STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE OAKS AT WHITAKER GLEN-MAYVIEW	**513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608**

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 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review the facility failed to provide a C-PAP brought to the facility from home for 1 of 1 resident reviewed for accommodation of needs. (Resident #1) Findings included: Resident #1 was admitted to the facility on [DATE]. Review of Resident #1 ' s minimum data set assessment dated [DATE] revealed he was assessed as cognitively intact. He had no moods or behaviors. His medical [DIAGNOSES REDACTED]. Review of Resident #1 ' s care plan dated 8/5/2020 revealed he was at risk for recurrent pneumonia respiratory distress. The interventions included to monitor for signs and symptoms of adverse reactions to medications, administer medications as ordered, oxygen as ordered, encourage fluids, and listen to lungs as ordered or indicated and notify the physician if condition worsen. Review of a nursing note dated 8/2/2020 revealed Resident #1 ' s daughter called Nurse #1 voicing her concern that Resident #1 was supposed to wear a C-PAP at night which she delivered 8/1/2020 but he was never given the C-PAP that night. Nurse #1 checked on the C-PAP and noted, due to COVID19 pandemic, any belonging received from family had either stay quarantined for 24 hours or sanitized before entering facility. Nurse #1 found the C-PAP machine still in quarantine from the day before, cleaned the C-PAP, delivered it to Resident #1, and acquired an order for [REDACTED].#1 had been sleeping poorly and he had used a C-PAP at home. She stated she was at the entrance waiting for a nurse to complete discharging a resident. Once it was completed, she then asked the nurse to take the C-PAP into the facility and stated she was told it would get cleaned and he would have it that night. She further stated the next day she discovered from Resident #1 that he did not have his C-PAP that night so she called the facility and spoke to a nurse who then went and found the C-PAP was in quarantine for 24 hours and had not been disinfected the day prior. She concluded she did not think it was appropriate for medical equipment to be held for 24 hours instead of disinfected and given to him upon arrival. During an interview on 8/17/2020 at 3:02 PM Administrative Assistant stated normally when a C-PAP is dropped off she disinfects it with Clorox wipes and takes it to the room and lets the nurse know. She stated she did work on 8/1/2020 and is the COVID19 door monitor and screener. She stated she did not remember Resident #1 family member dropping off a C-PAP and was unsure why it was left in the 24-hour holding area until the next day where the nurse found it. She concluded she did not remember anyone informing her of a C-PAP that needed to be disinfected and brought to Resident #1. During an interview on 8/17/2020 at 3:13 PM Nurse #1 stated Resident #1 was admitted and did not have an order for [REDACTED]. He told her he would get it and clean it. He got the C-PAP from outside and got an order for [REDACTED].#2 stated she could not remember the date, but a family member did at one point drop off a C-PAP and distilled water for a resident. She stated she did not remember who the resident was but she told the family member it would be placed in the vestibule area of the facility until the person observing the door could disinfect it and then it would be given to the resident. She concluded she left it in the location that items brought for family was quarantined and informed the Administrative Assistant of the C-PAP and returned to work. She did not know if the resident got the C-PAP that day or not. During an interview on 8/17/2020 at 2:07 PM the Director of Nursing stated medical equipment including C-PAPs must be disinfect and brought in the facility, not left in 24-hour quarantine. She concluded it should have been disinfected and brought to Resident #1 on 8/1/2020.

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