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	08/28/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses that included epilepsy (seizure disorder). Review of Resident #8’s quarterly MDS assessment dated [DATE] revealed Resident #8 was cognitively intact and used restraints (bedrails) on a daily basis. Review of the Bed Rail assessment dated [DATE] 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 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. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE] 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 [DATE]. Review of Resident #15’s quarterly MDS assessment dated [DATE] 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 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 [DATE] 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. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #35’s quarterly MDS assessment dated [DATE] revealed Resident #35 was coded to have sustained no falls with major injury. 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses which included type 2 diabetes and constipation.An admission Minimum Data Set (MDS) assessment dated [DATE] 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 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.