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	07/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Resident Representative, and staff interviews, the facility failed to provide dignity for a cognitively impaired resident who waited for incontinence care to be provided. Resident #1 was severely cognitively impaired and Resident Representative stated that Resident #1 would have felt awful and embarrassed when left in wet brief without incontinence care. This deficient practice affected 1 of 3 resident sampled for dignity and respect (Resident #1).The findings included:Resident #1 was admitted to the facility on [DATE]. Resident #1's diagnoses included dementia, cystitis with hematuria (inflammation of the bladder with bleeding), and overactive bladder. Resident #1 was discharged on 07/02/2025.An annual Minimum Data Set (MDS) dated [DATE] indicated Resident #1 was severely cognitively impaired. MDS further indicated she required extensive assistance for toileting, bathing, and personal hygiene. Resident #1 was always incontinent of urine.A review of Resident #1's care plan revealed a plan initially dated 09/19/23 and revised 06/25/25 for urinary incontinence. Stated goal was Resident #1 would have no urinary discomfort. Interventions included administer medications and monitor for medication effectiveness, provide incontinence care, and monitor for bladder discomfort.A review of facility grievances revealed a grievance for Resident #1 dated 01/13/25. Grievance revealed the Resident Representative reported incontinence care was not provided for hours on 1st shift 01/11/25. Investigation was completed by previous Director of Nursing (DON) and Social Worker. Investigation notes indicated that NA #5 received disciplinary action for failing to provide care. Folow-up with Resident #1's Representative was completed by Social Worker at care plan meeting on 01/16/25. Follow-up stated that all questions were addressed, and no new concerns were identified. A care plan meeting was scheduled. Grievance was signed completed by the Administrator on 04/04/25.An interview statement with Resident #1's Representative dated 01/13/25 was completed by Social Worker. The statement revealed Resident #1's Representative had visited on 01/11/25 and at 1:00 PM, inquired to Nurse #2 about Resident #1's hematuria. When Nurse #2 asked NA #5 about Resident #1's urine that day, NA #5 responded to Nurse #2 and Resident Representative that she had not yet provided incontinence care to Resident #1 during her shift which began at 7:00 AM. Incontinence care was provided for Resident #1 by NA #5 and NA #1.An interview with the Resident Representative on 07/16/25 at 12:14 PM revealed concerns Resident #1's incontinence care was not performed 01/11/25. Resident Representative stated that NA #5 had not change Resident #1 during NA #5's shift until asked to do so at 1:00 PM. Resident Representative stated she was satisfied with the facility's resolution of grievance and reported no further concerns about Resident #1's incontinence care.A review of NA #5's personnel file revealed a hire date of 10/15/24. Documented counseling form dated 01/17/25 described the reason for counseling was employee failed to provide incontinent care to resident for an overly extended amount of time on 01/11/25.NA #5 was not available for interview.A telephone interview with NA #1 on 07/16/25 at 11:36 AM revealed that she could not recall the specific date of 01/11/25. NA #1 stated that she could not recall any specific concerns about Resident #1's care.A review of Nurse #2's written statement dated 01/12/25 revealed that Resident #1 was not changed on 7:00 AM to 3:00 PM shift until NA #5 was asked to change Resident #1.Interview with Nurse #2 on 07/16/25 at 2:24 PM who provided care for Resident #1 on 01/11/25. Nurse #2 stated that she could not specifically recall the 01/11/25 shift. Nurse #2 stated that although she could not recall that specific date, Nurse #2 had to remind NA #5 often to provide incontinence care to residents including Resident #1. Nurse #2 indicated she verbalized her concerns to previous Director of Nursing (DON) who no longer worked at the facility but could not recall specific date or time of report.A telephone interview on 07/16/25 at 4:16 PM with NA #6 revealed she worked on 01/11/25 from 3:00 to 11:00 PM and was assigned to care for Resident #1. She stated she was familiar with Resident #1's care. NA #6 stated that she would often follow behind NA #5 who worked from 7:00 AM to 3:00 PM. When NA #6 arrived after NA #5, Resident #1 was often in her bed and her bed sheets would be saturated in urine with a brown ring around Resident #1. NA #6 reported that NA #5 left at 3:00 PM on 01/11/25. NA #6 stated that she would make a point to check Resident #1 first on rounds because NA #5 would not change her. NA #6 had previously verbalized concerns to nurses when Resident #1 was left with wet brief by NA #5 but could not recall specific nurses or times. NA #6 indicated that she could not recall if Resident #1 was left with wet brief on 01/11/25 and could not recall any specific concerns that day.An interview with Social Worker on 07/16/25 at 4:33 PM revealed that the grievance investigation indicated Resident #1 was left wet with urine on 01/11/25. The Social Worker stated that she

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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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and Nurse Practitioner interviews, the facility failed to provide care in a safe manner when Resident #1, who had a history of falls, slid out of a standard wheelchair onto the floor. The standard wheelchair was not the wheelchair Resident #1 was care planned to use when out of bed. Resident #1 later complained of pain and an x-ray revealed a femur fracture. Resident #1 was transferred to the hospital and diagnosed with a femur and knee fracture. The deficient practice occurred for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1).Resident #1 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, Parkinson's, type 2 diabetes mellitus, acute congestive heart failure, low back pain, other chronic pain, vitamin D deficiency, hypomagnesemia, major depressive disorder, unspecified atrial fibrillation, anxiety disorder, pain unspecified.Review of Resident #1's medical record revealed Resident #1 had received hospice services that started on 1/27/2025 related to end stage Parkinson's disease. On 2/18/2025 documentation revealed hospice services would not cover Resident #1's intravenous antibiotic therapy, and Resident #1's family agreed to revoke hospice services. Palliative services were requested by Resident #1's family on 2/21/2025, and a referral for Palliative services was sent on 2/24/2025. Review of Resident #1 physician's orders revealed active orders that read: Eliquis 5 milligram (mg) tablet one tablet by mouth every 12 hours for atrial fibrillation. Tramadol 50mg one tablet by mouth three times daily for chronic pain. Acetaminophen 325 mg tablet two tablets by mouth every 4 hours as needed for chronic pain.Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was severely cognitively impaired and indicated Resident #1 had impairment with range of motion for bilateral lower extremities, used a wheelchair for mobility, used a mechanical lift for transfers, required partial/moderate assist with rolling left and right in bed, and was dependent on staff for all other activities of daily living and mobility, and indicated Resident #1 received anticoagulant (blood thinner) medication. Review of Resident #1's comprehensive care plan last reviewed 6/25/2025 revealed Resident #1 was care planned at risk for falls due to narcotic use and dependence with mobility and history of falls with major injury with interventions that included: High back wheel chair with foam wedge cushion, elevating leg rests, and drop leg pad, when out of bed, assess transfer status as needed. Review of a progress note written by Nurse #1 on 7/1/2025 at 5:50 PM revealed Nurse #1 was called to Resident #1's room on 7/1/2025 at 2:45 PM by Nursing Assistant (NA) #1 and found Resident #1 lying on the floor in front of her wheelchair. NA #1 reported Resident #1 was sliding out of the wheelchair and NA#1 assisted Resident #1 to the floor. Resident #1 was assessed; range of motion was completed without complaint of pain. Resident #1 was transferred from the floor to the bed using the mechanical lift. Nurse #1 completed a skin audit and found no injuries. Family and provider were notified, and Resident #1 had no further complaints.During an interview on 7/16/2025 at 10:48 AM NA #1 stated on 7/1/2025 she worked from 7:00 AM to 3:00 PM and cared for Resident #1. NA #1 was told Resident #1 needed to be up in the wheelchair to go to a hair appointment. NA #1 stated she didn't normally work with Resident #1, and there were three chairs in Resident #1's room, a recliner and two wheelchairs. NA #1 stated NA #2 told her which wheelchair to use and it was the one that did not have a high back or attachments on the leg rests. NA #1 and NA#2 transferred Resident #1 into the standard wheelchair. NA #1 stated the hairdresser took Resident #1 to the beauty shop and brought Resident #1 back to her room when the hair appointment was finished. NA #1 stated she saw Resident #1 was back in her room around 2:35 PM, and Resident #1 requested to be put back in bed. NA #1 prepared Resident #1 to be transferred back to bed with the mechanical lift. NA #1 stated she brought the mechanical lift into Resident #1's room, positioned Resident #1 in the wheelchair next to the wall, locked the wheelchair and adjusted the footrests to the sides of the wheelchair and waited for another staff to assist with the transfer. NA #1 stated she noticed Resident #1 had started to slide out of the wheelchair. NA #1 stated she attempted to keep Resident #1 from sliding out of the wheelchair but was unable to reposition Resident #1 back into the wheelchair, and NA #1 assisted Resident #1 to the floor. NA #1 stated Resident #1's legs did not go behind her or under the wheelchair. NA#1 stated Resident #1's right leg went down straight in front of Resident #1 and her left leg bent out to the side. NA #1 stated it did not look out of place, and that Resident #1's left leg normally had a slight bend out and did not ever completely straighten out. NA #1 stated she called for a nurse to assess Resident #1. NA #1 stated Resident #1 was assessed by the nurses and no injury was noted. NA #1 stated after the nurse assessed Resident #1, she