EBP. The DON stated EBP were used for residents who had an indwelling urinary catheter, intravenous catheter (IV), wounds, or received tube feeding. The DON stated a gown, and gloves were to be worn when providing direct care to a resident on EBP. The DON stated there was a sign and PPE on the door if a resident was on EBP and the ADON was responsible for placing EBP signage. The DON stated a gown, and gloves should have been worn when staff provided indwelling urinary catheter care. The DON stated that there were no policies or procedures for EBP and stated that their corporate office had instructed them to go by Center for Disease Control (CDC) guidelines.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER White Oak Manor - Shelby		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>50045</p> <p>Based on staff interviews the facility failed to designate a qualified Infection Preventionist (IP) who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Control Program. The deficient practice had the potential to affect 105 of 105 residents at the facility.</p> <p>The findings included:</p> <p>An Entrance Conference was conducted on 10/17/2024 at 8:40 am with the Administrator. The Administrator stated the Assistant Director of Nursing (ADON) was the Infection Preventionist (IP).</p> <p>An interview was conducted on 10/18/2024 at 8:30 am with the Administrator. The Administrator stated that the ADON had immediately stepped into the IP role after the previous IP left on 7/25/24. The Administrator stated the facility had not had a qualified IP since 7/25/2024. The Administrator stated she had signed the ADON up for the Statewide Program for Infection Control and Epidemiology (SPICE) training on 10/17/2024 after she realized that the ADON not being SPICE trained might be an issue. The Administrator stated there were only two SPICE training classes per year and she signed the ADON up to take the class that started on 11/4/2024. The Administrator stated that she had every intention of enrolling the ADON in SPICE training but had just not signed the ADON up.</p> <p>An interview was conducted on 10/18/2024 at 8:32 am with the ADON. The ADON stated she began the role of IP immediately after the previous IP left. The ADON stated that she had not received any training for her role as an IP. The ADON stated a consultant did not come to the facility routinely but whenever she had a question about something related to Infection Control, she would call and ask a corporate consultant. The ADON stated the Administrator signed her up on 10/17/2024 to take SPICE training and she would attend training on 11/4/2024 through 11/6/2024. The ADON stated that she had no primary training in epidemiology or infection prevention/control.</p> <p>An interview was conducted on 10/18/2024 at 10:05 am with the Director of Nursing (DON). The DON stated that after the previous IP left, the ADON stepped into the IP role. The DON stated she had taken SPICE training more than five years ago but did not have a copy of her certification and was not able to obtain a copy.</p>		